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Great American Smokeout — November 18, 2010

The Great American Smokeout (GASO), sponsored by the American Cancer Society, is an annual event that encourages smokers to quit for at least 1 day in the hope that this might challenge them to stop permanently (*1*). This year, GASO will be held on November 18.

Major changes have occurred since the first GASO in 1977. In 1978, approximately 34% of adults smoked; by 2009, nearly 21% smoked (*2–4*). Federal laws now prohibit smoking on airlines, and 24 states and the District of Columbia have comprehensive smoking bans (*3,4*). The U.S. government also has added coverage of smoking cessation treatments to health plans. As of October 1, 2010, Medicaid programs are required to cover tobacco-dependence treatments for pregnant women, and in 2011, cessation coverage will be provided to all federal employees, retirees, and their spouses and dependents.

Despite progress, 46.6 million U.S. adults smoke, 40% of nonsmokers are exposed to secondhand smoke, and 443,000 deaths each year are attributed to smoking and secondhand smoke (*3–5*). Additional information and support for quitting is available online (http://www.smokefree.gov) or by telephone (800-QUIT-NOW [800-784-8669]; TTY 800-332-8615).

References

1. American Cancer Society. Great American Smokeout. Available at http://www.cancer.org/healthy/stayawayfromtobacco/greatamericansmokeout. Atlanta, GA: American Cancer Society; 2010. Accessed November 2, 2010.
2. CDC. Surveillance for selected tobacco-use behaviors—United States, 1900–1994. MMWR 1994;43(No. SS-3).
3. CDC. Vital signs: current cigarette smoking among adults aged ≥18 years—United States, 2009. MMWR 2010;59:1135–40.
4. CDC. Vital signs: nonsmokers' exposure to secondhand smoke—United States, 1999–2008. MMWR 2010;59:1141–6.
5. CDC. Smoking-attributable mortality, years of potential life lost, and productivity losses—United States, 2000–2004. MMWR 2008;57:1226–8.

Racial/Ethnic Disparities and Geographic Differences in Lung Cancer Incidence — 38 States and the District of Columbia, 1998–2006

Lung cancer is the second most commonly diagnosed cancer in both males and females and the leading cause of cancer-related death in the United States (*1*). Lung cancer affects some races more than others; blacks have higher incidence and mortality rates than do whites (*2,3*). This report presents the first analysis of lung cancer incidence among racial/ethnic groups by U.S. census region. CDC analyzed data collected by CDC's National Program of Cancer Registries (NPCR) and the National Cancer Institute's Surveillance, Epidemiology, and End Results (SEER) Program for the period 1998–2006. These combined data reflect new lung cancer cases representing approximately 80% of the U.S. population. During this study period, annual incidence per 100,000 population was highest among blacks (76.1), followed by whites (69.7), American Indians/Alaska Natives (AI/ANs) (48.4), and Asian/Pacific Islanders (A/PIs) (38.4). Hispanics had lower lung cancer incidence (37.3) than non-Hispanics (71.9). Incidence varied greatly with age, peaking among persons aged 70–79 years (426.7). The region with the highest incidence was the South (76.0); the lowest was the West (58.8). Among

INSIDE

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
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whites, the highest lung cancer incidence was in the South (76.3); the highest incidence among blacks (88.9), AI/ANs (64.2), and Hispanics (40.6) were in the Midwest, and the highest incidence among A/PIs was in the West (42.5). These findings identify the racial/ethnic populations and geographic regions that would most benefit from enhanced efforts in primary prevention, specifically by reducing tobacco use and exposure to environmental carcinogens.

Data available from population-based cancer registries affiliated with NPCR, the SEER Program, or both were used in this analysis; new cases of cancer were those reported in NPCR as of January 31, 2009, and in SEER as of November 1, 2008. Data were evaluated according to United States Cancer Statistics (USCS) eligibility criteria.* Thirty-eight states and the District of Columbia met these criteria, representing 79.5% of the U.S. population for the years 1998–2006. Because of the 79.5% population coverage, cancer rates derived from these data are considered to approximate national incidence. Only cancer cases with the primary site of lung or bronchus, according to the World Health Organization's *International Classification of Diseases for Oncology, Third Edition*, were included in this analysis. Incidence is presented as average annual number of new cases per 100,000 persons. All findings are statistically significant unless otherwise noted. With the exception of age-specific rates, rates are age-adjusted to the 2000 U.S. standard population with 19 age groups.† Adjustments to population data were made by the U.S. Census Bureau to account for the Gulf Coast population in Alabama, Mississippi, Louisiana, and Texas displaced by Hurricanes Katrina and Rita in 2005.§

During 1998–2006, a total of 1,433,172 persons received lung cancer diagnoses (annual incidence: 69.3 per 100,000) in the United States (Table 1). Annual incidence per 100,000 was higher among

* The USCS dataset is the combined incidence data from CDC and the National Cancer Institute. USCS data provide the official federal statistics on cancer incidence from registries that have high-quality data for each year during the 1998–2006 period; 38 states and the District of Columbia met the data-quality standards. States that did not meet data-quality standards were Alabama, Arkansas, Arizona, Georgia, Maryland, Mississippi, New Hampshire, North Carolina, South Dakota, Tennessee, Virginia, and Wisconsin.

† Additional information available at http://seer.cancer.gov/popdata/index.html.

§ Additional information available at http://www.census.gov/popest/topics/methodology.

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TABLE 1. Lung cancer incidence,* by sex and selected demographic characteristics — United States, 1998–2006†

Characteristic	Total			Males			Females		
	No.	Rate	(95% CI)	No.	Rate	(95% CI)	No.	Rate	(95% CI)
Total	**1,433,172**	**69.3**	**(69.1–69.4)**	**792,057**	**88.2**	**(88.0–88.4)**	**641,115**	**55.4**	**(55.3–55.6)**
Age group (yrs)									
<40	10,570	0.9	(0.9–0.9)	5,087	0.9	(0.8–0.9)	5,483	1.0	(0.9–1.0)
40–49	68,349	21.8	(21.7–22.0)	35,752	23.1	(22.8–23.3)	32,597	20.7	(20.4–20.9)
50–59	207,554	86.5	(86.1–86.9)	116,977	100.0	(99.4–100.5)	90,577	73.7	(73.2–74.1)
60–69	395,283	258.0	(257.2–258.8)	225,200	312.4	(311.1–313.7)	170,083	209.6	(208.6–210.6)
70–79	496,101	426.7	(425.5–427.9)	277,254	553.0	(551.0–555.1)	218,847	330.9	(329.6–332.3)
≥80	255,315	354.8	(353.4–356.2)	131,787	532.1	(529.2–535.0)	123,528	261.8	(260.3–263.2)
Race§									
White	1,269,605	69.7	(69.6–69.8)	695,882	87.5	(87.3–87.7)	573,723	56.6	(56.5–56.8)
Black	124,407	76.1	(75.7–76.5)	73,413	110.2	(109.4–111.1)	50,994	53.3	(52.8–53.8)
American Indian/Alaska Native	5,769	48.4	(47.1–49.8)	3,039	58.3	(56.1–60.6)	2,730	41.2	(39.6–42.8)
Asian/Pacific Islander	27,787	38.4	(38.0–38.9)	16,548	53.0	(52.1–53.8)	11,239	27.5	(26.9–28.0)
Ethnicity									
Non-Hispanic	1,378,181	71.9	(71.8–72.1)	852,058,465	91.2	(91.0–91.4)	618,608	57.8	(57.7–58.0)
Hispanic	54,990	37.3	(36.9–37.6)	159,589,451	51.7	(51.1–52.3)	22,507	26.8	(26.5–27.2)

Abbreviation: CI = confidence interval.

* Average annual rates of lung cancer diagnosed per 100,000 persons, age adjusted to the 2000 U.S. standard population.

† Data are from the population-based cancer registries covering 79.5% of the U.S. population. The United States Cancer Statistics (USCS) dataset is the combined incidence data from CDC and the National Cancer Institute. USCS data provide the official federal statistics on cancer incidence from registries that have high-quality data for each year from 1998 to 2006; 38 states and the District of Columbia met data-quality standards. States that did not meet data-quality standards included Alabama, Arkansas, Arizona, Georgia, Maryland, Mississippi, New Hampshire, North Carolina, South Dakota, Tennessee, Virginia, and Wisconsin.

§ All persons are of either Hispanic or non-Hispanic ethnicity. Hispanics might be of any race. Counts do not sum to total because rates for unknown race were not calculated.

males (88.2) than females (55.4). Incidence was highest among blacks (76.1), followed by whites (69.7), AI/ANs (48.4), and A/PIs (38.4). Hispanics had lower lung cancer incidence (37.3) than non-Hispanics (71.9). By age group, incidence was highest among persons aged 70–79 years (426.7), followed by ≥80 years (354.8), 60–69 years (258.0), 50–59 years (86.5), 40–49 years (21.8), and <40 years (0.9), a pattern that persisted within racial and ethnic categories (Table 2). Lung cancer incidence was higher among blacks and whites than among AI/ANs or A/PIs for all age groups. When analyzed by U.S. census region,¶ lung cancer incidence was highest in the South (76.0), followed by the Midwest (73.0), Northeast (68.6), and West (58.8) (Figure). Among whites, the highest lung cancer incidence was in the South (76.3); incidence among blacks (88.9), AI/ANs (64.2 [not significant]), and Hispanics (40.6 [not significant]) was highest in the Midwest, and incidence among A/PIs was highest in the West (42.5).

¶ *Northeast:* Connecticut, Maine, Massachusetts, Rhode Island, Vermont, New Jersey, New York, and Pennsylvania; *Midwest:* Indiana, Illinois, Michigan, Ohio, Iowa, Nebraska, Kansas, North Dakota, Minnesota, and Missouri; *South:* Delaware, District of Columbia, Florida, South Carolina, West Virginia, Kentucky, Louisiana, Oklahoma, and Texas; *West:* Colorado, Idaho, New Mexico, Montana, Utah, Nevada, Wyoming, Alaska, California, Hawaii, Oregon, and Washington.

Reported by

TL Fairley, PhD, E Tai, MD, JS Townsend, MS, SL Stewart, PhD, CB Steele, DO, Div of Cancer Prevention and Control, National Center for Chronic Disease Prevention and Health Promotion; SP Davis, PhD, Office on Smoking and Health, National Center for Chronic Disease Prevention and Health Promotion; JM Underwood, PhD, EIS Officer, CDC.

Editorial Note

The findings in this report indicate lung cancer incidence during 1998–2006 was higher in the black population and in persons in the southern United States. However, variation also was observed in lung cancer incidence among racial/ethnic groups by U.S. census region. These findings are consistent with reports indicating a higher incidence among blacks compared with other racial groups (*2*) and reports showing geographic differences in lung cancer incidence among AI/ANs (*4*). Racial/ethnic disparities in lung cancer incidence are associated with multiple factors, including differences in smoking prevalence,** metabolism of tobacco smoke products (*6*),

** Additional information available at http://apps.nccd.cdc.gov/brfss/race_c.asp?cat=tu&qkey=4396&yr=2008&state=ub&bkey=20089917&qtype=c&yr_c=1995&state_c=&bkey_c=19959910&qtype_c=c&grouping=&resp=1.

