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National HIV Testing Day — June 27, 2000

The National Association of People with AIDS will sponsor the 6th annual National HIV Testing Day on June 27. National HIV Testing Day is a nationwide campaign promoting human immunodeficiency virus (HIV) education and voluntary HIV counseling, testing, and referral to encourage persons at risk for HIV infection to know their HIV status and reduce their risks for HIV transmission.

Public health and other partners are encouraged to support community HIV education and counseling, testing, and referral efforts during the week of June 27. Activities can include sponsoring mobile HIV counseling, testing, and referral units; participating in health fairs where HIV education, counseling, testing, and referral are offered; and partnering with local media to promote HIV-prevention messages.

Additional information about HIV counseling, testing, and referral services is available on the World-Wide Web at http://www.hivtest.org*.

*References to sites of non-CDC organizations on the World-Wide Web 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.

National HIV Testing Day at CDC-Funded HIV Counseling, Testing, and Referral Sites — United States, 1994–1998

CDC-funded human immunodeficiency virus (HIV) counseling, testing, and referral sites are an integral part of national HIV prevention efforts (*1*). Voluntary counseling, testing, and referral opportunities are offered to persons at risk for HIV infection at approximately 11,000 sites, including dedicated HIV counseling and testing sites, sexually transmitted disease (STD) clinics, drug-treatment centers, hospitals, and prisons. Services also are offered to women in family planning and prenatal/obstetric clinics to increase HIV prevention efforts among women and decrease the risk for perinatal HIV transmission. To increase use of HIV counseling, testing, and referral services by those at risk for HIV infection, in 1995, the National Association of People with AIDS designated June 27 each year as National HIV Testing Day. This report compares use of CDC-funded counseling, testing, and referral services the week before and the week of June 27 from 1994 through 1998 and documents the importance of a national public health campaign designed to increase knowledge of HIV serostatus.

National HIV Testing Day — Continued

The HIV Counseling and Testing System (CTS) collects demographic and HIV risk information, laboratory test results, and return for post-test counseling from each HIV test episode in a CDC-funded counseling, testing, and referral site. CTS records contain no personal identifying information and it is not possible to link the results of repeat tests for the same person. Results from the system are summarized as number of HIV testing episodes rather than number of persons tested, and the proportion positive reflects the number of positive tests divided by the number of tests provided.

Data were available for analysis from 43 reporting areas. The observation period included tests conducted the week before National HIV Testing Day and the week of testing day: 79,133 tests (1555 positive) in 1994, 81,903 tests (1474 positive) in 1995, 88,077 tests (1453 positive) in 1996, 77,351 tests (1317 positive) in 1997, and 77,965 tests (1210 positive) in 1998 (Table 1).

In 1994, before the initiation of National HIV Testing Day, the number of HIV tests the week of June 27 was lower than the preceding week (Table 1). From 1995 to 1998, the number of tests during the week of National HIV Testing Day was higher than the preceding week. The overall percentage of HIV-positive tests declined during testing day week compared with the preceding week, primarily because of the higher number of tests reported during the week of testing day, with the exception of 1995 (Table 1). However, each year, the number positive HIV tests was higher the week of National HIV Testing Day than the week before testing day (range: 21–78 additional HIV-positive tests).

Use of CDC-funded HIV counseling, testing, and referral services varied by day of the week, with highest use in each year reported on Mondays through Thursdays, moderate use on Fridays, and lowest use on weekends when most sites are closed. In 1997 and 1998, National HIV Testing Day fell on a Friday and a Saturday, respectively. Despite the usual drop in demand for testing at the end of the week, testing on June 27 represented the highest level of tests reported for a Friday and Saturday in each respective year, with 8455 tests in 1997 (median: 5578.5) and 2707 tests in 1998 (median: 638.5). In 1995 and 1996, National HIV Testing Day fell on a Tuesday and Thursday, respectively, with both days in the top 10 of all Tuesdays and Thursdays in each respective year. The number of tests reported for Monday, June 27, 1994 (the year before initiation of testing day), was below the median number of tests reported for Mondays in 1994 (n=7958; median: 8081).

TABLE 1. Number of HIV tests and number of HIV-positive tests in CDC-funded HIV counseling, testing, and referral sites, from the week before and the week of National HIV Testing Day, June 27 — United States, HIV Counseling and Testing System, 1994–1998

	Year				
Time of tests	**1994**	**1995**	**1996**	**1997**	**1998**
Week before June 27					
No. tests	39,982	39,922	41,592	36,382	36,221
No. HIV-positive tests	825	698	698	648	570
% Positive	2.06%	1.75%	1.68%	1.78%	1.57%
Week of June 27					
No. tests	39,151	41,981	46,485	40,969	41,744
No. HIV-positive tests	730	776	755	669	640
% Positive	1.86%	1.85%	1.62%	1.63%	1.53%
No. additional tests	—	2,059	4,893	4,587	5,523
No. additional HIV-positive tests	—	78	57	21	70

National HIV Testing Day — Continued

From 1995 to 1998, during the National HIV Testing Day program, post-test counseling rates were comparable between the 2 weeks. The percentage of all HIV-negative test events with completed post-test counseling ranged from 72.7% to 78.8%, and the percentage of all HIV-positive test events with completed post-test counseling ranged from 80.8% to 85.9%.

Reported by: A Farmer, MBA, National Association of People with AIDS, Washington, DC. Prevention Svcs Research Br and Statistics and Data Management Br, Div of HIV/AIDS Prevention–Surveillance and Epidemiology, and Community Assistance, Planning, and National Partnerships Br, Div of HIV/AIDS Prevention–Intervention Research and Support, National Center for HIV, STD, and TB Prevention, CDC.

Editorial Note: The findings in this report indicate that from 1995 through 1998, use of CDC-funded HIV counseling, testing, and referral services increased during a national campaign designed to promote knowledge of a person's HIV serostatus. The National Association of People with AIDS, in coordination with other national HIV-prevention partners and AIDS care and service providers, provided campaign and media kits to state and local service providers during each year of the campaign. Social marketing and media tools were designed to increase actual use of counseling, testing, and referral services by those persons already infected with HIV but undiagnosed, and those at risk for acquiring HIV infection. Although the number of testing episodes and HIV-positive tests increased each year of the campaign, the capacity of the facilities providing services was not exceeded. Post-test counseling rates for the 2 weeks were similar, with a higher percentage of post-test services provided when an HIV-positive test was reported.

The findings in this report are subject to at least three limitations. First, because CTS is based on each encounter in an HIV counseling, testing, and referral site, the number of positive tests is not the same as the number of persons who tested positive because some persons may have tested multiple times. However, the number of repeat episodes during a 2-week period probably was small. Second, the population accessing services at publicly funded sites may not be representative of all persons tested for HIV infection during the observation period because most HIV tests are completed in the private sector (*2,3*). Finally, the choice of the observation time (i.e., the week before test day and the week of test day) was made to minimize the effects of service variation caused by season, day of the week, and holidays. Because some areas initiate information campaigns as early as 3 weeks before National HIV Testing Day, this compressed period may not account for all activity.

The benefits of early knowledge of HIV serostatus are greater now than at any time during the epidemic. For HIV-infected persons, highly active antiretroviral therapy has improved dramatically the quality and duration of life and may reduce the risk for transmission by decreasing viral load (*4–6*). Reduced HIV transmission also can occur because many infected persons may reduce sexual risk behavior after HIV-infection diagnosis (*7*). For these reasons, public health programs should work to diagnose HIV infection in each of the approximately 220,000 infected persons (*8*) who do not know their HIV status, link them to care and prevention services, and assist them in adhering to treatment regimens and in sustaining risk-reduction behavior. All HIV counseling, testing, and referral services, in either public or private settings, should be voluntary and confidential. CDC strongly encourages states to include anonymous testing as an integral component of HIV counseling, testing, and referral services.

To increase the number of infected persons who are aware of their HIV status early in the course of their infection, CDC recommends targeting efforts to reach persons at risk

National HIV Testing Day — Continued

for HIV infection in areas with high prevalence. Public health programs should attempt to remove barriers and tailor counseling, testing, and referral services to individual and community needs and preferences (e.g., offering services in nontraditional settings to increase accessibility, expanding clinic/office hours, and using less-invasive specimen collection such as oral fluid).

CDC encourages adults and adolescents to assess their risk for HIV infection on the basis of their past behavior. Persons who believe they might have been exposed to HIV but who have not been tested should seek HIV counseling, testing, and referral services. Additional information about HIV prevention services is available on the World-Wide Web at http://www.hivtest.org* or from the National AIDS Hotline, telephone (800) 342-2437.

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Laboratory-Acquired Human Glanders — Maryland, May 2000

On May 5, 2000, the Baltimore City Health Department was notified by hospital infection-control staff of a serious systemic febrile illness in a microbiologist whose research at the U.S. Army Medical Research Institute of Infectious Diseases (USAMRIID) involved several pathogenic bacteria, including *Burkholderia mallei*, the causative agent of glanders. This report summarizes the first human case of glanders in the United States since 1945, and emphasizes the importance of considering occupational exposures among laboratory workers with a febrile illness, the difficulty of characterizing unusual agents, including potential agents of biological terrorism such as glanders using routine

Laboratory-Acquired Human Glanders — Continued

laboratory techniques, the appropriate isolation practices for patients who may be infected by these agents, and laboratory safety.

The microbiologist, who has insulin-requiring diabetes mellitus, was well until early March 2000, when he developed an increasingly painful mass in his left axilla. On March 16, he had a temperature of 101.5 F (38.6 C) and was seen by a primary-care provider. He was given one dose of ceftriaxone intramuscularly and was started on a 10-day course of cephalexin. Despite completing the therapy, episodes of fever increased, and he experienced marked fatigue, malaise, night sweats, and weight loss. A medical evaluation, which included blood and urine cultures and chest radiographs, was unrevealing. In early April, the patient started a 10-day course of clarithromycin, which improved the symptoms and coincided with resolution of the left axillary mass; however, 4 days after completing the regimen, his symptoms returned. He continued to lose weight and began to experience mid-epigastric abdominal pain. Multiple blood cultures were obtained and were negative for bacteria.

An abdominal computerized tomography (CT) scan performed on May 2 revealed multiple hepatic and splenic lesions consistent with abscesses. Because of increased abdominal pain, hyperglycemia, and diabetic ketoacidosis, the patient was admitted to hospital A. An ultrasound-guided fine needle aspiration of a medial left hepatic lobe lesion was performed and yielded purulent-appearing material. Blood cultures again were obtained. Because of the patient's work history, occupationally acquired *Burkholderia* infection was considered, and one dose of piperacillin-tazobactam was administered intravenously. On the second hospital day, the patient developed respiratory distress requiring mechanical ventilatory support. He was placed in respiratory isolation, given intravenous tobramycin and doxycycline, and transferred to hospital B for further treatment.