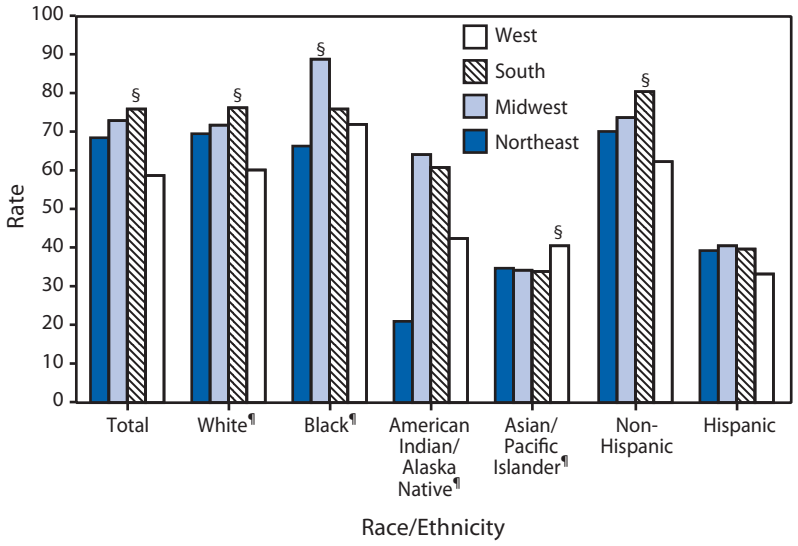
TABLE 2. Lung cancer incidence,* by race/ethnicity and age group — United States, 1998–2006†

Characteristic	Total			White§			Black§			American Indian/Alaska Native§		
	No.	Rate	(95% CI)	No.	Rate	(95% CI)	No.	Rate	(95% CI)	No.	Rate	(95% CI)
Total	**1,433,172**	**69.3**	**(69.1–69.4)**	1,269,605	69.7	(69.6–69.8)	124,407	76.1	(75.7–76.5)	5,769	48.4	(47.1–49.8)
Age group (yrs)												
<40	**10,570**	**0.9**	**(0.9–0.9)**	8,504	0.9	(0.9–0.9)	1,396	0.9	(0.9–1.0)	65	0.5	(0.4–0.6)
40–49	**68,349**	**21.8**	**(21.7–22.0)**	55,128	21.1	(20.9–21.3)	10,766	32.9	(32.3–33.6)	368	12.1	(10.9–13.4)
50–59	**207,554**	**86.5**	**(86.1–86.9)**	175,406	85.5	(85.1–85.9)	25,696	117.8	(116.4–119.3)	1,107	54.8	(51.6–58.1)
60–69	**395,283**	**258.0**	**(257.2–258.8)**	347,374	261.4	(260.5–262.3)	37,246	286.2	(283.3–289.1)	1,825	174.2	(166.3–182.4)
70–79	**496,101**	**426.7**	**(425.5–427.9)**	448,812	432.9	(431.6–434.2)	34,721	422.7	(418.3–427.2)	1,723	313.1	(298.5–328.2)
≥80	**255,315**	**354.8**	**(353.4–356.2)**	234,381	356.9	(355.5–358.4)	14,582	340.3	(334.8–345.9)	681	260.0	(240.8–280.2)

Characteristic	Asian/Pacific Islander§			Hispanic			Non-Hispanic		
	No.	Rate	(95% CI)	No.	Rate	(95% CI)	No.	Rate	(95% CI)
Total	**27,787**	**38.4**	**(38–38.9)**	**54,990**	**37.3**	**(36.9–37.6)**	**1,378,181**	**71.9**	**(71.8–72.1)**
Age group (yrs)									
<40	479	0.7	(0.7–0.8)	1,021	0.4	(0.4–0.5)	9,549	1.0	(1.0–1.0)
40–49	1,709	10.9	(10.4–11.5)	3,510	9.2	(8.9–9.5)	64,839	23.6	(23.4–23.8)
50–59	4,377	39.9	(38.7–41.1)	8,909	39.6	(38.8–40.4)	198,644	91.3	(90.9–91.7)
60–69	7,329	117.1	(114.4–119.8)	15,272	121.2	(119.3–123.2)	380,011	270.2	(269.4–271.1)
70–79	9,069	237.1	(232.2–242.0)	17,639	233.8	(230.3–237.3)	478,462	440.1	(438.9–441.3)
≥80	4,824	276.6	(268.9–284.5)	8,639	247.9	(242.7–253.2)	246,676	360.2	(358.8–361.7)

Abbreviations: CI = confidence interval.
* Average annual rates of lung cancer diagnosed per 100,000 persons, age adjusted to the 2000 U.S. standard population.
† Data are from the population-based cancer registries covering 79.5% of the U.S. population. The United States Cancer Statistics (USCS) dataset is the combined incidence data from CDC and the National Cancer Institute. USCS data provide the official federal statistics on cancer incidence from registries that have high-quality data for each year from 1998 to 2006; 38 states and the District of Columbia met data-quality standards. States that did not meet data-quality standards included Alabama, Arkansas, Arizona, Georgia, Maryland, Mississippi, New Hampshire, North Carolina, South Dakota, Tennessee, Virginia, and Wisconsin.
§ All persons are of either Hispanic or non-Hispanic ethnicity. Hispanics might be of any race.

FIGURE. Lung cancer incidence,* by race/ethnicity and U.S. census region — United States, 1998–2006†



* Average annual rates of lung cancer diagnosed per 100,000 persons, age adjusted to the 2000 U.S. standard population.
† Data are from the population-based cancer registries covering 79.5% of the U.S. population. The United States Cancer Statistics (USCS) dataset is the combined incidence data from CDC and the National Cancer Institute. USCS data provide the official federal statistics on cancer incidence from registries that have high-quality data for each year from 1998 to 2006; 38 states and the District of Columbia met data-quality standards. States that did not meet data-quality standards included Alabama, Arkansas, Arizona, Georgia, Maryland, Mississippi, New Hampshire, North Carolina, South Dakota, Tennessee, Virginia, and Wisconsin.
§ Difference is statistically significant (nonoverlapping 95% confidence intervals).
¶ All persons are of either Hispanic or non-Hispanic ethnicity. Hispanics might be of any race.

susceptibility to tobacco-induced lung cancer (*7*), and socioeconomic status (*8*). Blacks are more susceptible to smoking-induced lung cancer (*7*) and have less access to health-care services compared with whites.†† These factors might contribute to the higher lung cancer incidence in the black population. Lung cancer also is caused by environmental exposures. Radon, for example, is a naturally occurring, colorless, odorless gas that can become trapped in buildings; it is the second leading cause of lung cancer overall, and the leading cause of lung cancer in nonsmokers.§§

This report presents an analysis of lung cancer incidence in all racial/ethnic groups by U.S. census region. The observed variation in lung cancer incidence by region parallels a reported variation in smoking prevalence across the United States, including higher smoking rates in the South and Midwest and lower rates in the West (*9*). Regional differences also were observed in smoking prevalence by race/ethnicity, including a higher smoking prevalence among whites in the South, blacks and Hispanics in the Midwest, and A/PIs in the West (*9*). State

†† Additional information available at http://www.nap.edu/openbook.php?record_id=12875&page=R1.
§§ Additional information available at http://www.epa.gov/radon/healthrisks.html.

comprehensive tobacco control programs, which aim to reduce smoking and tobacco use, can help reduce regional variation of lung cancer incidence.

The findings in this report are subject to at least four limitations. First, USCS data include only 80% of the entire U.S. population and therefore might not accurately represent the whole U.S. population. National estimates of lung cancer incidence might be underreported because many of the states that did not meet data-quality standards[¶¶] are in the South, the region with the highest smoking prevalence (*9*). Despite incomplete U.S. population coverage, combined data from the NPCR and SEER programs provide the best source of information on population-based cancer incidence for the nation, and the only source of information for states having only NPCR-funded cancer surveillance programs. Second, information about smoking status is not available in the cancer registry data. As more complete incidence data become available for all populations in the United States, researchers might be able to further describe patterns of cancer incidence that are specifically related to tobacco use. Third, racial/ethnic data in registries generally are of varying quality for AI/ANs and Hispanics (*5*). Finally, the distribution of lung cancer histologic types was not considered in this analysis. Although racial differences in histology have been shown in previous studies (*3*), unpublished analyses by CDC show little variation in lung cancer histology by region or race/ethnicity (CDC, unpublished data, 2010).

Observed variations in lung cancer incidence among racial/ethnic groups likely are influenced by differences in smoking prevalence, exposure to carcinogens, and genetic susceptibility to lung cancer. Tobacco control efforts to prevent initiation and increase cessation have been effective in decreasing lung cancer incidence overall and in narrowing the race-based disparity among young adult smokers (i.e., those aged 20–39 years) (*10*). A recent CDC report indicates that smoking prevalence varies among racial/ethnic groups, and is highest among persons living below the federal poverty level and those with low educational attainment.[***] Use of the U.S. Public Health Service *Guidelines for Treating Tobacco Use and Dependence*[†††] is recommended for all persons who use tobacco across the racial/ethnic groups included in this report. Smoking cessation counseling interventions (e.g., quitlines) and medications have been found to be effective cessation interventions in these various populations. CDC also recommends a comprehensive approach to tobacco control, including evidence-based tobacco prevention and cessation strategies.[§§§] For example, given that disparities in cigarette use exist, targeted media campaigns should be implemented to reduce social inequalities in smoking and lower the risk for cancer-related morbidity and mortality in minority populations. Enhanced smoke-free laws, and reduced radon exposure also will help decrease lung cancer disparities.[¶¶¶] In addition to the implementation of population-based interventions, continued surveillance of lung cancer incidence and smoking prevalence within subpopulations in the United States is warranted.[****]

What is already known on this topic?

Racial and ethnic disparities in lung cancer incidence and mortality exist in the United States; blacks have been shown to have higher rates of lung cancer incidence and mortality than the general population, and Hispanics have had lower rates.

What is added by this report?

This report is the first comprehensive analysis of lung cancer incidence for racial/ethnic subpopulations by U.S. census region, and reveals lung cancer incidence is higher in the South; lung cancer incidence is highest for whites in the South, for blacks, Hispanics, and American Indians/Alaska Natives in the Midwest, and for Asians/Pacific Islanders in the West.

What are the implications for public health practice?

Antismoking initiatives and efforts to reduce exposure to environmental carcinogens (e.g., radon and secondhand smoke) should be implemented to reduce the toll of lung cancer among all populations, especially targeting those at risk.

¶¶ Additional information available at http://www.cdc.gov/cancer/npcr/uscs/2006/technical_notes/criteria.htm.

*** Additional information available at http://www.cdc.gov/vitalsigns/tobaccouse/smoking.

††† Available at http://www.surgeongeneral.gov/tobacco/treating_tobacco_use.pdf.

§§§ Additional information available at http://www.cdc.gov/tobacco/stateandcommunity/best_practices/pdfs/2007/bestpractices_complete.pdf.

¶¶¶ Additional information available at http://www.lungusa.org/assets/documents/publications/lung-disease-data/ala-lung-cancer-in-african.pdf.

**** Additional information available at http://apps.nccd.cdc.gov/uscs and http://www.cdc.gov/brfss.

References

1. Jemal A, Siegel R, Ward E, Hao Y, Xu J, Thun MJ. Cancer statistics, 2009. CA Cancer J Clin 2009;59:225–49.
2. Gadgeel SM, Kalemkerian GP. Racial differences in lung cancer. Cancer Metastasis Rev 2003;22:39–46.
3. Bach PB, Cramer LD, Warren JL, Begg CB. Racial differences in the treatment of early-stage lung cancer. N Engl J Med 1999;341:1198–205.
4. Bliss A, Cobb N, Solomon T, et al. Lung cancer incidence among American Indians and Alaska Natives in the United States, 1999–2004. Cancer 2008;113(5 Suppl):1168–78.
5. Clegg LX, Reichman ME, Hankey BF, et al. Quality of race, Hispanic ethnicity, and immigrant status in population-based cancer registry data: implications for health disparity studies. Cancer Causes Control 2007;18:177–87.
6. Wagenknecht LE, Cutter GR, Haley NJ, et al. Racial differences in serum cotinine levels among smokers in the Coronary Artery Risk Development in (Young) Adults study. Am J Public Health 1990;80:1053–6.
7. Haiman CA, Stram DO, Wilkens LR, et al. Ethnic and racial differences in the smoking-related risk of lung cancer. N Engl J Med 2006;354:333–42.
8. Ward E, Jemal A, Cokkinides V, et al. Cancer disparities by race/ethnicity and socioeconomic status. CA Cancer J Clin 2004;54:78–93.
9. Shopland DR, Hartman AM, Gibson JT, Mueller MD, Kessler LG, Lynn WR. Cigarette smoking among U.S. adults by state and region: estimates from the current population survey. J Natl Cancer Inst 1996;88:1748–58.
10. Jemal A, Center MM, Ward E. The convergence of lung cancer rates between blacks and whites under the age of 40, United States. Cancer Epidemiol Biomarkers Prev 2009;18:3349–52.

Increasing Prevalence of Parent-Reported Attention-Deficit/Hyperactivity Disorder Among Children — United States, 2003 and 2007

Attention-deficit/hyperactivity disorder (ADHD) is a neurobehavioral disorder that typically begins in childhood and often persists into adulthood. ADHD is characterized by developmentally inappropriate levels of inattention and hyperactivity resulting in functional impairment in academic, family, and social settings (*1*). ADHD is the most commonly diagnosed neurobehavioral disorder of childhood, with previous reports documenting increasing trends in prevalence during the past decade and increases in ADHD medication use (*2,3*). National estimates of the number of children reported by their parents to have ever been diagnosed with ADHD and the percentage of children with ADHD currently taking ADHD medications were published in 2005 using data from the 2003 National Survey of Children's Health (NSCH) (*4,5*). This report describes results from the second administration of NSCH in 2007 (*6*), which indicated that the percentage of children aged 4–17 years with a parent-reported ADHD diagnosis (ever) increased from 7.8% to 9.5% during 2003–2007, representing a 21.8% increase in 4 years. The findings in this report help to further characterize the substantial impact of ADHD on families.

The 2003 and 2007 NSCH were national, cross-sectional, random-digit–dialed landline telephone surveys used to estimate the prevalence of health and well-being indicators among children aged <18 years in the United States (*5,6*).* One child was selected randomly from each household to be the focus of the parent or guardian interview. Information about the design and response rates of the 2003 NSCH have been published (*5*). The design of the 2003 and 2007 surveys were similar. During April 2007–July 2008, a total of 91,642 interviews were completed for the 2007 NSCH (overall response rate = 46.7%; cooperation rate = 66.0%).† In 2007, data, including complete information on ADHD and sex, were obtained for 73,123 children aged 4–17 years. Data were weighted to account for unequal probabilities of selection of households and children, nonresponse, and households without landline telephones, and to reflect the demographic distribution of noninstitutionalized children in the United States.§

In both 2003 and 2007, parents were asked whether or not a doctor or other health-care provider had ever told them that their child had "attention deficit disorder or attention deficit hyperactive disorder, that is, ADD or ADHD." In 2007, parents who reported an ADHD diagnosis (ever) also were asked whether the child currently had ADHD and to describe its severity (mild, moderate, or severe). The question about medication use in the 2003 survey differed from that in the 2007 survey. Current medication treatment for ADHD was asked about children who ever had ADHD in 2003 and about children with current ADHD in 2007. Estimates of parent-reported ADHD (ever and current) among children aged 4–17 years, current medication use, and ADHD severity were calculated overall and by sociodemographic characteristics (Table 1) using 2007 data and NSCH survey weights. Rates of ADHD by sociodemographic characteristics using the 2003 survey data have been published (*4*) and were compared with 2007 data for the present analysis (Table 2). Estimated rates of children medicated for ADHD were calculated by dividing the weighted estimate of the number of children with current ADHD who were being medicated for the disorder by the total weighted estimate of the number of children aged 4–17 years. Prevalence ratios and 95% confidence intervals were calculated to

* The 2003 and 2007 NSCH were directed by the Health Resources and Services Administration's Maternal Child Health Bureau and conducted by CDC's National Center for Health Statistics through the State and Local Area Integrated Telephone Survey. Additional information about NSCH is available at http://www.cdc.gov/nchs/slaits/nsch.htm.

† The response rate represents the percentage of households that completed interviews among all eligible households, including those that were not successfully contacted. The cooperation rate is the percentage of households that completed interviews among all eligible households that were contacted. NSCH attempts to minimize nonresponse bias by incorporating nonresponse adjustments in the development of the sampling weights.

§ Demographic distributions were based on the 2007 American Community Survey of the U.S. Census Bureau.

TABLE 1. Weighted prevalence estimates of parent-reported attention-deficit/hyperactivity disorder (ADHD) among children aged 4–17 years,* by sociodemographic characteristics — National Survey of Children's Health, United States, 2007

	Ever diagnosed with ADHD			Current ADHD diagnosis			Current ADHD diagnosis and medicated for ADHD		
Characteristic	**%**	**(95% CI)**	**PR**	**%**	**(95% CI)**	**PR**	**%**	**(95% CI)**	**PR**
Overall	**9.5**	**(9.0–10.0)**	**NC**	**7.2**	**(6.8–7.7)**	**NC**	**4.8**	**(4.4–5.1)**	**NC**
Sex									
Male	13.2	(12.4–14.0)	2.33	10.3	(9.5–11.1)	2.57	6.9	(6.3–7.5)	2.76
Female	5.6	(5.1–6.3)	Referent	4.0	(3.6,4.5)	Referent	2.5	(2.2–2.8)	Referent
Age group (yrs)									
4–10	6.6	(6.1–7.3)	Referent	5.5	(4.9,6.1)	Referent	3.7	(3.3–4.1)	Referent
11–14	11.2	(10.3–12.2)	1.69	8.6	(7.8,9.5)	1.57	6.3	(5.6–7.0)	1.71
15–17	13.6	(12.3–15.1)	2.05	9.3	(8.2,10.5)	1.70	5.2	(4.5–6.0)	1.42
Highest education in household									
Less than high school	8.4	(7.0–10.0)	0.96†	6.5	(5.2–8.0)	0.96†	4.0	(3.0–5.2)	0.88†
High school graduate	12.2	(10.9–13.7)	1.40	9.0	(8.0–10.2)	1.34	5.9	(5.1–6.8)	1.31
More than high school	8.7	(8.2–9.3)	Referent	6.7	(6.2–7.3)	Referent	4.5	(4.1–4.9)	Referent
Race									
White	9.9	(9.3–10.5)	Referent	7.5	(7.0–8.0)	Referent	5.1	(4.7–5.6)	Referent
Black	10.1	(8.9–11.5)	1.02†	7.8	(6.7–9.1)	1.04†	5.1	(4.2–6.2)	0.99†
Multiracial	14.2	(11.5–17.4)	1.44	11.3	(8.9–14.1)	1.51	7.5	(5.6–10.0)	1.46
Other	5.0	(3.7–6.7)	0.51	3.7	(2.6–5.3)	0.50	1.7	(1.2–2.3)	0.33
Ethnicity									
Hispanic/Latino	5.6	(4.6–7.0)	0.54	4.1	(3.3–5.2)	0.52	2.4	(1.7–3.2)	0.44
Non-Hispanic/Latino	10.5	(9.9–11.0)	Referent	8.0	(7.5–8.5)	Referent	5.4	(5.0–5.8)	Referent
Primary language in home									
English	10.5	(9.9–11.1)	Referent	8.0	(7.5–8.5)	Referent	5.3	(4.9–5.7)	Referent
Any other language	2.3	(1.6–3.2)	0.22	1.8	(1.2–2.7)	0.23	0.9§	(0.5–1.6)	0.16
Poverty level¶									
≤100%	11.6	(10.3–13.0)	1.35†	9.2	(8.1–10.5)	1.42†	6.3	(5.3–7.4)	1.45†
>100% to ≤200%	10.3	(9.1–11.7)	1.20†	7.7	(6.6–8.9)	1.19†	4.7	(4.0–5.5)	1.08†
>200%	8.6	(8.0–9.2)	Referent	6.5	(6.0–7.0)	Referent	4.4	(4.0–4.8)	Referent
Any health-care coverage									
Yes	9.8	(9.3–10.3)		7.6	(7.1–8.1)		5.1	(4.7–5.5)	
Medicaid	13.6	(12.5–14.8)	1.68	10.9	(9.8–12.0)	1.77	7.5	(6.7–8.4)	1.84
Non-Medicaid	8.1	(7.5–8.7)	Referent	6.1	(5.6–6.7)	Referent	4.1	(3.7–4.5)	Referent
No	6.7	(5.2–8.6)	0.83†	3.7	(2.9–4.7)	0.60	1.7	(1.2–2.5)	0.42
Region									
Northeast	9.4	(8.3–10.6)	1.35	7.4	(6.5–8.6)	1.45	4.5	(3.8–5.4)	1.60
Midwest	9.9	(9.2–10.7)	1.43	7.6	(6.9–8.3)	1.47	5.3	(4.7–5.8)	1.85
South	10.9	(10.1–11.8)	1.57	8.3	(7.6–9.0)	1.61	5.8	(5.2–6.5)	2.05
West	7.0	(5.7–8.4)	Referent	5.1	(4.1–6.4)	Referent	2.8	(2.2–3.7)	Referent

Abbreviations: CI = confidence interval; NC = not calculated; PR = prevalence ratio (the ratio of the percentage of children with ADHD among the sociodemographic group to the percentage of children with ADHD among the referent sociodemographic group).

* Estimates do not include children aged 2–3 years with reported ADHD diagnosis because small sample size yields substantial (>30%) relative standard errors.

† PR is not significant at the α = 0.05 level.

§ Relative standard error >30%.

¶ Federal poverty level, imputed using multiple imputation for 8.9% of the sample for which reported household income was missing.

compare ADHD prevalence (ever diagnosed, current ADHD diagnosis, and currently taking medications for ADHD) of sociodemographic subgroups to referent subgroups (Table 1), and across the two surveys (ever diagnosed; Tables 2 and 3).

Prevalence of ADHD diagnosis (ever) was compared between the two surveys using weighted logistic regression, predicting ADHD from survey year, while controlling for sociodemographics. Statistical interactions of survey year by sociodemographics were tested. The average annual percentage difference was calculated by dividing the 2003 to 2007 percentage difference by 4.¶

In 2007, the estimated prevalence of parent-reported ADHD (ever) among children aged 4–17 years was 9.5%, representing 5.4 million children (Table 1). Of those with a history of ADHD, 78% (4.1 million, or 7.2% of all children aged 4–17 years)

¶ The time between the two surveys was calculated from the survey midpoints, which were September 2003 and August 2007.

What is already known on this topic?

Attention-deficit/hyperactivity disorder (ADHD) is the most common neurobehavioral disorder of childhood and often persists into adulthood. A 2003 survey found an estimated 7.8% of children aged 4–17 years had ever been diagnosed with ADHD.

What is added by this report?

The prevalence of parent-reported ADHD among children aged 4–17 years increased 21.8% during 2003–2007, from 7.8% to 9.5%. Among older teens, the increase was 42%, and among Hispanic children the increase was 53%.

What are the implications for public health practice?

Health practitioners should be aware of changes in the national, state, and demographic patterns of ADHD in the United States, and that an estimated 1 million more children were reported with ADHD in 2007 than in 2003.

were reported to currently have the condition. Of those with current ADHD, nearly half (46.7%) had mild ADHD, with the remainder having moderate (39.5%) or severe (13.8%) ADHD. ADHD (ever) was more than twice as common among boys as girls (13.2% versus 5.6%). High rates of ADHD (ever) were noted among multiracial children (14.2%) and children covered by Medicaid (13.6%).