At the time of transfer on May 4, hospital A identified small, bipolar, weakly-staining Gram-negative rods in cultures of the liver abscess fluid. On May 5, Gram-negative bacteria also were isolated from the blood cultures. An automated bacterial detection system at hospital A initially identified the bacteria as *Pseudomonas fluorescens/putida.* However, subsequent studies of the same isolate performed at hospital B and CDC, including motility studies, cellular fatty acid analyses, and 16S ribosome sequencing, identified the organism isolated from the liver abscess as *B. mallei.*

Because the patient worked with strains of *B. mallei* sensitive to imipenem and doxycycline, he was treated with those antibiotics and his symptoms rapidly improved. Repeat abdominal CT obtained after 10 days of therapy showed slight regression of the hepatic and splenic abscesses. The patient was treated with intravenous imipenem and doxycycline therapy for 2 weeks. When he was switched to oral doxycycline and azithromycin, the patient's liver and spleen abscesses continued to resolve.

The patient reported no exposures to horses, mules, or donkeys. He neither reported nor recalled any laboratory mishaps, although on occasion he had handled without wearing gloves laboratory equipment containing live *Burkholderia* strains. No other persons with whom he lived or worked reported recent febrile illnesses. No health-care workers who came in contact with him while he was a patient have reported symptoms consistent with glanders.

Reported by: D DeShazer, PhD, WR Byrne, MD, R Culpepper, MD, G Andrews, PhD, L Hartman, MS, G Parker, DVM, H Heine, PhD, US Army Medical Research Institute of Infectious Diseases, Frederick, Maryland. A Belani, MD, J Boyer, M Barrera-Oro, MD, Frederick Memorial Hospital, Frederick; C Kraus, MD, A Srinivasan, MD, L Karenfil, T Perl, MD, J Bartlett, MD, Johns Hopkins

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Medical Institutes, Baltimore; J Bowes, MD, J Smith, Frederick County Health Dept, Baltimore; A Danner, MPH, Baltimore City Health Dept; A Hankinson, MD, L Edwards, MHS, J Roche, MD, Acting State Epidemiologist, Maryland Dept of Health and Mental Hygiene. Bioterrorism Preparedness and Response Program and Meningitis and Special Pathogens Br, Div of Bacterial and Mycotic Diseases, National Center for Infectious Diseases; State Br, Div of Applied Public Health Training, Epidemiology Program Office; and an EIS Officer, CDC.

Editorial Note: Glanders is a bacterial infection caused by the Gram-negative rod, *B. mallei* (formerly *Pseudomonas mallei*). Primarily a disease of equids (e.g., horses, mules, and donkeys), glanders also has been reported in carnivores that have fed on infected horse carcasses and, although rare, glanders has been reported in humans. The disease was eliminated from domestic animals in the United States during the 1940s (*1*) and the last reported human case in the United States occurred in 1945 (*2*). Glanders still occurs occasionally in equids and humans in central and southeast Asia, the Middle East, parts of Africa, and possibly South America, and *B. mallei* is being researched in the United States because it is considered a potential agent of biological terrorism (*3*).

In humans, glanders usually is acquired through direct skin or mucous membrane contact with infected animal tissues. The incubation period usually is 1 to 14 days. The clinical presentation varies (*4,5*); cutaneous inoculation can result in localized infection with nodule formation and lymphandenitis (*4*). The disease often manifests as pneumonia, bronchopneumonia, or lobar pneumonia, with or without bacteremia (*4*). As in this case, hepatic and splenic involvement has been reported (*2*). A few antibiotics have been used to treat humans. Sulfadiazine (25 mg/kg intravenous, four times a day) was efficacious in some cases (*2*). In mice, doxycycline and ciprofloxacin have been effective therapies (*6*; W.R. Byrne, USAMRIID, personal communication, 2000). The mortality of apparent infection was approximately 95% before the use of antimicrobial agents; however, except when bacteremia develops, better diagnosis and more appropriate therapy have lowered mortality (*5*). No vaccine against *B. mallei* infection is available.

Glanders has been reported as a laboratory-acquired infection. During World War II, six unrelated cases of laboratory-acquired infection with *B. mallei* occurred at Camp Detrick, Frederick, Maryland (*3*). Some of these cases were attributed to inhalation of infectious aerosols generated by spillages of liquid culture media containing the bacterium. Other cases were reported to have no obvious cause other than the routine handling of the organism. In this report, the patient did not recall an unusual incident while working with *B. mallei*; however, the presentation of unilateral lymphadenopathy suggests a cutaneous inoculation. Most laboratory-acquired infections are associated with routine handling of microbes and not with injuries (*7*).

This case raises issues concerning the ability of clinical laboratories to identify rare agents like *B. mallei* rapidly and accurately and the importance of considering occupational exposures among laboratory workers presenting with febrile illness. Serologic and DNA-based diagnostic assays are not standardized, widely available, or approved by the Food and Drug Administration. Automated bacterial identification systems used by most clinical laboratories may not correctly speciate *B. mallei*, as occurred in this reported case. Effective communication between clinic and laboratory is essential in cases such as this so that unusual pathogens may be considered in the laboratory diagnosis.

Standard precautions (*8*) (i.e., the use of disposable surgical masks, face shields, and gowns, when appropriate, to prevent splashing of mucous membranes and skin) are

Laboratory-Acquired Human Glanders — Continued

sufficient to prevent transmission of this disease to those caring for patients, and biosafety level three is recommended for laboratory staff handling *B. mallei* (*9*).

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Contribution of Assisted Reproductive Technology and Ovulation-Inducing Drugs to Triplet and Higher-Order Multiple Births — United States, 1980–1997

In the United States, pregnancies associated with assisted reproductive technology (ART) or ovulation-inducing drugs are more likely to result in multiple births than spontaneously conceived pregnancies (*1*). In addition, triplet and higher-order multiple births are at greater risk than singleton births to be preterm (≤37 completed weeks' gestation), low birthweight (LBW) (i.e., ≤2500 g), or very low birthweight (i.e., <1500 g), resulting in higher infant morbidity and mortality (*2*). Because preterm and LBW infants often require costly neonatal care and long-term developmental follow-up, the continuing increase in triplet and higher-order multiple births causes concern among health-care providers and policymakers (*3*). This report provides estimates of the contribution of ART and ovulation-inducing drugs to these birth outcomes for 1996 and 1997, and summarizes trends during 1980–1997, which indicate that the ratio of triplet and higher-order multiple births has more than quadrupled and that a large proportion of this increase can be attributed to ART or the use of ovulation-inducing drugs.

CDC's National Center for Health Statistics (NCHS) provided data on live-born infants of triplet and higher-order multiple deliveries (*4*), and the Society for Assisted Reproductive Technology (SART) reporting system for ART clinics provided the clinical outcomes of ART-associated pregnancies. The 1992 Fertility Clinic Success Rate and Certification Act requires that every U.S. medical center that performs ART report to CDC data for every ART cycle* initiated annually to calculate clinic-specific pregnancy success rates (*5*). This report uses data from 1996, the first full year CDC collected ART data, and 1997, *Triplet and Higher-Order Multiple Births — Continued*

the latest year of completed data collection. In NCHS and SART, multiple births are counted as individual births rather than sets of triplet and higher-order multiple births.

Triplets constituted most triplet and higher-order multiple births: 5298 (89.2%) of 5939 in 1996 and 6148 (91.2%) of 6737 in 1997 (*4*). ART-related triplet and higher-order multiple births for 1996 and 1997 were expressed as a ratio (i.e., the proportion of ART-related triplet and higher-order multiple births to all live-born infants). The impact of ovulation-inducing drugs not associated with an ART procedure was estimated by subtracting both ART-related births (from the SART reporting system) and spontaneously occurring triplet and higher-order multiple births (*6*) from the total number of these births. To account for the upward shift in maternal age distribution since 1971 and the increase in spontaneously occurring triplets and higher-order multiple births in women of reproductive age, the ratios for spontaneously occurring outcomes were adjusted for the maternal age distribution of 1997 using the relevant ratios for 1971 (*2*). This adjustment resulted in a 10% increase in spontaneously occurring triplet and higher-order multiple births from 29 per 100,000 live-born infants in 1971 to 32 per 100,000 live-born infants in 1997.

The ratio of triplet and higher-order multiple births for all age groups increased from 29 in 1971 to 37 in 1980; this trend began after the Food and Drug Administration approved two ovulation-inducing drugs, one in 1967 and another in 1970. Following the introduction of ART approximately in 1980, the ratio more than quadrupled to 174 in 1997 (Table 1). Among mothers aged <20 years, the ratio increased from 15 to 21; among mothers aged 35–39 years, the ratio increased from 48 to 403.

The contribution of ART to the overall triplet and higher-order multiple birth ratio was estimated to be 38.7% in 1996 and 43.3% in 1997, a substantial increase from the estimated 22% for 1990 and 1991 (Table 2). For both years, approximately 20% were attributable to spontaneously occurring triplets and higher-order multiple births and approximately 40% were attributable to ovulation-inducing drugs without ART.

Reported by: Div of Reproductive Health, National Center for Chronic Disease Prevention and Health Promotion; Div of Applied Public Health Training, Epidemiology Program Office; Div of Vital Statistics, National Center for Health Statistics; and an EIS Officer, CDC.

Editorial Note: Despite small variations in fertility rates throughout the 1930s–1960s, the ratio for triplet and higher-order multiple births remained stable at approximately 30 per 100,000 live-born infants (*6*). The reported increase in the ratio of triplet and higher-order multiple births in subsequent decades illustrates the impact of ART and other infertility treatments.

The findings in this study are subject to at least three limitations. First, reliable information could not be obtained on the availability and use of ovulation-inducing drugs in the United States. Such information might have been useful in determining the contribution of these drugs to the reported increased ratios and to the increase in triplet and

*A cycle begins when a woman starts taking ovulation-inducing drugs or starts ovarian monitoring with the intent of having oocytes harvested for in vitro fertilization or other assisted reproductive technique. In most fresh, nondonor cycles, usually one of the following procedures is used: in vitro fertilization involves retrieving a woman's oocytes, fertilizing them in the laboratory, and transferring the resulting embryo(s) into the uterus through the cervix; gamete intra fallopian transfer involves placing unfertilized oocytes and sperm laparoscopically into the woman's fallopian tubes through a small abdominal incision; and zygote intra fallopian transfer involves fertilizing the woman's oocytes in the laboratory and then transferring the resulting zygotes into her fallopian tubes.

Triplet and Higher-Order Multiple Births — Continued

TABLE 1. Rate* of triplet and higher-order multiple births, by mothers' age — United States, 1980 and 1997

Age group (yrs)	Triplet and higher-order multiple births 1980	1997
<20	14.8	20.7
20–24	31.4	46.8
25–29	42.8	151.0
30–34	58.3	293.6
35–39	47.6	403.2
40–44	†	315.4
45–49	†	2100.2
All ages	**37.0**	**173.6**

* Per 100,000 live-born infants.
† Numbers do not meet standards of reliability or precision.
Source: Reference *4*.