Among children with current ADHD, 66.3% were taking medication for the disorder. In total, 4.8% of all children aged 4–17 years (2.7 million) were taking medication for ADHD. Among boys, the prevalence of medicated ADHD (current) was highest for boys 11–14 years. The rates of medicated ADHD (current) increased with age among girls. The proportion of children taking medication for ADHD increased with severity, from 56.4% among children with mild ADHD, to 71.6% among children with moderate ADHD and 85.9% among children with severe ADHD (p<0.0001). The national prevalence of ADHD (ever) increased significantly between the two surveys (from 7.8% to 9.5%; Table 2), even after adjustment for sociodemographics, equating to a 21.8% increase in 4 years, or an average annual increase of 5.5%. The national estimate of children aged 4–17 years with parent-reported ADHD (ever) increased from 4.4 million in 2003 to 5.4 million in 2007, an increase of approximately 1 million children. Compared with 2003, the 2007 rates were significantly higher for each subgroup, with three exceptions: among households with less than a high

TABLE 2. Weighted prevalence estimates and prevalence ratios of parent-reported attention-deficit/hyperactivity disorder (ADHD) among children 4–17 years,* by sociodemographic characteristics — National Survey of Children's Health, United States, 2003 and 2007

	Ever diagnosed with ADHD†				
Characteristic	2003 %	2007 %	PR	(95% CI)	p value
Overall	**7.8**	**9.5**	**1.22**	**(1.14–1.31)**	**<0.001**
Sex					
Male	11.0	13.2	1.20	(1.11–1.30)	<0.001
Female	4.4	5.6	1.28	(1.12–1.46)	<0.001
Age group (yrs)§					
4–10	5.7	6.6	1.16	(1.03–1.30)	0.013
11–14	9.8	11.2	1.14	(1.03–1.27)	0.016
15–17	9.6	13.6	1.42	(1.25–1.61)	<0.001
Highest education in household					
Less than high school	6.5	8.4	1.30	(0.99–1.69)	0.055
High school graduate	8.6	12.2	1.42	(1.24–1.63)	<0.001
More than high school	7.6	8.7	1.15	(1.06–1.25)	<0.001
Race					
White	8.6	9.9	1.15	(1.06–1.24)	<0.001
Black	7.7	10.1	1.31	(1.09–1.57)	0.004
Multiracial	9.7	14.2	1.46	(1.07–2.00)	0.017
Other	4.5	5.0	1.11	(0.72–1.71)	NS
Ethnicity					
Hispanic/Latino	3.7	5.6	1.53	(1.16–2.02)	0.002
Non-Hispanic/Latino	8.6	10.5	1.22	(1.14–1.31)	<0.001
Primary language in home					
English	8.6	10.5	1.22	(1.14–1.30)	<0.001
Any other language	1.3	2.3	1.82	(1.15–2.90)	0.011
Poverty level¶					
≤100%	9.3	11.6	1.25	(1.06–1.47)	0.007
>100% to ≤200%	7.9	10.3	1.31	(1.11–1.54)	0.001
>200%	7.3	8.6	1.18	(1.08–1.29)	<0.001
Any health-care coverage					
Yes	8.1	9.8	1.21	(1.13–1.30)	<0.001
Medicaid	10.8	13.6	1.26	(1.12–1.41)	<0.001
Non-Medicaid	7.0	8.1	1.16	(1.06–1.27)	0.001
No	4.9	6.7	1.38	(1.00–1.90)	0.050
Region					
Northeast	7.4	9.4	1.27	(1.09–1.49)	0.003
Midwest	7.9	9.9	1.25	(1.13–1.39)	<0.001
South	9.1	10.9	1.20	(1.09–1.32)	<0.001
West	5.8	7.0	1.20	(0.96–1.51)	NS

Abbreviations: CI = confidence interval; NS = not statistically significant (p≥0.1); PR = prevalence ratio (the ratio of the percentage of children with ADHD among the sociodemographic group in 2007 to the percentage of children with ADHD among the sociodemographic group in 2003).

* Estimates do not include children aged 2–3 years with reported ADHD diagnosis because small sample sizes yield substantial (>30%) relative standard errors in the 2003 survey sample.

† The analytic sample included totals of 79,264 children aged 4–17 years in 2003 and 73,123 children aged 4–17 years in 2007.

§ A statistically significant interaction was noted (p=0.013) with the magnitude, but not direction, of change across time differing significantly by age group.

¶ Federal poverty level; multiple imputations were used for the 10.0% of the sample in 2003 and 8.9% in 2007 for which reported household income was missing.

TABLE 3. Weighted percentage of children aged 4–17 years with parent-reported attention-deficit/hyperactivity disorder (ADHD), by state — United States, 2003 and 2007

State/Area	Ever diagnosed with ADHD				Difference* (%)
	2003		2007		
	%	(95% CI)	%	(95% CI)	
Alabama	11.1	(9.3–13.2)	14.3	(11.8–17.2)	NS
Alaska	7.1	(5.8–8.7)	9.2	(7.2–11.6)	NS
Arizona	5.9	(4.6–7.5)	7.6	(5.9–9.7)	NS
Arkansas	9.9	(8.3–11.8)	13.1	(11.0–15.6)	32.3
California	5.3	(4.2–6.7)	6.2	(4.1–9.1)	NS
Colorado	5.0	(3.8–6.4)	7.6	(5.8–9.8)	52.0
Connecticut	7.3	(6.0–9.0)	7.8	(6.3–9.6)	NS
Delaware	9.8	(8.1–11.7)	14.1	(11.8–16.8)	43.9
District of Columbia	6.7	(5.3–8.6)	7.7	(6.1–9.7)	NS
Florida	9.2	(7.6–11.2)	11.6	(8.8–15.1)	NS
Georgia	9.4	(7.7–11.4)	9.2	(7.3–11.4)	NS
Hawaii	6.2	(4.8–7.8)	6.3	(4.9–8.1)	NS
Idaho	6.4	(5.1–8.0)	8.3	(6.6–10.3)	NS
Illinois	6.3	(5.0–7.9)	6.2	(4.9–7.9)	NS
Indiana	7.9	(6.5–9.7)	13.2	(10.7–16.1)	67.1
Iowa	8.4	(6.8–10.2)	9.7	(7.4–12.7)	NS
Kansas	8.1	(6.6–10.0)	10.0	(8.2–12.1)	NS
Kentucky	10.1	(8.4–12.2)	12.4	(10.5–14.7)	NS
Louisiana	10.3	(8.7–12.2)	14.2	(11.6–17.3)	37.9
Maine	7.9	(6.5–9.7)	9.6	(7.8–11.7)	NS
Maryland	9.1	(7.7–10.8)	11.9	(9.8–14.5)	NS
Massachusetts	8.5	(7.1–10.2)	9.8	(7.8–12.3)	NS
Michigan	9.2	(7.7–11.0)	9.9	(8.0–12.2)	NS
Minnesota	7.5	(6.1–9.2)	7.8	(6.2–9.8)	NS
Mississippi	9.6	(7.9–11.6)	9.9	(8.1–11.9)	NS
Missouri	7.7	(6.3–9.3)	10.8	(9.0–12.9)	40.3
Montana	7.1	(5.8–8.8)	8.5	(6.9–10.4)	NS
Nebraska	6.4	(5.0–8.2)	9.0	(7.0–11.7)	NS
Nevada	7.2	(5.9–8.8)	5.6	(4.0–7.8)	NS
New Hampshire	9.2	(7.7–10.9)	8.5	(6.9–10.4)	NS
New Jersey	7.2	(5.8–9.0)	9.0	(7.0–11.5)	NS
New Mexico	6.1	(4.7–7.9)	7.1	(5.5–9.1)	NS
New York	6.3	(4.9–8.0)	9.2	(7.1–11.7)	46.0
North Carolina	9.6	(8.0–11.4)	15.6	(13.0–18.5)	62.5
North Dakota	9.4	(7.7–11.4)	10.0	(8.2–12.0)	NS
Ohio	8.9	(7.5–10.5)	13.3	(10.6–16.4)	49.4
Oklahoma	8.1	(6.5–9.9)	11.0	(8.9–13.4)	35.8
Oregon	7.2	(5.8–8.8)	8.8	(6.8–11.2)	NS
Pennsylvania	8.2	(6.8–9.9)	10.2	(7.6–13.4)	NS
Rhode Island	9.8	(8.1–11.8)	11.1	(9.0–13.5)	NS
South Carolina	10.0	(8.4–11.8)	12.0	(9.9–14.5)	NS
South Dakota	6.5	(5.0–8.3)	8.1	(6.6–10.1)	NS
Tennessee	9.9	(8.1–12.0)	11.3	(9.2–13.8)	NS
Texas	7.7	(6.3–9.3)	7.7	(5.7–10.4)	NS
Utah	5.5	(4.2–7.1)	6.7	(5.1–8.7)	NS
Vermont	6.9	(5.5–8.6)	9.9	(7.8–12.4)	43.5
Virginia	9.3	(7.7–11.1)	10.2	(8.4–12.3)	NS
Washington	7.2	(5.8–8.9)	9.5	(7.3–12.2)	NS
West Virginia	10.1	(8.4–12.1)	13.3	(11.1–15.8)	31.7
Wisconsin	8.1	(6.5–10.0)	9.9	(8.1–12.1)	NS
Wyoming	7.1	(5.8–8.7)	9.1	(7.3–11.3)	NS

Abbreviations: CI = confidence interval; NS = difference in rate of parent-reported ADHD (ever) was not statistically significant ($p \geq 0.05$).

* The percentage change (relative difference) between 2003 and 2007 for states with a statistically significant difference ($p < 0.05$).

school education, "other" (not white or black) races, and those living in the western United States. The magnitude of increase was largest among older teens, multiracial and Hispanic children, and children with a primary language other than English. A significant interaction was identified for age and survey year, with the rate of ADHD diagnosis (ever) increasing more for those in the oldest age group (15–17 years). The national increase in ADHD (ever) was reflected in significant increases within 12 states (Table 3).

Reported by

SN Visser, MS, RH Bitsko, PhD, ML Danielson, MSPH, R Perou, PhD, Div of Human Development and Disability, National Center on Birth Defects and Developmental Disabilities; SJ Blumberg, PhD, Div of Health Interview Statistics, National Center for Health Statistics, CDC.

Editorial Note

The findings in this report demonstrate a substantial increase in the percentage of children ever diagnosed with ADHD (according to parent report), with nearly one in 10 children aged 4–17 years diagnosed with ADHD by 2007. The overall estimate for the prevalence of children with a history of ADHD diagnosis in 2007 was higher than a recent estimate (8.4% of children aged 6–17 years) based on annual data from the 2004–2006 National Health Interview Survey (NHIS) (*2*). The NHIS report documented an average annual increase in diagnosed ADHD (ever) of 3% from 1997 to 2006; this present report documents a greater average annual increase (5.5%) over a slightly later period (2003–2007). The differences might reflect the inclusion of more recent data in this present report or differences in survey methods.

The increase in ADHD diagnosis (ever) over time was seen among all sociodemographic groups studied. The increases among Hispanic children and older teens were of particular interest. Although rates among Hispanics remained lower than non-Hispanics, the prevalence of ever receiving an ADHD diagnosis among Hispanic children was 53% higher in 2007 than in 2003. This might indicate a shift in the cultural acceptance of ADHD or changes in access to care (*7,8*). The magnitude of change by age over time was greatest among the oldest children (ages 15–17 years). Additional studies are needed to explain why increases in the prevalence of ADHD among older children are outpacing those of younger children. Twelve states

had significant increases in ADHD (ever diagnosed). Changes in the sociodemographic composition of states or state-based policy or practice changes, such as widespread behavioral health screening, might have contributed to the increasing rates.

The findings in this report are subject to at least five limitations. First, ADHD status was based on parental report, requiring that the parent correctly recall a past or current ADHD diagnosis and make a judgment as to the disorder's severity. Second, current ADHD, which might have incurred less recall bias, was not added to the survey until 2007, making it impossible to compare current ADHD prevalence across time using these data. Third, comparing estimates of ADHD medication treatment across time also is problematic, because questions about ADHD medication treatment were asked of different subgroups (ever diagnosed in 2003 versus only current ADHD in 2007) across the two surveys. Fourth, the survey sample did not include families without landline telephones or those who elected not to participate; however, noncoverage and nonresponse bias was reduced through sampling weight adjustments. Finally, the annual rate increases noted in this report represent an average for the 4-year period between surveys rather than observed annual rate increases because annual data were not available.

ADHD has a multidimensional effect on a person's daily life functioning, and can culminate in significant costs attributable to greater health-care needs, more frequent unintentional injury, co-occurring psychiatric conditions, and work loss (*9*). ADHD medications can reduce symptoms, but might be associated with side effects and might not completely address functional impairment. Earlier reports also have noted increases in ADHD prevalence (*2*); However, this study demonstrated an increase in parent-reported ADHD prevalence across time for every demographic group studied. The highest rates of ADHD diagnosis (ever) in 2007 were among multiracial children and those with Medicaid coverage. Increasing rates of estimated ADHD prevalence might indicate an actual increase in the number of cases of ADHD or changes in diagnostic practice over time, which might have been influenced by increased awareness of the disorder over the period of study. Additional studies are needed to understand other geographic or environmental risk factors associated with rates of ADHD diagnosis, such as state-based policy and health-care provider characteristics (*10*). Ongoing surveillance is critical to understanding the public health effect of ADHD and the needs of a growing number of families affected by this disorder.