TABLE 2. Contribution of assisted reproductive technology (ART) to triplet and higher-order multiple births (≥triplets) — United States, 1989–1997

Year	Total no. live-born infants*	No. of ≥triplets	% ≥triplets of total no. live-born infants	≥Triplets ratio†	% ≥triplets by spontaneous conception	% ≥triplets using ART	Estimated % ≥triplets using ovulation drugs
1989	4,040,958	2,798	0.07	69.2	—	—	
1990	4,158,212	3,028	0.07	72.8	—	22.0§	—
1991	4,110,907	3,346	0.08	81.4	—	22.0§	—
1992	4,065,014	3,883	0.09	95.6	—	—	—
1993	4,000,240	4,168	0.10	104.2	—	—	—
1994	3,952,767	4,594	0.12	116.2	—	—	—
1995	3,899,589	4,973	0.13	127.2	—	—	—
1996¶	3,891,494	5,939	0.15	152.6	20.9	38.7	40.4
1997¶	3,880,894	6,737	0.17	173.6	18.4	43.3	38.2

* Source: Reference *4*.
† Number of ≥triplets per 100,000 live-born infants.
§ Based on number of ART-associated ≥triplets and total number of ≥triplets, 1990 and 1991 (*3*).
¶ Percentage of ≥triplets by spontaneous conception, percentage of ≥triplets using ART, and estimated percentage of ≥triplets using ovulation drugs add up to 100% overall ≥triplet ratio.

higher-order multiple births affecting all age groups. Second, because ART data were available for only 2 full years (1996 and 1997), trend analysis was not possible. Third, bias might have been introduced using 1971 triplet and higher-order multiple birth ratios for direct age adjustment, which were based on a 50% sample of birth certificate data compared with 100% of data for 1985–1997.

Because of the risk factors associated with multifetal births, continued surveillance of pregnancies associated with infertility treatments is important. Although the impact of ART on overall triplet and higher-order multiple births can be estimated using SART data, no reporting system has information on the use of ovulation-inducing drugs not associated with ART. Modifying birth certificate registration to include the type of infertility treatment used to achieve pregnancy would provide such information. Massachusetts has implemented this modification.

Given the increased morbidity and mortality associated with multifetal pregnancies, efforts are needed to monitor patients receiving ovulation-inducing drugs and to limit the number of embryos transferred for patients receiving ART (*7*). These approaches should be preceded by evaluation and specific diagnosis of the infertility status of each patient, and should follow guidelines issued by organizations such as the American Society for Reproductive Medicine and the American College of Obstetricians and Gynecologists (*8,9*). Strategies to reduce the risk for multifetal gestation have important public health implications that must be integrated with patient needs and concerns, provider practices, and rapidly changing technology.

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Gonorrhea — United States, 1998

Neisseria gonorrhoeae infections are a major cause of pelvic inflammatory disease, infertility, and ectopic pregnancy in women and facilitate the transmission of human immunodeficiency virus (*1*). To characterize the epidemiology of gonorrhea in the United States, CDC examined national surveillance data on gonorrhea cases reported to CDC through state health departments in 1998 and surveyed selected states with increases and decreases in gonorrhea rates since 1996. This report summarizes the results of this analysis, which indicate that following a 13-year decline, the number of gonorrhea cases in 1998 increased by 9% compared with 1997. Although changes in gonorrhea screening and surveillance practices may have contributed to the higher reported rates, reports from states suggest that true increases in gonorrhea cases also occurred in some populations.

Surveillance data from the 50 states were used to determine trends in gonorrhea cases. Thirty states provided individual-level gonorrhea case reports that included age, sex, and race/ethnicity. The remaining states provided aggregate data with information

Gonorrhea — Continued

by age group, sex, and race/ethnicity. Crude incidence was calculated annually per 100,000 population. Rates were calculated using postcensal population estimates (*2*); rates for 1998 used population estimates for 1997. Sexually transmitted disease (STD) program staff from states with a >10% increase in cases each year from 1996 to 1998 and those states with annual decreases during this period were interviewed about the trends in gonorrhea rates for their state. Questions addressed changes in gonorrhea screening policies, clinic testing volume, gonorrhea diagnostic test methods, and reporting practices.

In 1998, 355,131 gonorrhea cases were reported to CDC (132.9 cases per 100,000 population) compared with 325,861 cases (121.8) in 1997 (Figure 1). From 1997 to 1998, the rate in the Midwest* increased by 16.4% (from 120.0 to 139.7), in the South by 8.7% (from 186.4 to 202.7), and in the West by 6.5% (from 50.6 to 53.9). In the Northeast, the gonorrhea rate declined by 0.8% (from 87.8 to 87.1). From 1997 to 1998, gonorrhea rates increased in 34 states (Table 1). In 1998 in 22 states, the rate was above the national health objective for 2000 of 100 cases per 100,000 population (Table 1), and represented 79% of gonorrhea cases reported in 1998.

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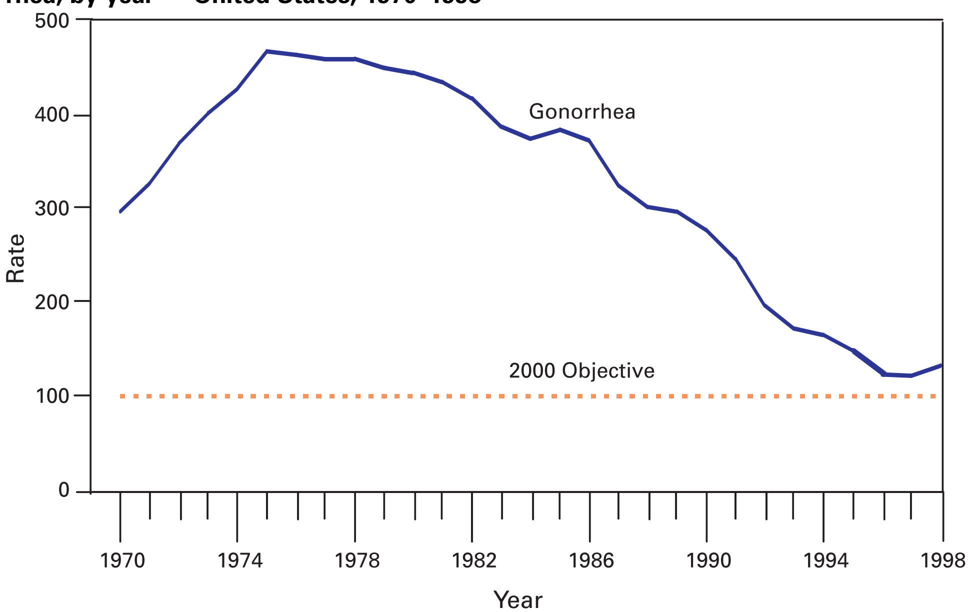
* *Northeast*=Connecticut, Maine, Massachusetts, New Hampshire, New Jersey, New York, Pennsylvania, Rhode Island, and Vermont; *Midwest*=Illinois, Indiana, Iowa, Kansas, Michigan, Minnesota, Missouri, Nebraska, North Dakota, Ohio, South Dakota, and Wisconsin; *South*=Alabama, Arkansas, Delaware, Florida, Georgia, Kentucky, Louisiana, Maryland, Mississippi, North Carolina, Oklahoma, South Carolina, Tennessee, Texas, Virginia, and West Virginia; and *West*=Alaska, Arizona, California, Colorado, Hawaii, Idaho, Montana, Nevada, New Mexico, Oregon, Utah, Washington, and Wyoming.

FIGURE 1. Reported gonorrhea rates* and 2000 national health objective for gonorrhea, by year — United States, 1970–1998



* Per 100,000 population.

Gonorrhea — Continued

TABLE 1. Reported gonorrhea rates*, by state, year, and percentage change from 1997 to 1998 — United States

State	Rate 1997	Rate 1998	% Change
Alabama	278.5	294.9	5.9
Alaska	64.2	54.3	–15.4
Arizona	83.5	92.5	10.8
Arkansas	173.7	156.7	–9.8
California	55.7	60.5	8.6
Colorado	59.5	52.2	–12.3
Connecticut	96.5	97.2	0.7
Delaware	174.0	212.7	22.2
Florida	130.2	130.2	0
Georgia	246.7	276.1	11.9
Hawaii	43.0	42.6	–0.9
Idaho	13.1	15.0	14.5
Illinois	154.9	182.7	18.0
Indiana	105.0	107.6	2.5
Iowa	46.0	56.7	23.3
Kansas	80.0	101.0	26.3
Kentucky	103.0	97.6	–5.2
Louisiana	247.8	287.2	15.9
Maine	5.3	5.4	1.9
Maryland	227.1	220.9	–2.7
Massachusetts	36.4	36.9	1.4
Michigan	161.0	167.4	4.0
Minnesota	51.6	57.8	12.0
Mississippi	343.1	391.5	14.1
Missouri	141.8	175.2	23.6
Montana	7.5	6.3	–16.0
Nebraska	73.0	72.7	–0.4
Nevada	49.4	86.2	74.5
New Hampshire	8.2	7.8	–4.9
New Jersey	94.0	97.6	3.8
New Mexico	49.5	55.3	11.7
New York	123.5	105.1	–14.9
North Carolina	227.4	259.0	13.9
North Dakota	10.6	12.5	17.9
Ohio	133.7	163.4	22.2
Oklahoma	143.5	158.1	10.2
Oregon	23.8	27.1	13.9
Pennsylvania	82.9	97.5	17.6
Rhode Island	42.7	43.5	1.9
South Carolina	305.5	307.8	0.8
South Dakota	23.3	29.9	28.3
Tennessee	205.3	220.6	7.5
Texas	136.9	168.9	23.4
Utah	13.5	11.5	–14.8
Vermont	9.0	6.5	–27.8
Virginia	132.0	137.6	4.2
Washington	34.9	34.7	–0.6
West Virginia	52.7	50.7	–3.8
Wisconsin	83.5	122.9	47.2
Wyoming	11.3	7.5	–33.7
Total	**122.0**	**132.9**	**8.9**

*Per 100,000 population.

Gonorrhea — Continued

From 1997 to 1998, the gonorrhea rate increased 10.5% among women (from 119.2 to 131.7) and 7.4% among men (from 124.5 to 133.7). In 1998, the gonorrhea rate among non-Hispanic whites increased by 11.3% (from 18.6 to 20.7), among non-Hispanic blacks by 13.5% (from 593.1 to 673.1), among Hispanics by 15.9% (from 47.9 to 55.5), among American Indians/Alaska Natives by 17.0% (from 77.7 to 90.9), and among Asians/Pacific Islanders by 19.8% (from 13.1 to 15.7). Among women aged 15–19 years, the sex-age group with the highest rate of gonococcal infection, the rate increased by 11.4% (from 683.2 to 761.4). Among men aged 20–24 years, the rate increased by 11.3% (from 506.7 to 564.0).