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References

1. American Psychiatric Association. Diagnostic and statistical manual of mental disorders. 4th ed. Washington, DC: American Psychiatric Association; 2000:85–93.
2. Pastor PN, Reuben CA. Diagnosed attention deficit hyperactivity disorder and learning disability: United States, 2004–2006. Vital Health Stat 2008;10(237).
3. Castle L, Aubert RE, Verbrugge RR, Khalid M, Epstein RS. Trends in medication treatment for ADHD. J Atten Disord 2007;10:335–42.
4. CDC. Mental health in the United States: prevalence of diagnosis and medication treatment for attention-deficit/hyperactivity disorder—United States, 2003. MMWR 2005; 54:842–7.
5. Blumberg SJ, Olson L, Frankel MR, Osborn L, Srinath KP, Giambo P. Design and operation of the National Survey of Children's Health, 2003. Vital Health Stat 2005;1(43).
6. Blumberg SJ, Foster EB, Frasier AM, et al. Design and operation of the National Survey of Children's Health, 2007. Vital Health Stat;1(in press).
7. Eiraldi RB, Mazzuca LB, Clarke AT, Power TJ. Service utilization among ethnic minority children with ADHD: a model of help-seeking behavior. Adm Policy Ment Health 2006;33:607–22.
8. Rowland AS, Umbach DM, Stallone L, Naftel AJ, Bohlig EM, Sandler DP. Prevalence of medication treatment for attention deficit-hyperactivity disorder among elementary school children in Johnston County, North Carolina. Am J Public Health 2002;92:231–4.
9. Matza LS, Paramore C, Prasad M. A review of the economic burden of ADHD. Cost Eff Resour Alloc 2005;3:5.
10. Fulton BD, Scheffler RM, Hinshaw SP, et al. National variation of ADHD diagnostic prevalence and medication use: health care providers and education policies. Psychiatr Serv 2009;60:1075–83.

Neonatal Intensive-Care Unit Admission of Infants with Very Low Birth Weight — 19 States, 2006

Neonatal mortality is disproportionately common among infants with very low birth weight (VLBW) (<1,500 g [3.3 lbs]). In 2006, the mortality rate among infants with VLBW was 240.4 per 1,000 live births (*1*). Because neonatal intensive care has been shown to reduce mortality among infants with VLBW, current standards call for neonatal intensive-care for all infants with VLBW (*2*); however, the proportion of infants with VLBW who are admitted to a neonatal intensive care unit (NICU) is not known, nor are the predictors for NICU admission. To estimate the prevalence of admission to NICUs among infants with VLBW and assess factors predicting admission, CDC analyzed birth data from 2006 for 19 states (*3*). This report summarizes the results of that analysis, which found that overall, 77.3% of infants with VLBW were admitted to NICUs (range: 63.7% in California to 93.4% in North Dakota). Among infants with VLBW born to Hispanic mothers, 71.8% were admitted to NICUs, compared with 79.5% of those with non-Hispanic black mothers and 80.5% of those with non-Hispanic white mothers. Multivariate analysis of the data indicated that preterm delivery, multiple births, and cesarean delivery all were independently associated with greater prevalence of NICU admission among infants with VLBW. Wide variation was observed among states in the prevalence of NICU admission of infants with VLBW; these state data should be assessed further, and barriers to NICU admission should be identified and addressed.

Analyses were limited to live births to U.S. residents that occurred in the 19 states* that adopted the 2003 revised birth certificate because earlier revisions of the birth certificate did not include information on NICU admission. The 19 states represented 49% of U.S. births in 2006, the most recent year for which data were available (*3*). The revised birth certificate collects information on maternal risk factors, obstetric history, newborn anthropometrics, and NICU admission. Instructions for completing the birth certificate define NICU admission as "admission into a facility or unit staffed and equipped to provide continuous mechanical ventilatory support for the newborn for at least 24 hours" (*3*). Prevalence estimates with 95% confidence intervals were calculated for NICU admission of infants with VLBW. Overall and pairwise (i.e., non-Hispanic white versus non-Hispanic black and non-Hispanic white versus Hispanic) differences in NICU admission by race/ethnicity were tested using chi-square analyses (with significance at $p<0.05$). Multivariate log-binomial regression was conducted to assess the independent associations between NICU admission of infants with VLBW and infant gestational age (in weeks, based on the date of last menses) and sex, and mother's parity, race/ethnicity, age group, years of education, plurality, and delivery mode. Generalized estimating equations were used for multivariate models to account for variation among states in NICU admission of VLBW infants. Prevalence ratios and adjusted prevalence ratios (APRs) with 95% confidence intervals were calculated.

Infants weighing <500 g typically are not admitted to an NICU because they are not considered viable (*4*); therefore, these infants were excluded from analysis. Infants born to Asian/Pacific Islander and American Indian/Alaska Native women (1,252) and to women with unknown race/ethnicity (252) were included in descriptive analyses, but not in multivariate regression analyses. Prevalence estimates also were withheld, because of small numbers, for any state or category with <30 in either the numerator or denominator (0.6% of infants with VLBW).

In 2006, a total of 25,231 infants with VLBW were delivered in the 19-state reporting area; 19,512 (77.3%) of these infants were admitted to NICUs (Table 1). Among the 19 states, the prevalence of NICU admission ranged from 63.7% in California to 93.4% in North Dakota. Overall, a smaller percentage of infants with VLBW born to Hispanic mothers were admitted to NICUs than infants born to non-Hispanic white or black mothers (71.8% compared with 80.5% and 79.5%, respectively). However, racial/ethnic differences in NICU admission varied by state.

Using multivariate analysis, three factors were associated with greater prevalence of NICU admission

* California, Delaware, Florida, Idaho, Kansas, Kentucky, Nebraska, New Hampshire, New York (excluding New York City), North Dakota, Ohio, Pennsylvania, South Carolina, South Dakota, Tennessee, Texas, Vermont, Washington, and Wyoming.

TABLE 1. Number and percentage of infants with very low birth weight (VLBW) (<1,500 g) admitted to neonatal intensive-care units (NICUs), by state and maternal race/ethnicity — 19 states, 2006

State	No. of infants with VLBW	No. and % admitted to NICUs											
		Total*			White, non-Hispanic			Black, non-Hispanic			Hispanic		
		No.	%	95% CI†	No.	%	95% CI†	No.	%	95% CI†	No.	%	95% CI†
Overall§	**25,231**	**19,512**	**77.3**	**(76.8–77.9)**	**8,579**	**80.5**	**(79.7–81.3)**	**5,053**	**79.5**	**(78.5–80.5)**	**4,819**	**71.8**	**(70.7–72.9)**
California	5,965	3,801	63.7	(62.5–64.9)	1,036	68.1	(65.8–70.4)	451	60.4	(56.9–63.9)	1,788	62.1	(60.3–63.9)
Delaware	193	172	89.0	(84.5–93.4)	74	91.4	(85.3–97.5)	82	88.2	(81.6–94.8)	—¶		—
Florida	3,306	2,718	82.2	(80.9–83.5)	943	82.1	(79.9–84.3)	1,098	81.8	(79.7–83.9)	602	82.4	(79.6–85.2)
Idaho	206	176	85.4	(80.5–90.2)	138	85.7	(80.3–91.1)	—		—	34	85.0	(73.9–96.1)
Kansas	411	331	80.7	(76.9–84.5)	227	84.4	(80.1–88.7)	52	75.4	(65.2–85.6)	45	71.4	(60.2–82.6)
Kentucky	647	573	88.6	(86.1–91.0)	423	87.8	(84.9–90.7)	120	90.2	(85.1–95.3)	—		—
North Dakota	82	77	93.4	(87.8–99.0)	67	93.1	(87.2–99.0)	—		—	—		—
Nebraska	276	232	84.3	(79.9–88.6)	172	86.9	(82.2–91.6)	—		—	—		—
New Hampshire	121	102	84.3	(77.8–90.8)	90	84.1	(77.2–91.0)	—		—	—		—
New York**	1,588	1,401	88.2	(86.6–89.8)	840	88.1	(86.0–90.2)	325	88.1	(84.8–91.4)	188	90.0	(85.9–94.1)
Ohio	1,991	1,534	77.0	(75.2–78.9)	990	79.1	(76.8–81.4)	465	73.6	(70.2–77.0)	48	78.7	(68.4–89.0)
Pennsylvania	1,998	1,667	83.4	(81.8–85.0)	985	86.0	(84.0–88.0)	492	82.1	(79.0–85.2)	120	75.5	(68.8–82.2)
South Carolina	944	815	86.4	(84.2–88.6)	304	86.9	(83.4–90.4)	461	87.0	(84.1–89.9)	33	76.7	(64.1–89.3)
South Dakota	111	104	92.8	(87.2–98.3)	65	91.6	(85.1–98.1)	—		—	—		—
Tennessee	1,316	1,132	86.0	(84.1–87.9)	633	86.8	(84.3–89.3)	412	84.8	(81.6–88.0)	68	88.3	(81.1–95.5)
Texas	5,266	4,107	78.1	(76.9–79.2)	1,246	76.1	(74.0–78.2)	1,018	82.0	(79.9–84.1)	1,717	77.1	(75.4–78.8)
Vermont	57	45	79.0	(68.4–89.5)	44	80.0	(69.4–90.6)	—		—	—		—
Washington	726	518	71.5	(68.2–74.8)	299	73.5	(69.2–77.8)	38	55.9	(44.1–67.7)	108	77.7	(70.8–84.6)

* Includes 1,252 births to Asian/Pacific Islander and American Indian/Alaska Native women and 252 births to women with unspecified race/ethnicity.
† Confidence interval.
§ Because of small numbers, stratified data for Wyoming infants are not shown, but are included in the overall estimates.
¶ Data excluded because cell size <30.
** Excludes New York City.

among infants with VLBW: preterm delivery (<28 weeks, APR = 1.32; 28–31 weeks, APR = 1.36; and 32–36 weeks, APR = 1.27), multiple births (twins, APR = 1.04; triplets or more, APR = 1.08), and cesarean delivery (APR = 1.11) (Table 2). Multivariate analysis found no difference in the prevalence of NICU admission based on infant sex or maternal race/ethnicity, parity, age group, or years of education.

Reported by

WD Barfield, MD, SE Manning, MD, C Kroelinger, PhD, Div of Reproductive Health, National Center for Chronic Disease Prevention and Health Promotion; JA Martin, MPH, Div of Vital Statistics, National Center for Health Statistics; DT Barradas, PhD, EIS Officer, CDC

Editorial Note

The findings in this report indicate that, overall in the 19 states sampled, 77.3% of infants with VLBW were admitted to NICUs in 2006, although the percentage of infants admitted to NICUs varied widely by state. Preterm delivery, multiple births, and cesarean delivery were positively associated with VLBW infant NICU admission. Preterm infants and those from multiple births might be perceived as needing more specialized care than term or singleton infants (*5*), which might explain why they were found more likely to be admitted to an NICU in this analysis. Infants with VLBW delivered by cesarean might have had medical indications that led to choosing cesarean delivery (e.g., congenital cardiac or respiratory abnormalities), and those indications also might have made them more likely to be admitted to an NICU. In addition, multiple births and cesarean deliveries might be more common at facilities with NICUs.

The American Academy of Pediatrics classification system for neonatal care facilities includes three distinct levels of care: level I (basic neonatal care), level II (specialty neonatal care), and level III (subspecialty [i.e., NICU] care) (*2*). Although all level III neonatal facilities include an NICU, all NICUs do not have a level III designation (certain NICUs offer level II care). Epidemiologic evidence indicates higher survival rates among infants with VLBW born at facilities offering level III care, compared with those born at facilities with lower levels of care or infants transferred after birth (*6*).

Two national performance measures and objectives have been created to monitor improvements in the availability of neonatal intensive care. The Maternal and Child Health Bureau (MCHB) collects state-level data on the percentage of infants with

TABLE 2. Number (n = 22,427) and percentage of infants with very low birth weight (<1,500 g) admitted to neonatal intensive-care units (NICUs), by selected characteristics — 19 states,* 2006

Characteristic	No.	%	(95% CI)	Bivariate analysis PR	Bivariate analysis (95% CI)	Multivariate analysis† APR	Multivariate analysis† (95% CI)
Infant gestational age (wks)							
<28	8,477	77.4	(76.5–78.3)	1.39	(1.31–1.47)	1.32	(1.21–1.44)
28–31	9,347	82.9	(82.1–83.7)	1.49	(1.41–1.57)	1.36	(1.25–1.48)
32–36	3,597	76.1	(75.2–78.0)	1.36	(1.29–1.45)	1.27	(1.17–1.37)
≥37	1,006	55.8	(52.7–58.9)	1.00	Referent	1.00	Referent
Plurality							
Singleton	16,694	76.8	(76.2–77.4)	1.00	Referent	1.00	Referent
Twin	4,798	82.3	(81.2–83.4)	1.07	(1.05–1.09)	1.04	(1.02–1.05)
Triplet or more	935	88.9	(86.9–90.9)	1.16	(1.13–1.19)	1.08	(1.01–1.15)
Delivery mode							
Vaginal	7,060	71.4	(70.3–72.5)	1.00	Referent	1.00	Referent
Cesarean	15,367	81.8	(81.2–82.4)	1.15	(1.13–1.16)	1.11	(1.08–1.15)
Sex							
Male	11,297	78.2	(77.4–79.0)	1.00	Referent	1.00	Referent
Female	11,130	78.8	(78.0–79.6)	1.01	(0.99–1.02)	1.00	(0.99–1.01)
Parity							
0	7,766	77.5	(76.6–78.4)	1.00	Referent	1.00	Referent
1	5,733	79.6	(78.6–80.6)	1.03	(1.01–1.05)	1.01	(1.00–1.02)
2	3,740	78.4	(77.1–79.7)	1.01	(0.99–1.03)	1.00	(0.98–1.02)
≥3	5,188	78.8	(77.7–79.9)	1.02	(0.99–1.04)	1.00	(0.98–1.01)
Maternal race/ethnicity							
White, non-Hispanic	10,157	81.1	(80.3–81.9)	1.00	Referent	1.00	Referent
Black, non-Hispanic	5,946	80.6	(79.6–81.6)	0.99	(0.98–1.01)	1.00	(0.96–1.03)
Hispanic	6,324	72.3	(71.2–73.4)	0.89	(0.88–0.91)	1.00	(0.98–1.01)
Maternal age (yrs)							
<20	3,059	77.8	(76.3–79.3)	0.97	(0.98–0.99)	1.00	(0.98–1.02)
20–24	5,554	77.0	(75.9–78.1)	0.96	(0.94–0.98)	0.97	(0.95–1.00)
25–29	5,394	78.4	(77.3–79.5)	0.98	(0.96–0.99)	0.98	(0.97–1.00)
30–34	4,673	80.1	(79.0–81.2)	1.00	Referent	1.00	Referent
35–39	2,910	79.9	(78.4–81.4)	1.00	(0.97–1.02)	1.00	(0.97–1.02)
≥40	837	78.0	(75.2–80.8)	0.97	(0.94–1.01)	0.99	(0.95–1.03)
Maternal educational attainment (yrs)							
<12	6,240	73.7	(72.6–74.8)	0.92	(0.90–0.94)	0.97	(0.93–1.00)
12	6,273	80.0	(79.0–81.0)	1.00	Referent	1.00	Referent
13–15	5,827	80.1	(79.1–81.1)	1.00	(0.97–1.02)	0.99	(0.98–1.02)
≥16	4,087	81.1	(79.9–82.3)	1.01	(0.99–1.03)	0.99	(0.98–1.00)

Abbreviations: APR = adjusted prevalence ratio; CI = confidence interval; PR = prevalence ratio.

* California, Delaware, Florida, Idaho, Kansas, Kentucky, Nebraska, New Hampshire, New York (excluding New York City), North Dakota, Ohio, Pennsylvania, South Carolina, South Dakota, Tennessee, Texas, Vermont, Washington, and Wyoming.

† To produce APR, variables were adjusted for all other variables included in the model; generalized estimating equations were used to account for variation in NICU admissions among states.

VLBW delivered at facilities for high-risk deliveries and neonates (performance measure 17) through the Title V Reporting System (*7*). These data are provided by states and are generally based on birth certificate data. Although some differences exist in the proportion of infants with VLBW receiving specialized care, the findings in this report are generally comparable to MCHB data. However, definitions, criteria, and regulation of hospital-based perinatal centers vary greatly (*8*); some states identify level II perinatal centers as "facilities for high-risk deliveries and neonates," while others only include level III perinatal centers for this indicator.

In addition to MCHB performance measure 17, *Healthy People 2010* objective 16-8 seeks to increase to 90% the percentage of infants with VLBW born at level III hospitals or subspecialty perinatal centers (*9*). This target is a 23% increase from the baseline of 73% reported in the Title V reporting system during 1996–1997. Current perinatal standards of care recommend admission of all viable infants with VLBW born in a level III facility into the NICU; those standards and the findings in this report should be considered in light of waning efforts in the United States to regionalize perinatal services, which would geographically distribute facilities in such a manner that mothers with high-risk pregnancies will be more likely to give birth in level III facilities.

The findings in this report are subject to at least three limitations. First, these data are representative

What is already known on this topic?

Neonatal intensive-care unit (NICU) admission at birth for infants with very low birth weight (VLBW) can reduce their risk for mortality.

What is added by this report?

Among the 19 states with data available (having adopted the 2003 revision of the birth certificate), 77.3% of infants with VLBW overall were admitted to NICUs; however, the proportion varied widely by state. In addition, preterm delivery, multiple births, and cesarean delivery all were associated with greater prevalence of NICU admission.

What are the implications for public health practice?

Given the wide variability in NICU care of infants with VLBW among states, any barriers to infants being admitted to NICUs should be identified and addressed at the state level to reduce mortality among infants in this high-risk group.

of 19 states and cannot be generalized to the entire U.S. population. Second, NICU admission is a new variable added to the revised birth certificate. The quality of this new variable has not yet been assessed. For example, these data cannot distinguish between NICU admission at the facility of birth and admission in another facility. Finally, NICU admission might be underreported overall or differentially reported by maternal or infant characteristics, including state of residence and race/ethnicity.

The survival rate is highest when infants with VLBW are born at level III facilities (*6*). A previous study showed that infants with VLBW who received NICU care, despite being born at a non-level III facility, were 24% more likely to survive than infants who did not receive NIUC care (*10*); however, another study found that infants with VLBW who are born at a level III facility were 51% more likely to survive than infants born at a lower-level facility (*6*). Therefore, the ultimate goal of regionalization of perinatal services should be to ensure that mothers with high-risk pregnancies deliver their children in level III facilities with access to NICU services at birth. Understanding barriers to admission of infants with VLBW into NICUs could provide guidance for shaping perinatal care infrastructure and practices within states. Future studies should evaluate the validity of the NICU admission item on the birth certificate and provide suggestions for how data quality might be improved.

References

1. Matthews TJ, MacDorman MF. Infant mortality statistics from the 2006 period linked birth-infant death dataset. Natl Vital Stat Rep 2010;58(17).
2. American Academy of Pediatrics and the American College of Obstetricians and Gynecologists. Guidelines for perinatal care. 6th ed. Elk Grove Village, IL: American Academy of Pediatrics; 2007.
3. Martin JA, Hamilton BE, Sutton PD, et al. Births: final data for 2006. Natl Vital Stat Rep 2009;57(7).
4. Donohue PK, Boss RD, Shepard J, Graham E, Allen MC. Intervention at the border of viability: perspective over a decade. Arch Pediatr Adolesc Med 2009;163:902–6.
5. Lee SK, Penner PL, Cox M. Comparison of the attitudes of health care professionals and parents toward active treatment of infants with VLBW. Pediatrics 1991;88:110–4.
6. Lasswell SM, Barfield WD, Rochat RW, Blackmon L. Perinatal regionalization for very low-birth-weight and very preterm infants: a meta-analysis. JAMA 2010;304:992–1000.
7. Maternal and Child Health Bureau. Title V Information System: national performance measures. Rockville, MD: US Department of Health and Human Services, Health Resources and Services Administration, Maternal and Child Health Bureau; 2010. Available at https://perfdata.hrsa.gov/mchb/tvisreports/measurementdata/measurementdatamenu.aspx. Accessed November 4, 2010.
8. Blackmon LR, Barfield WD, Stark AR. Hospital neonatal services in the United States: variation in definitions, criteria, and regulatory status, 2008. J Perinatol 2009;29:788–94.
9. US Department of Health and Human Services. Maternal, infant, and child health. Objective 16-8: increase the proportion of very low birth weight (VLBW) infants born at level III hospitals or subspecialty perinatal centers. Healthy People 2010 (conference ed, in 2 vols). Washington DC: US Department of Health and Human Services; 2000. Available at http://www.healthypeople.gov/document/html/volume2/16mich.htm. Accessed November 4, 2010.
10. Cifuentes J, Bronstein J, Phibbs CS, Phibbs RH, Schmitt SK, Carlo WA. Mortality in low birth weight infants according to levels of neonatal care at hospital of birth. Pediatrics 2002;109:745–51.

Vital Signs: Health Insurance Coverage and Health Care Utilization — United States, 2006–2009 and January–March 2010

On November 9, this report was posted as an MMWR *Early Release on the* MMWR *website (http://www.cdc.gov/mmwr).*

ABSTRACT

Background: The increasing number of persons in the United States with no health insurance has implications both for individual health and societal costs. Because of cost concerns, millions of uninsured persons forgo some needed health care, which can lead to poorer health and potentially to greater medical expenditures in the long term.

Methods: CDC analyzed data from the National Health Interview Survey (NHIS) for 2006, 2007, 2008, and 2009 and early release NHIS data from the first quarter of 2010 to determine the number of persons without health insurance or with gaps in coverage and to assess whether lack of insurance coverage was associated with increased levels of forgone health care. Data were analyzed further by demographic characteristics, family income level, and selected chronic conditions.

Results: In the first quarter of 2010, an estimated 59.1 million persons had no health insurance for at least part of the year before their interview, an increase from 58.7 million in 2009 and 56.4 million in 2008. Of the 58.7 million in 2009, 48.6 million (82.8%) were aged 18–64 years. Among persons aged 18–64 years with family incomes two to three times the federal poverty level (approximately $43,000–$65,000 for a family of four in 2009), 9.7 million (32.1%) were uninsured for at least part of the preceding year. Persons aged 18–64 years with no health insurance during the preceding year were seven times as likely (27.6% versus 4.0%) as those continuously insured to forgo needed health care because of cost. Among persons aged 18–64 years with diabetes mellitus, those who had no health insurance during the preceding year were six times as likely (47.5% versus 7.7%) to forgo needed medical care as those who were continuously insured.

Conclusions: An increasing number of persons in the United States, including those at middle income levels, have had periods with no health insurance coverage in recent years, which is associated with increased levels of forgone health care. Persons aged 18–64 years with chronic conditions and without consistent health insurance coverage are much more likely to forgo needed medical care than persons with the same conditions and continuous coverage.

Implications for Public Health Practice: Increasing the number of persons with continuous health insurance coverage can reduce the number of occasions that persons forgo needed health care, which can reduce complications from illness and avoidable long-term expenditures.