Idaho, Iowa, Louisiana, Mississippi, North Dakota, and Texas had annual increases of >10% in gonorrhea from 1996 to 1998. STD program managers in each state reported that changes in screening and reporting practices may have contributed to the increases. Increased gonorrhea rates reported from Iowa and Mississippi were attributed partly to increases in the numbers of persons screened by family planning clinics. In Louisiana and Texas, the increases were attributed to targeted screening efforts and improved access to STD clinic services. In three states, publicly funded screening programs switched from gonorrhea culture to nonculture tests; health departments in Iowa and Mississippi switched to using nucleic acid probe assays, and in North Dakota to ligase chain reaction tests. Louisiana expanded its case definition from accepting only reports from clinicians to also accepting laboratory reports. However, two states reported that they had true increases in gonorrhea cases in some populations; in Iowa, increases appeared among methamphetamine users and their sex partners, and in Texas, increases in gonorrhea test positivity were seen among women attending family planning clinics, even without a change in diagnostic test type, screening criteria, or number tested.

Alaska, Arkansas, Kentucky, Maryland, and New Hampshire reported consecutive annual gonococcal infection decreases from 1996 to 1998. None of these states reported changes in testing methods or reporting practices. However, Kentucky reported that fewer women were attending family planning clinics, resulting in fewer screenings. In Alaska and New Hampshire, STD program managers attributed the declines in part to increases in presumptive treatment without laboratory testing. However, three states that reported declines had data on increases in gonococcal infections in specific populations, including men who have sex with men (MSM) (Alaska and New Hampshire) and drug users (Arkansas). In New Hampshire, 11.1% of gonorrhea cases were reported among MSM, compared with 6.6% in 1997 and 0% in 1996.

Reported by: State and local health depts. Epidemiology and Surveillance Br, Statistics and Data Management Br and Program Development and Support Br, Div of Sexually Transmitted Disease Prevention, National Center for HIV, STD, and TB Prevention, CDC.

Editorial Note: The increase in the reported rate of gonorrhea in 1998 followed an overall decline of 64.2% from 1985 to 1997 (*3,4*). A portion of the increase may be attributed to changes in screening and reporting practices. Data reported to the Regional Infertility Prevention Projects also showed that substantially more clinics were screening for gonorrhea during this period, and that they began to use nonculture methods for gonorrhea diagnosis (CDC, unpublished data, 1999). Under optimal conditions, the sensitivity of culture may be similar to nonculture methods (*5,6*); however, under field conditions, culture may be substantially less sensitive.

Changes in screening and reporting practices probably did not account for all of the reported increases across states in 1998. For example, an investigation of the increase in

Gonorrhea — Continued

South Dakota found that increased screening volume and change in testing methods accounted for 14% of the 80% increase in reported gonorrhea cases from 1997 to 1998 (*7*). In addition to Alaska and New Hampshire, reported increases in gonorrhea and other STDs among MSM have been documented in other states, possibly as a result of an increase in unsafe sexual behavior related to the availability of highly active antiretroviral therapy (*8,9*).

The findings in this report are subject to at least three limitations. First, the quality of surveillance varies at the local and state levels. Second, STD reporting may be incomplete. Finally, reporting of gonorrhea may be biased toward the overreporting of infections among persons of minority races/ethnicities who attend public STD clinics. The degree to which this bias influences reported rates of gonorrhea is unknown. Race and ethnicity are not risk factors for disease, but markers used to better understand risk factors, and therefore, should be viewed within public health surveillance as a sociologic phenomenon (*10*).

Following a series of transitions in diagnostic testing, screening practices, and surveillance methods, the decline in gonorrhea rates from 1985 to 1997 could resume; preliminary data suggest that in 1999, the gonorrhea rate is again declining. However, the overall number of gonorrhea cases remains high and the increasing rates of gonorrhea in some populations in 1998 should guide public health efforts to prevent this disease.

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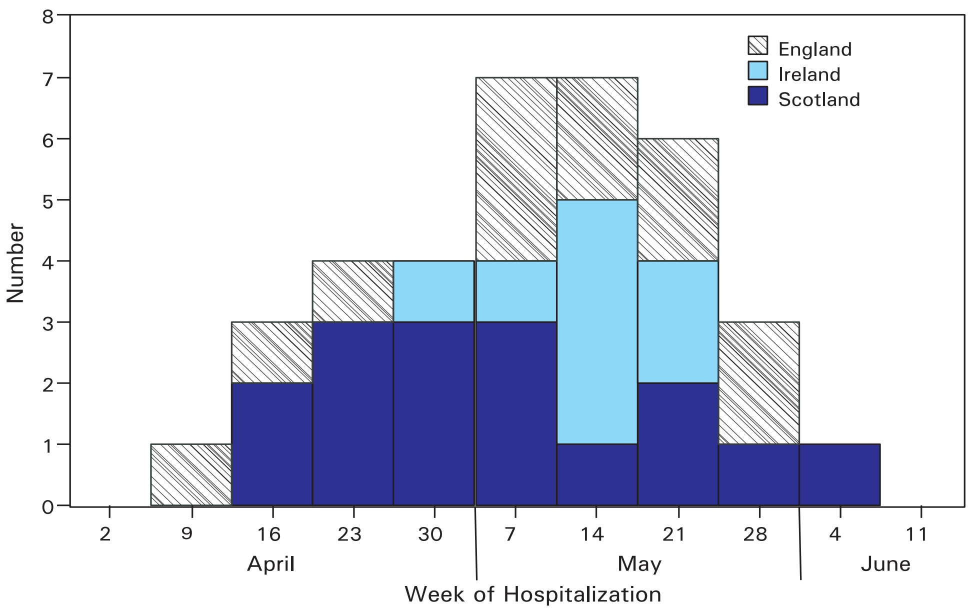
Update: *Clostridium novyi* and Unexplained Illness Among Injecting-Drug Users — Scotland, Ireland, and England, April–June 2000

Since April 19, 2000, health authorities in Scotland, Ireland, England, and the United States have been investigating an outbreak of unexplained illness and death among injecting-drug users (IDUs) in the United Kingdom and Ireland (*1–3*). Initial testing of specimens from 76 IDUs identified *Clostridium* species in 18 (24%) patients; nine were *Clostridium novyi*. This report updates the investigation of this outbreak, which indicates that *Clostridium* species may be associated with these illnesses.

During April 1–June 19, investigators identified 88 IDUs in Scotland (n=48), Ireland (n=19), and England (n=21) with injection-site soft tissue inflammation resulting in hospitalization or death; 40 (45%) have died. Thirty-five (40%) patients had illnesses that met the syndrome-based case-definition (*1*), including sustained hypotension and markedly elevated white blood cell count (WBC), or postmortem evidence of a diffuse toxic or infectious process, with initial hospitalization during April 11–June 6 (Figure 1). The median age of the 35 case-patients was 32 years (range: 20–51 years); 18 (51%) were men, and 34 (97%) died. Median peripheral WBC was 63,600 cells/mm^3 (range: 8,200–153,000 cells/mm^3). In Ireland, cases remained limited to Dublin, and in Scotland cases have been reported from both the Glasgow and Aberdeen areas. In England, most cases have been identified in and around Manchester, but several cases have been reported from other parts of the country.

FIGURE 1. Cases of unexplained severe illness and death among injecting drug users — Scotland, Ireland, and England, April–June 2000



Unexplained Illness Among Injecting-Drug Users — Continued

Among the 35 patients with illnesses meeting the case definition, nine (26%) have laboratory evidence of clostridial infections based on culture isolation or 16S ribosomal DNA polymerase chain reaction and sequencing performed on blood or tissue, including three *C. novyi*, three *C. perfringens*, one with both *C. novyi* and *C. perfringens*, and two clostridial species awaiting further typing. Of the remaining 41 patients with illnesses who failed to meet the case definition but who may be linked to this outbreak, and for whom data are available, nine (22%) have evidence of clostridial infections, including five *C. novyi* and four with species pending. Although the role of other pathogens requires further delineation, only four (11%) patients with illnesses meeting the case definition have evidence of other etiologic agents (*Staphylococcus aureus*, group A *Streptococcus*, and group C *Streptococcus*), compared with 12 (29%) of 41 patients with unexplained soft tissue infections but lacking severe systemic toxicity.

Reported by: S Ahmed, MD, L Gruer, MD, C McGuigan, MD, G Penrice, MD, K Roberts, MPhil, Dept of Public Health, Greater Glasgow Health Board; J Hood, MD, Dept of Microbiology, Glasgow Royal Infirmary; P Redding, MD, Dept of Microbiology, Victoria Infirmary Glasgow; G Edwards, MD, Stobhill General Hospital; M Black, MD, J McFarlane, MD, Dept of Forensic Pathology, Univ of Glasgow; D Cromie, MD, Dept of Public Health, Lanarkshire Health Board; H Howie, MD, Dept of Public Health, Grampian Health Board; A Leonard, MD, Dept of Microbiology, Monklands Hospital; D Goldberg, MD, A Taylor, PhD, S Hutchinson, MSc, K Roy, PhD, S Wadd, PhD, R Andraghetti, MD (EPIET), Scottish Center for Infection and Environmental Health, Glasgow, Scotland. J Barry, MD, G Sayers, MD, M Cronin, MD, T O'Connell, MD, M Ward, MD, P O'Sullivan, MD, B O'Herlihy, MD, Eastern Regional Health Authority, Dept of Public Health; E Keenan, MD, J O'Connor, MD, L Mullen, MSc, B Sweeney, MD, Eastern Regional Health Authority Area Health Boards' Drug Svcs; D O'Flanagan, MD, D Igoe, MD, National Disease Surveillance Center; C Bergin, MD, S O'Briain, MD, C Keane, MD, E Mulvihill, MD, P Plunkett, MD, G McMahon, MD, T Boyle, MD, S Clarke, MD, St. James's Hospital; E Leen, MD, James Connolly Memorial Hospital; M Cassidy, MD, State Pathology Svc, Dublin, Ireland. T Djuretic, MD, N Gill, MD, V Hope, PhD, J Jones, MD, G Nichols, PhD, A Weild, MPhil, Public Health Laboratory Svc (PHLS) Communicable Disease Surveillance Centre; R George, MD, PHLS Respiratory and Systemic Infection Laboratory; P Borriello, PhD, PHLS Central Public Health Laboratory, London, England; J Brazier, PhD, J Salmon, MD, PHLS Anaerobe Reference Unit, Cardiff, Wales; N Lightfoot, MD, PHLS North, Newcastle; A Roberts, PhD, Centre for Applied Microbiology and Research, Porton Down, England. Infectious Diseases Pathology Activity, Div of Viral and Rickettsial Diseases; Bioterrorism Preparedness and Response Program; Meningitis and Special Pathogens Br, Div of Bacterial and Mycotic Diseases, National Center for Infectious Diseases; and EIS officers, CDC.

Editorial Note: Although clostridial species have been implicated previously in clusters of wound infections among IDUs (*4,5*), the number of cases and severity of illness associated with this outbreak appear to be unique. *C. perfringens* can produce fulminant shock through direct toxogenic effects on myocardial contractility, but this organism usually causes extensive tissue destruction and gas production, features that are not prominent in the current cases (*6*). *C. sordellii* can also cause a distinctive, toxin-mediated illness characterized by tissue edema, myonecrosis, leukemoid reaction and sudden onset of shock (*7*). However, perhaps because of its fastidious and strict anaerobic growth requirements (*6*), *C. novyi* has been less commonly implicated in such a clinical syndrome. The significance of isolating clostridial species from the tissue of the patients described in this report remains unclear, but the presence of these organisms suggests soil or fecal contamination of the drugs or other materials used by these IDUs and may provide the causative explanation for their illnesses.

Unexplained Illness Among Injecting-Drug Users — Continued

Clinical, epidemiologic, and laboratory investigations continue to characterize these illnesses, confirm the role of *C. novyi* as one of the potential etiologic agents, identify risk factors for disease, and implement measures to prevent further cases. Surveillance activities to identify additional cases in the United Kingdom and Ireland are ongoing, and efforts to find cases in the rest of Europe or the United States have been expanded. Health-care providers and public health personnel are encouraged to report persons with illnesses meeting the case definition to their designated public health authorities.

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Notice to Readers

Injuries From Fireworks in the United States

Fireworks traditionally are used in the United States to celebrate Independence Day on July 4th. The U.S. Consumer Product Safety Commission (CPSC) estimates that 8500 persons in the United States are treated in emergency departments each year for fireworks-related injuries (*1*). Of all fireworks-related injuries, 70%–75% occur during a 30-day period that surrounds the July 4th holiday (June 23–July 23) (*2*). Seven of every 100 persons injured by fireworks are hospitalized, approximately 40% of those injured are children aged ≤14 years, and males are injured three times more often than females (*1*). The injury rate is highest among boys aged 10–14 years (*3*). Most commonly, injuries from fireworks affect the hands (34%), face (12%), and eyes (17%) (*4*). Injuries are more frequent and more severe among persons who are active participants than among bystanders (*3*).

The estimated annual cost of fireworks-related injuries is $100 million (*4*). In 1997, the U.S. National Fire Protection Association (NFPA) estimated that fireworks were responsible for direct property damage of $22.7 million (*5*).

Although some types of fireworks are legal in some states, CDC, NFPA, and CPSC recommend that fireworks be used only by professionals. All fireworks potentially are dangerous (e.g., sparklers burn at more than 1000 F [538 C]), especially to children.

Notices to Readers — Continued

Because fireworks are unregulated, there is always a risk for injury with fireworks. Additional information about fireworks safety is available from CDC on the World-Wide Web, http://www.cdc.gov/ncipc, or CPSC, http://www.cpsc.gov.*

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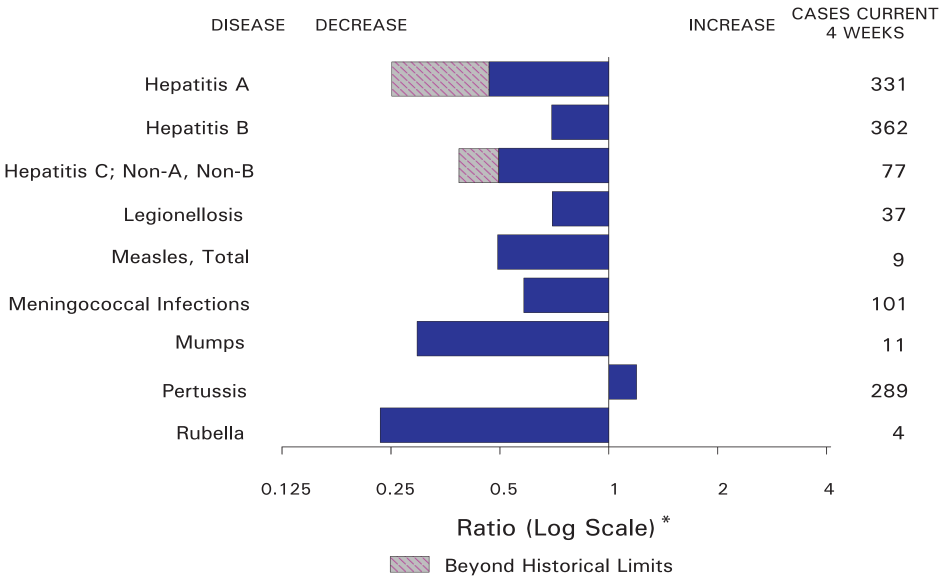
Notice to Readers

Satellite Broadcast on Environmental Health

The Agency for Toxic Substances and Disease Registry and CDC's Public Health Practice Program Office and Public Health Training Network will cosponsor a live satellite broadcast, "Environmental Health: A Nursing Opportunity," on August 10, 2000, from noon to 2:30 p.m. eastern time. The broadcast is intended for nurses in all areas of nursing practice (nurse practitioners, registered nurses, licensed practical nurses, and student nurses), physicians, and other health-care professionals whose work involves environmental health concerns. The program will address taking an exposure history, strategies for intervention and prevention, and tools and resources to integrate into practice.

Continuing education credit for many professions will be offered based on 2.5 hours of instruction. Additional information about the broadcast is available on the World-Wide Web at http://www.cdc.gov/phtn/envhealth/nursing.htm.

FIGURE I. Selected notifiable disease reports, United States, comparison of provisional 4-week totals ending June 17, 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 June 17, 2000 (24th Week)

	Cum. 2000		Cum. 2000
Anthrax	-	HIV infection, pediatric*§	98
Brucellosis*	24	Plague	3
Cholera	-	Poliomyelitis, paralytic	-
Congenital rubella syndrome	4	Psittacosis*	8
Cyclosporiasis*	10	Rabies, human	-
Diphtheria	1	Rocky Mountain spotted fever (RMSF)	89
Encephalitis: California serogroup viral*	2	Streptococcal disease, invasive, group A	1,515
eastern equine*	-	Streptococcal toxic-shock syndrome*	52
St. Louis*	-	Syphilis, congenital¶	61
western equine*	-	Tetanus	11
Ehrlichiosis human granulocytic (HGE)*	34	Toxic-shock syndrome	75
human monocytic (HME)*	11	Trichinosis	4
Hansen disease (leprosy)*	19	Typhoid fever	133
Hantavirus pulmonary syndrome*†	9	Yellow fever	-
Hemolytic uremic syndrome, postdiarrheal*	38		

-: 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 May 28, 2000.
¶ Updated from reports to the Division of STD Prevention, NCHSTP.

TABLE II. Provisional cases of selected notifiable diseases, United States, weeks ending June 17, 2000, and June 19, 1999 (24th Week)

Reporting Area	AIDS Cum. 2000[§]	AIDS Cum. 1999	Chlamydia[†] Cum. 2000	Chlamydia[†] Cum. 1999	Cryptosporidiosis Cum. 2000	Cryptosporidiosis Cum. 1999	*Escherichia coli* O157:H7* NETSS Cum. 2000	NETSS Cum. 1999	PHLIS Cum. 2000	PHLIS Cum. 1999
UNITED STATES	16,820	18,490	257,537	310,035	551	789	839	652	457	622
NEW ENGLAND	1,003	939	9,370	9,308	32	30	91	90	78	91
Maine	16	22	595	122	9	1	6	1	6	-
N.H.	13	26	467	471	2	5	6	11	7	13
Vt.	2	6	247	231	13	6	3	9	3	3
Mass.	681	612	4,595	4,046	6	15	44	42	35	44
R.I.	41	61	1,112	1,082	2	-	4	6	-	6
Conn.	250	212	2,354	3,356	-	3	28	21	27	25
MID. ATLANTIC	4,030	4,449	15,898	31,417	59	167	109	46	62	47
Upstate N.Y.	213	529	N	N	36	50	91	30	41	3
N.Y. City	2,325	2,109	3,569	13,222	6	95	4	3	-	-
N.J.	885	957	2,758	5,714	6	14	14	13	13	43
Pa.	607	854	9,571	12,481	11	8	N	N	8	1
E.N. CENTRAL	1,641	1,280	42,731	53,732	115	125	141	128	49	106
Ohio	218	211	10,394	12,624	22	16	29	42	13	34
Ind.	149	167	5,434	5,427	11	9	23	17	9	15
Ill.	1,012	590	12,405	14,628	7	19	37	45	-	25
Mich.	190	248	10,331	10,167	24	17	31	24	18	17
Wis.	72	64	4,167	10,886	51	64	21	N	9	15
W.N. CENTRAL	376	388	15,257	17,377	49	44	136	108	89	138
Minn.	79	69	2,938	3,536	11	13	40	29	31	41
Iowa	38	46	1,995	1,959	13	9	23	15	10	14
Mo.	164	154	5,529	6,296	9	5	41	10	26	15
N. Dak.	-	4	282	409	3	4	7	3	6	2
S. Dak.	3	11	801	747	5	3	3	4	3	11
Nebr.	25	32	1,434	1,601	6	9	13	37	9	54
Kans.	67	72	2,278	2,829	2	1	9	10	4	1
S. ATLANTIC	4,484	5,163	54,172	64,355	103	150	70	80	39	56
Del.	78	72	1,364	1,292	3	-	-	3	-	-
Md.	459	561	5,475	5,973	7	6	10	7	1	-
D.C.	315	207	1,487	N	5	6	-	-	U	U
Va.	327	263	7,241	7,029	4	8	14	23	13	20
W. Va.	29	25	753	835	3	-	3	4	3	2
N.C.	279	358	9,904	10,263	9	4	14	16	3	18
S.C.	326	481	4,739	8,408	-	-	4	10	2	6
Ga.	430	827	9,524	16,391	54	81	8	5	8	U
Fla.	2,241	2,369	13,685	14,164	18	45	17	12	9	10
E.S. CENTRAL	805	840	21,090	20,128	21	9	37	50	22	33
Ky.	99	128	3,698	3,591	1	2	13	11	9	9
Tenn.	337	337	6,243	6,468	4	4	15	23	11	13
Ala.	213	212	6,715	4,543	9	2	3	11	-	10
Miss.	156	163	4,434	5,526	7	1	6	5	2	1
W.S. CENTRAL	1,511	2,075	40,578	41,463	24	40	48	32	44	43
Ark.	94	70	2,326	2,708	1	-	29	5	3	4
La.	281	409	8,623	7,105	5	21	-	4	13	6
Okla.	110	55	3,861	3,613	3	2	7	7	3	5
Tex.	1,026	1,541	25,768	28,037	15	17	12	16	25	28
MOUNTAIN	582	717	17,326	21,780	36	38	82	47	28	35
Mont.	7	4	730	654	5	7	11	3	-	-
Idaho	11	11	765	796	3	2	10	1	-	4
Wyo.	2	3	316	360	3	-	3	3	2	4
Colo.	130	143	5,163	3,985	9	4	32	21	9	11
N. Mex.	58	37	2,147	2,381	2	15	4	2	3	1
Ariz.	193	352	5,851	11,231	3	7	17	7	13	4
Utah	61	70	1,126	949	9	N	4	8	1	9
Nev.	120	97	1,228	1,424	2	3	1	2	-	2
PACIFIC	2,388	2,639	41,115	50,475	112	186	125	71	46	73
Wash.	247	151	5,867	5,472	N	N	35	24	22	27
Oreg.	86	63	2,247	2,920	5	73	16	16	18	14
Calif.	1,987	2,377	31,075	39,748	107	113	66	28	-	31
Alaska	5	6	1,078	872	-	-	1	-	-	-
Hawaii	63	42	848	1,463	-	-	7	3	6	1
Guam	13	1	-	207	-	-	N	N	U	U
P.R.	431	627	142	U	-	-	2	10	U	U
V.I.	18	13	-	U	-	U	-	U	U	U
Amer. Samoa	-	-	-	U	-	U	-	U	U	U
C.N.M.I.	-	-	-	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 May 28, 2000.