Millions of persons in the United States have no health insurance. In addition to paying for their health care out of pocket, uninsured persons often are charged significantly higher fees than insured persons for the same care because of insurance plan discounts negotiated with health-care providers (*1*). Consequently, uninsured persons forgo needed care, including preventive care, because of cost concerns (*2,3*). Absent or delayed health care can lead to poorer health and potentially to greater medical expenditures in the long term (*4,5*). Although Medicare provides near-universal health insurance coverage for persons aged ≥65 years, and expansions in Medicaid and the Children's Health Insurance Program have increased coverage for children in the United States, a substantial percentage of adults aged 18–64 years have experienced disruptions in access to health care during the past decade, including those with chronic conditions, who have a greater need for care than the general population (*6*). In this report, CDC uses NHIS data to assess the association between lack of health insurance coverage and delaying or forgoing health care.

Methods

NHIS data regarding health insurance status and health-care utilization were collected via in-person

interviews of a sample of the noninstitutionalized civilian population. Persons were considered uninsured if they did not have private health insurance, Medicare, Medicaid, Children's Health Insurance Program insurance, a state-sponsored or other government-sponsored health plan, or a military plan. Persons also were defined as uninsured if they had only a private plan that paid for one type of coverage (e.g., injury, eye care, or dental care) or had only Indian Health Service coverage.* Participants were asked whether they had insurance at the time of interview; whether they had been uninsured for at least part (i.e., even if only 1 day) of the preceding 12 months and, if so, for how long; whether they had delayed or forgone health care because of cost in the preceding 12 months†; whether they had ever been diagnosed with hypertension, diabetes mellitus, or asthma; and whether they had a usual source of care. Persons reporting that they typically visited an emergency department were considered not to have a usual source of care.

Of the households contacted, 82.2% participated in the 2009 survey. The response rate from participants exceeded 98% for the questions that produced the findings in this report, except for questions on income and race/ethnicity. Multiple imputations were performed on family§ income and personal earnings data and hot-deck imputations were performed on race/ethnicity data to account for missing responses to these questions.¶ NHIS data were adjusted for nonresponse and weighted to provide national estimates of insurance status, usual source of care, and care utilization; 95% confidence intervals were calculated, taking into account the survey's multistage probability sample design. The Wald test and logistic regression analyses were used to identify the statistical significance of differences in care utilization between persons who were continuously insured and those with either a 1–3 month gap in coverage in the preceding 12 months or with no health insurance for >12 months before the interview. Insurance status, usual source of care, and care utilization were examined by age group, sex, race/ethnicity, income level, and the highest level of education attained in the family. Data from the final release 2009 NHIS and early release NHIS data (i.e., compiled before final data editing and weighting) for the first quarter of 2010 were analyzed. Additional data from NHIS for 2006, 2007, and 2008 were used for comparison purposes.

Results

In 2009, an estimated 58.7 million (19.5%) persons of all ages had no health insurance for at least part of the year preceding their interview (Table 1). Of these 58.7 million, 48.6 million (82.8%) were persons aged 18–64 years, and 9.5 million (16.2%) were persons aged ≤17 years. From 2008 to 2009, the number of children without coverage for at least part of the year decreased 5.0%, from 10.0 million to 9.5 million. In contrast, the number of adults aged 18–64 years in this same insurance category increased 5.7%, from 46.0 million to 48.6 million. In 2009, 25.7% of all adults aged 18–64 years were without coverage for at least part of the preceding year; 15.4% reported being uninsured for more than a year (Table 1).

In the first quarter of 2010, the estimated number of persons without coverage for at least part of the year increased by 400,000 (0.7%), from 2009 to 59.1 million. The number of persons aged 18–64 years without coverage for at least part of the year increased by 1.3 million (2.7%) to 49.9 million, and the number without coverage for more than a year increased by 1.3 million (4.5%) to 30.4 million (Table 1).

In 2009, among persons aged 18–64 years with family incomes two to three times the federal poverty level (approximately $43,000–$65,000 for a family of four),** 9.7 million (32.1%) were uninsured for at least part of the preceding year. Among persons aged 18–64 years with family incomes three to four times the federal poverty level (approximately $65,000–$87,000 for a family of four), 5.2 million (20.6%) were uninsured for at least part of the preceding year (Table 2). From 2006 to 2009, the largest increase of any income group in the number (from 8.0 million to 9.7 million) and

* Consistent with other population surveys conducted by U.S. federal agencies, CDC does not regard Indian Health Service coverage as health insurance for the purpose of identifying uninsured populations.

† Participants were asked two different questions: "During the past 12 months, has [person] delayed seeking medical care because of worry about the cost?" and "During the past 12 months, was there any time when [person] needed medical care but did not get it because [person] couldn't afford it?" Additional information available at http://www.cdc.gov/nchs/nhis/nhis_2009_data_release.htm.

§ The 2009 NHIS defined a family as "an individual or group of two or more related persons who are living together in the same occupied housing unit (i.e., household) in the sample. In some instances, unrelated persons sharing the same household may also be considered as one family, such as unmarried couples who are living together." Additional information available at http://www.cdc.gov/nchs/nhis/quest_data_related_1997_forward.htm.

¶ Additional information available at http://www.cdc.gov/nchs/nhis/2009imputedincome.htm.

** Additional information available at http://www.census.gov/hhes/www/poverty/about/overview/measure.html.

TABLE 1. Number and percentage of persons with no health insurance coverage for at least part of the 12 months before interview* or for >12 months before interview, by age group — National Health Interview Survey, United States, 2008, 2009, and January–March 2010

Age group/Insurance status	2008		2009		January–March 2010†	
	No. in millions	(%)	No. in millions	(%)	No. in millions	(%)
≤17 yrs						
No health insurance for at least part of the 12 mos before interview	10.0	(13.5)	9.5	(12.8)	8.7	(11.7)
No health insurance for >12 mos before interview	4.1	(5.6)	3.6	(4.8)	3.4	(4.6)
18–64 yrs						
No health insurance for at least part of the 12 mos before interview	46.0	(24.5)	48.6	(25.7)	49.9	(26.2)
No health insurance for >12 mos before interview	27.5	(14.6)	29.1	(15.4)	30.4	(16.0)
All ages						
No health insurance for at least part of the 12 mos before interview	56.4	(18.9)	58.7	(19.5)	59.1	(19.5)
No health insurance for >12 mos before interview	31.7	(10.6)	32.8	(10.9)	33.9	(11.2)

* No insurance even if only for 1 day.
† Early release of estimates. Additional information available at http://www.cdc.gov/nchs/data/nhis/earlyrelease/insur201009.htm.

TABLE 2. Number* and percentage of persons aged 18–64 years with no health insurance coverage for at least part of the 12 months† before interview, by household income level — National Health Interview Survey, United States, 2006–2009

Annual family income relative to the federal poverty level§	2006		2007		2008		2009	
	No. in millions	(%)	No. in millions	(%)	No. in millions	(%)	No. in millions	(%)
≤100%	11.4	(47.2)	10.0	(45.5)	10.1	(45.3)	11.8	(49.1)
101%–200%	13.6	(43.2)	13.9	(44.0)	14.2	(46.0)	15.2	(45.9)
201%–300%	8.0	(27.8)	8.9	(29.9)	8.9	(29.8)	9.7	(32.1)
301%–400%	4.8	(18.6)	5.2	(20.0)	5.3	(20.3)	5.2	(20.6)
>400%	7.5	(10.0)	6.8	(8.8)	7.6	(9.7)	6.9	(9.0)
Total	**45.2**	**(24.4)**	**44.8**	**(23.9)**	**46.0**	**(24.5)**	**48.6**	**(25.7)**

* Numbers might not sum to totals because of rounding.
† No insurance even if only for 1 day.
§ In 2009, the poverty level for a family with two adults and two children was $21,756. Additional information available at http://www.census.gov/hhes/www/poverty/about/overview/measure.html.

percentage (27.8% to 32.1%) of adults aged 18–64 without insurance at some point during the prior year occurred among those with a family income of two to three times the federal poverty level.

Persons aged 18–64 years who were without health insurance for more than a year were approximately six times as likely (55.2% versus 9.3%) to not have a usual source of care, compared with those who were continuously insured (Table 3). Similarly, persons aged 18–64 years with no health insurance during the preceding year were seven times as likely (27.6% versus 4.0%) to forgo needed health care because of cost, compared with those continuously insured (Table 4). Persons aged 18–64 years with no health insurance during the preceding year were approximately six times as likely to forgo needed care if they had hypertension (42.7% versus 6.7%) or diabetes mellitus (47.5% versus 7.7%) and five times as likely (40.8% versus 8.0%) to forgo needed care if they had asthma, compared with those with continuous coverage who had the same chronic condition (Table 4).

Currently insured persons aged 18–64 years who had a 1–3 month gap in coverage during the preceding year were nearly twice as likely (16.4% versus 9.3%) to not have a usual source of care, and three times as likely (26.5% versus 7.1%) to delay care because of cost, compared with persons with continuous coverage (Table 3). Currently insured persons aged 18–64 years who had a 1–3 month gap in coverage during the preceding year were approximately four times as likely (16.4% versus 4.0%) to forgo needed care because of cost, compared with persons with continuous coverage (Table 4). Among persons aged 18–64 years with continuous coverage, those with family income less than or equal to twice the federal poverty level were twice as likely (7.7% versus 3.1%) to forgo needed care because of cost as those with continuous coverage and income greater than twice the poverty level (Table 4).

TABLE 3. Percentage of adults aged 18–64 years who did not have a usual source of health care or who delayed care because of cost during the 12 months before interview, by selected health insurance status — National Health Interview Survey, United States, 2009

Health-care characteristic	Continuously insured during 12 months before interview %	Currently insured, but had a 1–3 month gap in coverage during the 12 months before interview %	No health insurance for >12 months before interview %
No usual source of health care, excluding emergency room	9.3	16.4*	55.2*
Delayed health care because of cost	7.1	26.5*	32.3*

* Significantly different from the percentage for continuous coverage (p<0.005).

TABLE 4. Percentage of adults aged 18–64 years who chose to forgo needed health care because of cost during the 12 months before interview, by selected health insurance status, chronic conditions, and household income level — National Health Interview Survey, United States, 2009

Chronic condition*	Annual household income relative to the federal poverty level†	Health insurance status: Continuously insured during 12 months before interview %	Health insurance status: Currently insured, but had a 1–3 month gap in coverage during the 12 months before interview %	Health insurance status: No health insurance for >12 months before interview %
Total population aged 18–64 yrs	≤200%	7.7	21.0§	28.1§
	>200%	3.1	13.8§	22.6§
	All income levels	4.0	16.4§	27.6§
Hypertension	≤200%	13.2	28.4	49.1§
	>200%	4.6	23.6§	31.6§
	All income levels	6.7	25.3§	42.7§
Diabetes mellitus	≤200%	12.8	—¶	47.9§
	>200%	5.1	—	46.8**
	All income levels	7.7	30.8**	47.5§
Asthma	≤200%	12.3	41.9§	44.5§
	>200%	6.2	17.2	36.1§
	All income levels	8.0	26.0§	40.8§

* In the total population aged 18–64 years, 23.1% reported having been diagnosed with hypertension, 13.8% with asthma, and 7% with diabetes.
† In 2009, the poverty level for a household with two adults and two children was $21,756. Additional information available at http://www.census.gov/hhes/www/poverty/about/overview/measure.html.
§ Significantly different from the percentage for continuous coverage (p<0.005).
¶ Data not reported because of standard error >30%.
** Significantly different from the percentage for continuous coverage (p<0.05).

Among those aged 18–64 years with family income less than or equal to twice the federal poverty level, currently insured persons who had a 1–3 month gap in coverage during the preceding year were approximately three times as likely (21.0% versus 7.7%) to forgo needed health care, compared with those with continuous coverage. Among those with income greater than twice the poverty level, currently insured persons who had a 1–3 month gap in coverage during the preceding year were four times as likely (13.8% versus 3.1%) to forgo needed health care, compared with those with continuous coverage (Table 4). Currently insured persons aged 18–64 years who had a 1–3 month gap in coverage during the preceding year were approximately three times as likely to forgo needed care if they had hypertension (25.3% versus 6.7%), diabetes (30.8% versus 7.7%), or asthma (26.0% versus 8.0%), compared with those with continuous coverage who had the same chronic condition (Table 4).