TABLE II. (Cont'd) Provisional cases of selected notifiable diseases, United States, weeks ending June 17, 2000, and June 19, 1999 (24th Week)

Reporting Area	Gonorrhea		Hepatitis C; Non-A, Non-B		Legionellosis		Lyme Disease	
	Cum. 2000	Cum. 1999	Cum. 2000	Cum. 1999	Cum. 2000	Cum. 1999	Cum. 2000	Cum. 1999
UNITED STATES	134,438	162,309	1,158	1,725	301	386	1,888	2,928
NEW ENGLAND	2,480	2,956	26	8	22	21	330	754
Maine	34	49	1	-	2	-	-	2
N.H.	47	39	-	-	2	3	35	-
Vt.	29	26	3	3	1	4	1	1
Mass.	1,173	1,140	19	2	9	5	170	234
R.I.	282	277	3	3	3	3	26	42
Conn.	915	1,425	-	-	5	6	98	475
MID. ATLANTIC	10,435	17,947	30	62	58	99	1,175	1,551
Upstate N.Y.	2,930	2,735	30	30	24	25	477	587
N.Y. City	1,393	6,172	-	-	-	12	4	43
N.J.	1,492	3,349	-	-	2	8	171	317
Pa.	4,620	5,691	-	32	32	54	523	604
E.N. CENTRAL	26,111	32,009	103	978	74	124	27	180
Ohio	6,061	7,812	3	-	35	37	18	18
Ind.	2,480	2,938	1	-	13	14	6	9
Ill.	8,778	9,838	7	25	6	16	1	8
Mich.	7,186	7,042	92	365	14	33	-	1
Wis.	1,606	4,379	-	588	6	24	2	144
W.N. CENTRAL	6,524	7,273	318	74	23	18	62	58
Minn.	1,194	1,297	4	2	1	1	15	13
Iowa	400	451	1	-	3	6	2	6
Mo.	3,332	3,539	288	70	15	8	14	26
N. Dak.	6	39	-	-	-	-	-	1
S. Dak.	119	70	-	-	1	1	-	-
Nebr.	525	718	3	2	-	2	-	7
Kans.	948	1,159	22	-	3	-	31	5
S. ATLANTIC	39,946	46,538	47	101	64	44	242	283
Del.	769	758	-	-	4	4	30	17
Md.	3,765	5,370	5	27	19	5	145	206
D.C.	1,058	1,621	1	-	1	-	1	1
Va.	4,650	4,499	1	9	6	11	36	17
W. Va.	227	275	5	12	N	N	8	8
N.C.	8,371	8,771	13	22	8	8	8	28
S.C.	5,650	4,560	1	12	2	7	2	2
Ga.	5,971	10,707	1	1	4	-	-	-
Fla.	9,485	9,977	20	18	20	9	12	4
E.S. CENTRAL	15,005	15,648	194	126	8	21	8	34
Ky.	1,542	1,563	17	7	5	10	2	5
Tenn.	4,811	5,060	43	43	1	9	4	14
Ala.	5,172	4,125	7	1	2	2	1	6
Miss.	3,480	4,900	127	75	-	-	1	9
W.S. CENTRAL	21,146	23,342	272	223	10	1	1	8
Ark.	1,270	1,325	3	12	-	-	-	1
La.	6,073	5,908	169	153	8	1	1	3
Okla.	1,670	1,846	2	3	1	-	-	2
Tex.	12,133	14,263	98	55	1	-	-	2
MOUNTAIN	4,564	6,403	99	91	17	25	1	3
Mont.	25	21	2	4	-	-	-	-
Idaho	36	39	3	4	3	-	-	-
Wyo.	28	12	60	34	1	-	-	1
Colo.	1,462	1,093	13	13	7	5	1	-
N. Mex.	451	441	6	15	1	1	-	1
Ariz.	1,920	4,142	11	16	2	3	-	-
Utah	114	89	-	2	3	10	-	-
Nev.	528	566	4	3	-	6	-	1
PACIFIC	8,227	10,193	69	62	25	33	42	57
Wash.	1,009	963	9	8	9	8	-	1
Oreg.	284	422	16	7	N	N	2	4
Calif.	6,675	8,465	44	47	16	24	40	52
Alaska	140	146	-	-	-	1	-	-
Hawaii	119	197	-	-	-	-	N	N
Guam	-	29	-	-	-	-	-	-
P.R.	247	160	1	-	-	-	N	N
V.I.	-	U	-	U	-	U	-	U
Amer. Samoa	-	U	-	U	-	U	-	U
C.N.M.I.	-	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 June 17, 2000, and June 19, 1999 (24th Week)

Reporting Area	Malaria		Rabies, Animal		Salmonellosis* NETSS		Salmonellosis* PHLIS	
	Cum. 2000	Cum. 1999	Cum. 2000	Cum. 1999	Cum. 2000	Cum. 1999	Cum. 2000	Cum. 1999
UNITED STATES	431	538	2,366	2,877	11,796	12,838	8,316	12,011
NEW ENGLAND	18	19	314	584	733	764	710	801
Maine	4	-	65	268	57	51	33	40
N.H.	1	-	4	25	53	38	47	44
Vt.	2	1	32	58	51	29	55	33
Mass.	6	10	106	84	410	451	388	448
R.I.	3	-	20	46	32	38	49	64
Conn.	2	8	87	103	130	157	138	172
MID. ATLANTIC	67	150	433	494	1,567	1,769	1,565	1,606
Upstate N.Y.	22	32	300	336	439	399	442	445
N.Y. City	22	70	U	U	334	512	485	549
N.J.	8	31	71	99	407	412	259	403
Pa.	15	17	62	59	387	446	379	209
E.N. CENTRAL	46	69	24	32	1,788	1,945	1,051	1,743
Ohio	6	9	5	10	468	361	385	348
Ind.	3	8	-	-	201	166	150	163
Ill.	19	32	1	-	530	658	1	650
Mich.	13	15	18	22	375	406	399	396
Wis.	5	5	-	-	214	354	116	186
W.N. CENTRAL	21	20	234	363	838	797	870	921
Minn.	7	5	36	46	179	204	241	275
Iowa	1	5	36	60	121	84	94	73
Mo.	3	8	10	13	290	250	323	334
N. Dak.	2	-	69	76	25	15	30	27
S. Dak.	-	-	40	106	34	43	37	53
Nebr.	2	-	-	3	60	84	44	74
Kans.	6	2	43	59	129	117	101	85
S. ATLANTIC	122	132	1,033	968	2,287	2,579	1,461	2,222
Del.	3	1	20	29	36	52	43	56
Md.	38	42	206	213	322	314	287	347
D.C.	6	10	-	-	26	39	U	U
Va.	26	23	247	240	322	451	266	414
W. Va.	-	1	55	55	61	43	50	43
N.C.	10	10	263	198	314	404	237	430
S.C.	1	1	58	71	201	138	140	137
Ga.	4	12	123	86	380	423	392	570
Fla.	34	32	61	76	625	715	46	225
E.S. CENTRAL	17	11	80	130	581	685	368	490
Ky.	3	2	12	22	138	162	76	117
Tenn.	5	4	42	44	135	170	165	192
Ala.	8	4	26	64	178	197	111	155
Miss.	1	1	-	-	130	156	16	26
W.S. CENTRAL	6	11	33	57	947	1,076	1,043	980
Ark.	1	2	-	-	149	134	66	76
La.	2	8	-	-	116	196	118	222
Okla.	3	1	33	57	132	137	88	95
Tex.	-	-	-	-	550	609	771	587
MOUNTAIN	20	21	103	87	1,109	1,119	763	1,061
Mont.	1	3	30	32	50	25	-	1
Idaho	-	1	1	-	58	39	-	39
Wyo.	-	1	26	28	21	17	14	21
Colo.	11	8	-	1	344	354	310	369
N. Mex.	-	2	7	2	90	127	83	121
Ariz.	2	3	37	24	289	310	220	268
Utah	3	2	2	-	156	170	136	189
Nev.	3	1	-	-	101	77	-	53
PACIFIC	114	105	112	162	1,946	2,104	485	2,187
Wash.	9	5	-	-	180	190	237	317
Oreg.	22	13	-	1	141	160	171	210
Calif.	81	81	93	155	1,523	1,560	-	1,515
Alaska	-	-	19	6	25	18	18	11
Hawaii	2	6	-	-	77	176	59	134
Guam	-	-	-	-	-	20	U	U
P.R.	-	-	24	43	92	234	U	U
V.I.	-	U	-	U	-	U	U	U
Amer. Samoa	-	U	-	U	-	U	U	U
C.N.M.I.	-	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 June 17, 2000, and June 19, 1999 (24th Week)

Reporting Area	Shigellosis*				Syphilis (Primary & Secondary)		Tuberculosis	
	NETSS		PHLIS					
	Cum. 2000	Cum. 1999	Cum. 2000	Cum. 1999	Cum. 2000	Cum. 1999	Cum. 2000	Cum. 1999†
UNITED STATES	7,275	5,899	3,298	3,381	2,704	3,127	4,498	6,583
NEW ENGLAND	135	147	102	135	34	28	147	160
Maine	5	-	-	-	-	-	2	-
N.H.	1	7	4	6	-	-	3	3
Vt.	1	4	-	3	-	2	-	-
Mass.	95	95	67	88	28	17	95	90
R.I.	10	14	8	9	3	1	17	19
Conn.	23	27	23	29	3	8	30	48
MID. ATLANTIC	930	408	588	242	96	139	1,012	1,063
Upstate N.Y.	398	94	140	31	7	12	118	131
N.Y. City	348	138	296	113	31	60	561	562
N.J.	109	115	76	86	20	30	234	212
Pa.	75	61	76	12	38	37	99	158
E.N. CENTRAL	1,525	1,012	430	512	568	521	522	640
Ohio	116	250	58	50	36	41	117	81
Ind.	611	38	33	15	209	167	25	48
Ill.	342	396	2	324	167	195	282	332
Mich.	348	148	306	103	136	95	61	138
Wis.	108	180	31	20	20	23	37	41
W.N. CENTRAL	720	501	492	336	37	67	212	233
Minn.	133	76	138	84	3	7	73	88
Iowa	197	7	125	10	10	5	19	26
Mo.	298	362	188	202	19	47	83	84
N. Dak.	2	2	3	2	-	-	-	2
S. Dak.	2	8	1	5	-	-	9	3
Nebr.	25	25	9	18	2	4	9	10
Kans.	63	21	28	15	3	4	19	20
S. ATLANTIC	992	1,015	256	254	901	1,020	994	1,275
Del.	7	8	4	2	4	4	-	12
Md.	45	58	15	15	132	209	108	113
D.C.	14	27	U	U	27	23	3	24
Va.	130	36	86	14	63	75	108	104
W. Va.	3	5	3	2	1	2	15	19
N.C.	56	107	22	54	274	236	127	187
S.C.	57	46	45	20	94	129	41	151
Ga.	111	100	32	37	148	190	181	268
Fla.	569	628	49	110	158	152	411	397
E.S. CENTRAL	377	578	226	387	401	547	305	413
Ky.	92	100	36	65	48	47	49	79
Tenn.	181	377	176	294	250	301	123	121
Ala.	23	55	11	27	47	125	133	136
Miss.	81	46	3	1	56	74	-	77
W.S. CENTRAL	878	1,028	741	422	371	466	136	955
Ark.	98	44	24	21	45	27	81	76
La.	69	83	53	49	89	126	1	U
Okla.	54	268	15	77	72	102	54	59
Tex.	657	633	649	275	165	211	-	820
MOUNTAIN	429	304	173	194	102	184	206	202
Mont.	3	6	-	-	-	-	6	5
Idaho	29	5	-	3	-	1	5	-
Wyo.	1	2	2	1	1	-	1	1
Colo.	76	50	30	37	2	1	24	U
N. Mex.	48	39	22	23	12	6	24	24
Ariz.	169	157	83	99	85	172	88	104
Utah	35	23	36	25	-	2	22	18
Nev.	68	22	-	6	2	2	36	50
PACIFIC	1,289	906	290	899	194	155	964	1,642
Wash.	296	47	222	52	31	35	89	76
Oreg.	91	34	54	29	4	3	8	53
Calif.	876	803	-	799	158	115	770	1,408
Alaska	7	-	3	-	-	1	40	29
Hawaii	19	22	11	19	1	1	57	76
Guam	-	7	U	U	-	1	-	-
P.R.	1	39	U	U	59	83	-	73
V.I.	-	U	U	U	-	U	-	U
Amer. Samoa	-	U	U	U	-	U	-	U
C.N.M.I.	-	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).

† Cumulative reports of provisional tuberculosis cases for 1999 are unavailable ("U") for some areas using the Tuberculosis Information System (TIMS).

TABLE III. Provisional cases of selected notifiable diseases preventable by vaccination, United States, weeks ending June 17, 2000, and June 19, 1999 (24th 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	576	571	4,950	8,835	2,796	3,081	2	17	3	9	26	55
NEW ENGLAND	39	37	115	101	32	72	-	-	2	2	2	9
Maine	1	-	7	2	5	-	-	-	-	-	-	-
N.H.	8	8	13	7	9	7	-	-	-	-	-	1
Vt.	2	4	3	1	4	1	-	-	2	2	2	-
Mass.	21	17	51	35	5	27	-	-	-	-	-	6
R.I.	1	-	7	9	9	15	-	-	-	-	-	-
Conn.	6	8	34	47	-	22	-	-	-	-	-	2
MID. ATLANTIC	86	95	217	559	269	446	-	-	1	1	1	5
Upstate N.Y.	41	38	102	110	59	92	-	-	-	-	-	2
N.Y. City	18	32	115	145	179	137	-	-	-	-	-	3
N.J.	20	23	-	71	31	66	-	-	-	-	-	-
Pa.	7	2	-	233	-	151	-	-	1	1	1	-
E.N. CENTRAL	73	91	612	1,519	308	295	1	5	-	-	5	1
Ohio	31	32	135	349	58	45	-	2	-	-	2	-
Ind.	10	13	26	54	26	23	-	-	-	-	-	1
Ill.	27	38	217	303	46	-	1	2	-	-	2	-
Mich.	5	8	221	771	177	206	-	1	-	-	1	-
Wis.	-	-	13	42	1	21	-	-	-	-	-	-
W.N. CENTRAL	32	24	558	350	346	134	-	2	-	1	3	-
Minn.	16	12	120	33	16	19	-	-	-	1	1	-
Iowa	-	1	47	71	20	22	-	1	-	-	1	-
Mo.	5	3	269	204	267	78	-	-	-	-	-	-
N. Dak.	1	-	-	1	2	-	-	-	-	-	-	-
S. Dak.	-	2	-	8	-	1	-	-	-	-	-	-
Nebr.	4	3	18	25	18	11	-	-	-	-	-	-
Kans.	6	3	104	8	23	3	-	1	-	-	1	-
S. ATLANTIC	158	127	603	813	537	462	-	-	-	-	-	4
Del.	-	-	-	2	-	-	-	-	-	-	-	-
Md.	42	30	77	153	62	86	-	-	-	-	-	-
D.C.	-	4	11	33	16	11	-	-	-	-	-	-
Va.	28	12	66	68	73	45	-	-	-	-	-	3
W. Va.	5	4	39	15	6	11	-	-	-	-	-	-
N.C.	13	21	87	57	123	100	-	-	-	-	-	-
S.C.	7	2	23	17	4	37	-	-	-	-	-	-
Ga.	42	35	80	237	84	54	U	-	U	-	-	-
Fla.	21	19	220	231	169	118	-	-	-	-	-	1
E.S. CENTRAL	30	41	213	215	200	207	-	-	-	-	-	2
Ky.	11	6	24	41	41	16	-	-	-	-	-	2
Tenn.	14	20	80	88	85	92	-	-	-	-	-	-
Ala.	4	13	29	35	25	50	-	-	-	-	-	-
Miss.	1	2	80	51	49	49	U	-	U	-	-	-
W.S. CENTRAL	31	39	849	2,599	332	523	1	1	-	-	1	3
Ark.	-	1	83	23	46	40	1	1	-	-	1	-
La.	7	10	29	75	50	104	-	-	-	-	-	-
Okla.	22	26	141	277	69	62	-	-	-	-	-	-
Tex.	2	2	596	2,224	167	317	-	-	-	-	-	3
MOUNTAIN	65	52	424	678	217	286	-	8	-	1	9	1
Mont.	-	1	2	12	3	15	-	-	-	-	-	-
Idaho	2	1	15	27	5	15	-	-	-	-	-	-
Wyo.	1	1	6	4	2	6	-	-	-	-	-	-
Colo.	11	7	89	122	48	42	-	1	-	1	2	-
N. Mex.	13	11	39	26	53	92	-	-	-	-	-	-
Ariz.	33	27	209	401	77	74	-	-	-	-	-	1
Utah	4	2	33	25	12	14	-	3	-	-	3	-
Nev.	1	2	31	61	17	28	U	4	U	-	4	-
PACIFIC	62	65	1,359	2,001	555	656	-	1	-	4	5	30
Wash.	3	1	135	141	29	31	-	-	-	-	-	5
Oreg.	18	23	106	133	44	57	-	-	-	-	-	10
Calif.	24	34	1,112	1,711	473	551	-	-	-	3	3	15
Alaska	2	5	6	4	4	10	U	1	U	-	1	-
Hawaii	15	2	-	12	5	7	-	-	-	1	1	-
Guam	-	-	-	2	-	2	U	-	U	-	-	1
P.R.	1	1	53	138	45	126	-	-	-	-	-	-
V.I.	-	U	-	U	-	U	U	-	U	-	-	U
Amer. Samoa	-	U	-	U	-	U	U	-	U	-	-	U
C.N.M.I.	-	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 126 cases among children aged <5 years, serotype was reported for 56 and of those, 14 were type b.

TABLE III. (Cont'd) Provisional cases of selected notifiable diseases preventable by vaccination, United States, weeks ending June 17, 2000, and June 19, 1999 (24th 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	1,122	1,307	3	182	192	80	2,189	2,787	-	54	137
NEW ENGLAND	63	60	-	2	4	6	540	327	-	5	7
Maine	5	-	-	-	-	-	14	46	-	-	-
N.H.	6	9	-	-	1	2	61	53	-	1	-
Vt.	2	4	-	-	-	4	115	11	-	-	-
Mass.	39	38	-	-	3	-	313	205	-	3	7
R.I.	4	2	-	1	-	-	8	3	-	-	-
Conn.	7	7	-	1	-	-	29	9	-	1	-
MID. ATLANTIC	109	129	-	9	25	5	174	567	-	2	17
Upstate N.Y.	32	35	-	6	5	3	100	488	-	2	11
N.Y. City	24	39	-	-	6	-	-	13	-	-	2
N.J.	23	25	-	-	1	-	-	15	-	-	1
Pa.	30	30	-	3	13	2	74	51	-	-	3
E.N. CENTRAL	198	225	-	23	25	8	261	211	-	-	-
Ohio	44	82	-	7	7	1	162	105	-	-	-
Ind.	27	31	-	-	2	3	25	11	-	-	-
Ill.	46	60	-	5	7	-	21	44	-	-	-
Mich.	62	28	-	11	8	4	22	20	-	-	-
Wis.	19	24	-	-	1	-	31	31	-	-	-
W.N. CENTRAL	97	135	-	12	8	14	119	85	-	1	71
Minn.	7	27	-	-	1	4	57	25	-	-	-
Iowa	18	26	-	5	3	4	21	18	-	-	20
Mo.	55	49	-	1	1	4	22	21	-	-	-
N. Dak.	2	3	-	-	-	-	1	-	-	-	-
S. Dak.	5	8	-	-	-	1	3	2	-	-	-
Nebr.	5	8	-	2	-	-	3	1	-	-	51
Kans.	5	14	-	4	3	1	12	18	-	1	-
S. ATLANTIC	185	203	2	32	33	5	178	135	-	32	17
Del.	-	3	-	-	-	-	4	-	-	-	-
Md.	16	33	1	7	4	-	40	41	-	-	1
D.C.	-	1	-	-	2	-	1	-	-	-	-
Va.	30	26	-	5	8	3	20	13	-	-	-
W. Va.	7	4	-	-	-	-	-	1	-	-	-
N.C.	30	25	-	4	7	-	49	33	-	23	16
S.C.	12	26	1	10	3	-	16	8	-	7	-
Ga.	32	37	U	2	1	U	20	16	U	-	-
Fla.	58	48	-	4	8	2	28	23	-	2	-
E.S. CENTRAL	81	98	-	6	3	2	36	53	-	4	2
Ky.	17	19	-	-	-	1	17	12	-	1	-
Tenn.	35	34	-	2	-	-	9	26	-	-	-
Ala.	24	27	-	2	1	1	9	13	-	3	2
Miss.	5	18	U	2	2	U	1	2	U	-	-
W.S. CENTRAL	85	132	1	19	23	17	100	72	-	4	4
Ark.	7	24	-	1	-	1	10	6	-	-	-
La.	27	45	-	3	4	-	3	3	-	-	-
Okla.	21	19	-	-	1	-	6	8	-	-	-
Tex.	30	44	1	15	18	16	81	55	-	4	4
MOUNTAIN	63	86	-	14	9	6	381	301	-	1	15
Mont.	1	2	-	1	-	-	7	2	-	-	-
Idaho	6	8	-	-	1	-	42	94	-	-	-
Wyo.	-	3	-	1	-	-	1	2	-	-	-
Colo.	21	23	-	1	3	2	210	86	-	1	-
N. Mex.	7	10	-	1	N	1	68	24	-	-	-
Ariz.	18	28	-	3	-	3	40	60	-	-	13
Utah	7	7	-	4	2	-	9	31	-	-	1
Nev.	3	5	U	3	3	U	4	2	U	-	1
PACIFIC	241	239	-	65	62	17	400	1,036	-	5	4
Wash.	28	37	-	3	2	16	149	477	-	-	-
Oreg.	31	40	N	N	N	1	43	19	-	-	-
Calif.	173	152	-	55	54	-	197	517	-	5	4
Alaska	3	6	U	4	1	U	7	3	U	-	-
Hawaii	6	4	-	3	5	-	4	20	-	-	-
Guam	-	1	U	-	1	U	-	1	U	-	-
P.R.	4	11	-	-	-	-	-	8	-	-	-
V.I.	-	U	U	-	U	U	-	U	U	-	U
Amer. Samoa	-	U	U	-	U	U	-	U	U	-	U
C.N.M.I.	-	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 June 17, 2000 (24th Week)

Reporting Area	All Causes, By Age (Years)						P&I† Total
	All Ages	≥65	45-64	25-44	1-24	<1	
NEW ENGLAND	498	341	108	34	9	6	52
Boston, Mass.	146	84	42	12	4	4	10
Bridgeport, Conn.	45	33	8	4	-	-	3
Cambridge, Mass.	28	21	5	2	-	-	2
Fall River, Mass.	24	20	4	-	-	-	3
Hartford, Conn.	U	U	U	U	U	U	U
Lowell, Mass.	38	24	10	2	1	1	4
Lynn, Mass.	15	11	2	1	1	-	4
New Bedford, Mass.	23	18	4	1	-	-	1
New Haven, Conn.	61	45	11	2	2	1	7
Providence, R.I.	U	U	U	U	U	U	U
Somerville, Mass.	5	5	-	-	-	-	-
Springfield, Mass.	35	22	8	4	1	-	5
Waterbury, Conn.	25	22	2	1	-	-	7
Worcester, Mass.	53	36	12	5	-	-	6
MID. ATLANTIC	2,287	1,550	490	163	34	48	137
Albany, N.Y.	54	39	6	6	-	3	2
Allentown, Pa.	U	U	U	U	U	U	U
Buffalo, N.Y.	97	67	21	4	1	3	8
Camden, N.J.	19	13	6	-	-	-	-
Elizabeth, N.J.	22	16	5	1	-	-	-
Erie, Pa.§	43	34	9	-	-	-	5
Jersey City, N.J.	54	36	12	6	-	-	-
New York City, N.Y.	1,061	707	251	75	18	10	56
Newark, N.J.	93	48	24	19	-	2	6
Paterson, N.J.	19	10	7	2	-	-	2
Philadelphia, Pa.	381	237	87	30	9	17	15
Pittsburgh, Pa.§	76	50	16	4	-	6	7
Reading, Pa.	30	26	-	1	1	2	6
Rochester, N.Y.	122	91	19	8	2	2	12
Schenectady, N.Y.	15	12	2	1	-	-	1
Scranton, Pa.§	34	25	7	1	1	-	5
Syracuse, N.Y.	103	89	7	3	1	3	8
Trenton, N.J.	32	25	5	1	1	-	2
Utica, N.Y.	17	14	3	-	-	-	1
Yonkers, N.Y.	15	11	3	1	-	-	1
E.N. CENTRAL	1,992	1,352	388	139	56	54	147
Akron, Ohio	44	31	8	2	1	2	3
Canton, Ohio	44	36	6	2	-	-	3
Chicago, Ill.	385	251	83	30	10	8	34
Cincinnati, Ohio	76	47	13	10	2	4	7
Cleveland, Ohio	134	89	31	5	4	5	3
Columbus, Ohio	210	133	48	19	6	4	13
Dayton, Ohio	126	94	23	4	3	2	7
Detroit, Mich.	199	117	50	21	4	7	19
Evansville, Ind.	46	33	11	2	-	-	5
Fort Wayne, Ind.	71	58	9	3	-	1	5
Gary, Ind.	16	6	2	4	4	-	-
Grand Rapids, Mich.	60	46	8	1	3	2	8
Indianapolis, Ind.	182	118	35	10	9	10	10
Lansing, Mich.	U	U	U	U	U	U	U
Milwaukee, Wis.	111	76	26	5	1	3	7
Peoria, Ill.	40	32	3	2	1	2	5
Rockford, Ill.	52	43	4	2	3	-	4
South Bend, Ind.	51	31	9	6	3	2	4
Toledo, Ohio	88	66	12	8	1	1	8
Youngstown, Ohio	57	45	7	3	1	1	2
W.N. CENTRAL	947	671	168	65	24	19	90
Des Moines, Iowa	97	68	18	6	2	3	12
Duluth, Minn.	25	23	2	-	-	-	4
Kansas City, Kans.	47	28	10	5	4	-	6
Kansas City, Mo.	81	55	19	5	-	2	2
Lincoln, Nebr.	50	42	5	2	1	-	2
Minneapolis, Minn.	179	134	30	9	4	2	14
Omaha, Nebr.	73	47	13	9	2	2	2
St. Louis, Mo.	118	72	25	13	3	5	-
St. Paul, Minn.	107	82	14	4	3	4	9
Wichita, Kans.	170	120	32	12	5	1	39

Reporting Area	All Causes, By Age (Years)						P&I† Total
	All Ages	≥65	45-64	25-44	1-24	<1	
S. ATLANTIC	951	597	198	97	33	24	57
Atlanta, Ga.	U	U	U	U	U	U	U
Baltimore, Md.	145	78	29	28	4	6	13
Charlotte, N.C.	105	61	23	10	4	7	11
Jacksonville, Fla.	123	64	34	12	10	3	4
Miami, Fla.	109	70	20	13	3	1	9
Norfolk, Va.	29	15	8	3	2	1	4
Richmond, Va.	51	32	13	2	2	2	4
Savannah, Ga.	61	42	13	2	3	1	-
St. Petersburg, Fla.	45	35	6	4	-	-	2
Tampa, Fla.	166	123	27	12	3	1	9
Washington, D.C.	100	60	25	11	2	2	1
Wilmington, Del.	17	17	-	-	-	-	-
E.S. CENTRAL	811	568	164	48	19	12	70
Birmingham, Ala.	149	98	36	8	3	4	15
Chattanooga, Tenn.	89	62	16	6	3	2	9
Knoxville, Tenn.	64	46	14	3	1	-	7
Lexington, Ky.	67	43	19	2	3	-	3
Memphis, Tenn.	180	132	33	10	5	-	13
Mobile, Ala.	85	55	19	9	1	1	4
Montgomery, Ala.	54	41	6	6	-	1	6
Nashville, Tenn.	123	91	21	4	3	4	13
W.S. CENTRAL	1,219	815	252	86	37	29	78
Austin, Tex.	81	48	18	7	5	3	3
Baton Rouge, La.	56	36	11	6	1	2	2
Corpus Christi, Tex.	60	49	8	1	1	1	5
Dallas, Tex.	202	133	42	18	6	3	7
El Paso, Tex.	57	46	4	2	4	1	2
Ft. Worth, Tex.	87	63	19	3	1	1	6
Houston, Tex.	320	205	63	30	13	9	29
Little Rock, Ark.	55	29	17	3	1	5	-
New Orleans, La.	U	U	U	U	U	U	U
San Antonio, Tex.	221	158	47	11	3	2	15
Shreveport, La.	80	48	23	5	2	2	9
Tulsa, Okla.	U	U	U	U	U	U	U
MOUNTAIN	1,011	646	219	81	33	32	51
Albuquerque, N.M.	127	81	32	6	3	5	2
Boise, Idaho	43	31	11	1	-	-	6
Colo. Springs, Colo.	78	58	11	7	-	2	5
Denver, Colo.	86	51	21	8	3	3	6
Las Vegas, Nev.	219	133	60	17	5	4	9
Ogden, Utah	21	12	5	1	1	2	2
Phoenix, Ariz.	174	100	41	20	7	6	9
Pueblo, Colo.	21	16	4	1	-	-	1
Salt Lake City, Utah	111	81	10	9	6	5	6
Tucson, Ariz.	131	83	24	11	8	5	5
PACIFIC	1,067	763	199	59	19	26	74
Berkeley, Calif.	22	16	3	1	-	2	1
Fresno, Calif.	122	89	17	11	4	1	-
Glendale, Calif.	U	U	U	U	U	U	U
Honolulu, Hawaii	66	46	15	3	-	2	9
Long Beach, Calif.	69	53	9	4	3	-	6
Los Angeles, Calif.	U	U	U	U	U	U	U
Pasadena, Calif.	29	15	8	3	-	3	3
Portland, Oreg.	135	93	30	4	2	6	4
Sacramento, Calif.	U	U	U	U	U	U	U
San Diego, Calif.	178	131	29	12	2	4	21
San Francisco, Calif.	U	U	U	U	U	U	U
San Jose, Calif.	161	126	22	6	3	4	12
Santa Cruz, Calif.	28	20	6	2	-	-	1
Seattle, Wash.	124	85	31	2	3	3	7
Spokane, Wash.	48	25	19	2	1	1	6
Tacoma, Wash.	85	64	10	9	1	-	4
TOTAL	10,783¶	7,303	2,186	772	264	250	756

U: Unavailable. -:No reported cases.

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

†Pneumonia and influenza.

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

¶Total includes unknown ages.

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