Among persons aged 18–64 years, those who were uninsured at the time of the interview were approximately three times as likely to forgo needed care because of cost as those with Medicaid (26.3% versus 8.7%) at the time of interview and six times as likely to forgo needed care because of cost as those with private insurance (26.3% versus 4.2%) at the time of interview (Table 5). Persons aged 18–64 years living in a family in which no one had a high school diploma or equivalent were approximately four times as likely to forgo needed care because of cost as those living in a family with a holder of a graduate degree (16.3% versus 4.2%) (Table 5).

TABLE 5. Percentage of persons who had a usual source of health care, who delayed care because of cost, or who went without some needed health care because of cost during the 12 months before interview, by age group and selected characteristics — National Health Interview Survey, United States, 2009

Age group/Characteristic	Had usual source of health care, excluding emergency room		Delayed health care because of cost		Went without some needed health care because of cost	
	%	(95% CI)	%	(95% CI)	%	(95% CI)
≤17 yrs						
Sex						
Men	95.1	(94.5–95.8)	4.7	(4.1–5.2)	2.5	(2.1–2.9)
Women	95.6	(95.1–96.2)	4.8	(4.1–5.4)	2.5	(2.1–2.8)
Race/Ethnicity						
Hispanic	92.1	(90.9–93.2)	5.9	(4.8–7.1)	3.7	(2.9–4.4)
White, non-Hispanic	96.5	(96.0–97.1)	4.4	(3.7–5.1)	1.9	(1.5–2.3)
Black, non-Hispanic	95.5	(94.4–96.5)	4.5	(3.7–5.4)	2.8	(2.1–3.5)
Highest education level in family						
No high school diploma	90.0	(88.0–92.0)	5.0	(3.8–6.1)	3.4	(2.4–4.3)
High school diploma or GED	95.0	(94.3–95.6)	5.9	(5.0–6.7)	2.9	(2.4–3.4)
Bachelor's degree	97.2	(96.3–98.0)	3.4	(2.7–4.1)	1.9*	(1.3–2.5)*
Graduate degree	97.6	(96.7–98.4)	2.2*	(1.5–2.9)*	1.1*	(0.6–1.6)*
Health insurance status at interview						
Uninsured	74.7	(71.6–77.9)	22.6	(19.7–25.5)	13.8	(11.8–15.8)
Medicaid	96.2	(95.4–97.1)	3.1	(2.3–3.9)	1.9*	(1.4–2.5)*
Private insurance	97.7	(97.3–98.2)	3.3	(2.7–3.8)	1.3	(1.0–1.7)
18–64 yrs						
Sex						
Men	75.2	(74.1–76.4)	12.2	(11.6–12.7)	8.9	(8.4–9.4)
Women	86.7	(85.9–87.5)	14.4	(13.9–15.0)	10.2	(9.7–10.7)
Race/Ethnicity						
Hispanic	69.8	(67.9–71.7)	13.5	(12.6–14.5)	11.1	(10.3–12.0)
White, non-Hispanic	83.6	(82.7–84.5)	13.4	(12.9–14.0)	9.0	(8.5–9.5)
Black, non-Hispanic	82.0	(80.5–83.5)	14.0	(12.9–15.1)	12.2	(11.1–13.2)
Highest education level in family						
No high school diploma	67.1	(64.5–69.8)	17.6	(16.0–19.2)	16.3	(14.7–17.8)
High school diploma or GED	79.9	(78.9–80.8)	15.9	(15.2–16.5)	11.9	(11.3–12.4)
Bachelor's degree	85.3	(84.0–86.6)	10.2	(9.3–11.0)	5.9	(5.3–6.4)
Graduate degree	88.7	(87.0–90.3)	7.4	(6.5–8.2)	4.2	(3.6–4.8)
Health insurance status at interview						
Uninsured	48.5	(46.8–50.2)	31.5	(30.3–32.7)	26.3	(25.1–27.4)
Medicaid	90.8	(89.1–92.5)	10.9	(9.5–12.3)	8.7	(7.5–9.8)
Private insurance	89.7	(89.0–90.4)	7.8	(7.4–8.2)	4.2	(3.9–4.5)

Abbreviations: CI = Confidence interval; GED = General Education Development.
* Estimates have a relative standard error between 30% and 50% and should be used with caution.

Conclusions and Comments

This report indicates that an increasing proportion of persons aged 18–64 years in the United States lack health insurance, even for brief periods, and that gaps in insurance coverage are associated with delaying or forgoing health care, irrespective of family income level. These findings are particularly important for persons with chronic diseases. Approximately 40% of persons in the United States have one or more chronic diseases, and continuity in the health care they receive is essential to prevent complications, avoidable long-term expenditures, and premature mortality (*6*). The number of uninsured persons increased in 2009 and the first quarter of 2010, but the Affordable Care Act of 2010 (ACA) is projected to reverse this trend by extending insurance coverage to 94% of the nonelderly population by 2019 (*7*).

The data in this report support previous findings that continuous insurance coverage is an important factor in reducing delayed or forgone health care, which other studies have associated with avoidable hospitalizations for persons with chronic conditions (*8*). In addition, the data demonstrate that cost can be a barrier to health care, even for those with insurance coverage. Increasing the number of persons who receive five high-value prevention services (i.e., smoking cessation assistance, colorectal cancer screening, breast cancer screening, annual influenza

Key Points

- In the first quarter of 2010, approximately 50 million (26%) persons aged 18–64 years had no health insurance for at least part of the 12 months preceding their interview, and 30 million (16%) had no insurance for more than a year.
- From 2006 to 2009, the number of adults aged 18–64 years without health insurance at some point during the prior year increased by an average of about 1.1 million per year. About half of the total increase occurred among those with family incomes two to three times the federal poverty level.
- Although lack of insurance can be linked to poverty, in 2009, 32% of persons aged 18–64 years with family incomes two to three times the poverty level and 21% with family incomes three to four times the poverty level went without health insurance for part of the preceding 12 months.
- In 2009, adults aged 18–64 years with no health insurance for the previous 12 months were seven times as likely to forgo needed health care because of cost as those with continuous insurance coverage.
- In 2009, more than 40% of adults aged 18–64 years who had high blood pressure, asthma, or diabetes and no health insurance went without some medical care because of cost during the preceding 12 months.
- Additional information is available at http://www.cdc.gov/vitalsigns.

immunization, and daily aspirin to prevent heart disease) could save an estimated 100,000 lives each year (*9*). By requiring insurance coverage and no cost-sharing for these and other recommended prevention services,[††] ACA is projected to help increase the number of persons who receive preventive care.

Like insurance coverage, family income is an important influence on receipt of health care. The data show that among persons aged 18–64 years with continuous insurance coverage, those with lower family incomes are twice as likely to forgo needed care because of cost when compared to those with higher family incomes. This disparity in health-care utilization might result from multiple factors outside the scope of this analysis, including personal choice, underinsurance, more difficulty making copayments, and barriers to accessing care (e.g., transportation costs and physician acceptance of publicly insured patients). This report focuses on persons aged 18–64 years and particularly those with chronic conditions, because these populations are large and their ability to receive all needed care has decreased substantially in recent years (*6*). As a result of near-universal coverage of persons aged ≥65 years through Medicare and expansions in coverage for persons aged ≤17 years through Medicaid and the Children's Health Insurance Program, coverage for these age groups has improved or remained relatively stable in recent years.[§§]

The findings in this report are subject to at least two limitations. First, although the data show that insurance coverage is a key factor in receipt of health care, coverage alone does not guarantee receipt of care or even having a usual source of care. Whether a person has a usual source of care is dependent, in part, on personal and societal characteristics. For example, some healthy persons might not have a usual source of care because they have not needed care or have moved recently. Also, some persons might not attach importance to having a usual source of care, yet still might be able to receive any care they need. Second, the association between receipt of care and health outcomes is beyond the scope of this analysis. NHIS respondents were not asked to identify the nature, cost, frequency, or urgency of any medical care that they delayed or went without because of cost concerns. Delaying or forgoing certain health care on an infrequent basis might not negatively impact health.

Even after ACA is implemented fully, some persons eligible for coverage might go uninsured. ACA is expected to extend Medicaid eligibility to a large number of persons, and 16 million are projected to enroll, which amounts to approximately half of the total insurance expansion estimated in response to the legislation (*7*). Some persons will be eligible for Medicaid but might remain uninsured. Studies have indicated that 60%–74% of children who are eligible

[††] Additional information available at http://www.healthcare.gov/center/regulations/prevention/recommendations.html.

[§§] Additional information available at http://www.cdc.gov/nchs/data/nhis/earlyrelease/insur201009.htm.

for Medicaid are uninsured, in part as a result of failure to renew enrollment in Medicaid (*10*). Because ACA will require persons to obtain insurance coverage, the proportion of persons who are eligible for Medicaid but not enrolled likely will decline from current levels. Further efforts to increase enrollment and coverage retention for children and to add persons aged 18–64 years who will be newly eligible for Medicaid could help these populations maintain continuous coverage, thereby increasing receipt of preventive services and reducing avoidable complications from illness, long-term health-care costs, and premature deaths (*10*).

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References

1. Anderson GF. From 'soak the rich' to 'soak the poor': recent trends in hospital pricing. Health Aff (Millwood) 2007;26:780–9.
2. Freeman JD, Kadiyala S, Bell JF, Martin DP. The causal effect of health insurance on utilization and outcomes in adults: a systematic review of US studies. Med Care 2008;46:1023–32.
3. Gruber J. Covering the uninsured in the United States. Journal of Economic Literature 2008;46:571–606.
4. McWilliams JM, Meara E, Zaslavsky AM, Ayanian JZ. Use of health services by previously uninsured Medicare beneficiaries. N Engl J Med 2007;357:143–53.
5. Partnership for Solutions. Chronic care: making the case for ongoing care: February 2010 update. Baltimore, MD: Partnership for Solutions; 2010. Available at http://www.rwjf.org/pr/product.jsp?id=50968. Accessed October 24, 2010.
6. Hoffman C, Schwartz K. Eroding access among nonelderly U.S. adults with chronic conditions: ten years of change. Health Aff (Millwood) 2008;27:w340–8.
7. Congressional Budget Office. Letter to the Honorable Nancy Pelosi, speaker of the U.S. House of Representatives. Available at http://www.cbo.gov/ftpdocs/113xx/doc11379/AmendReconProp.pdf. Accessed September 27, 2010.
8. Bindman AB, Grumach K, Osmond D, et al. Preventable hospitalizations and access to health care. JAMA 1995;274:305–11.
9. National Commission on Prevention Priorities. Preventive care: a national profile on use, disparities, and health benefits. Washington, DC: Partnership for Prevention; August 2007. Available at http://www.rwjf.org/files/publications/other/PreventiveCareReportFinal080707.pdf. Accessed September 24, 2010.
10. Sommers BD. Why millions of children eligible for Medicaid and SCHIP are uninsured: poor retention versus poor take-up. Health Aff (Millwood) 2007;26:w560–7.

Announcement

Get Smart About Antibiotics Week — November 15–21, 2010

November 15–21, 2010, is the third annual Get Smart About Antibiotics Week. This week focuses attention on the need to reduce antibiotic resistance by improving antibiotic use. Antibiotics are one of the most important tools available to combat life-threatening bacterial diseases. However, increasing antibiotic resistance is compromising the effectiveness of antibiotics. In recognition of this as a global public health issue, Get Smart About Antibiotics Week will coincide with Antibiotic Awareness Day, November 18, 2010, in the European Union and Canada.

CDC's Get Smart: Know When Antibiotics Work and Get Smart for Healthcare programs are designed to educate consumers and health-care providers about appropriate use of antibiotics. Infections with resistant bacteria have become more common in health-care and community settings, and many bacteria have become resistant to multiple antibiotics. As resistance increases, so does a patient's risk for dying from the infection (*1*).

Patients, health-care providers, hospital administrators, and policy makers must work together to apply effective strategies for improving antibiotic use to improve health, save lives, and reduce health-care expenditures. Information regarding appropriate use of antibiotics and about Get Smart About Antibiotics Week and how to participate is available at http://www.cdc.gov/getsmart.

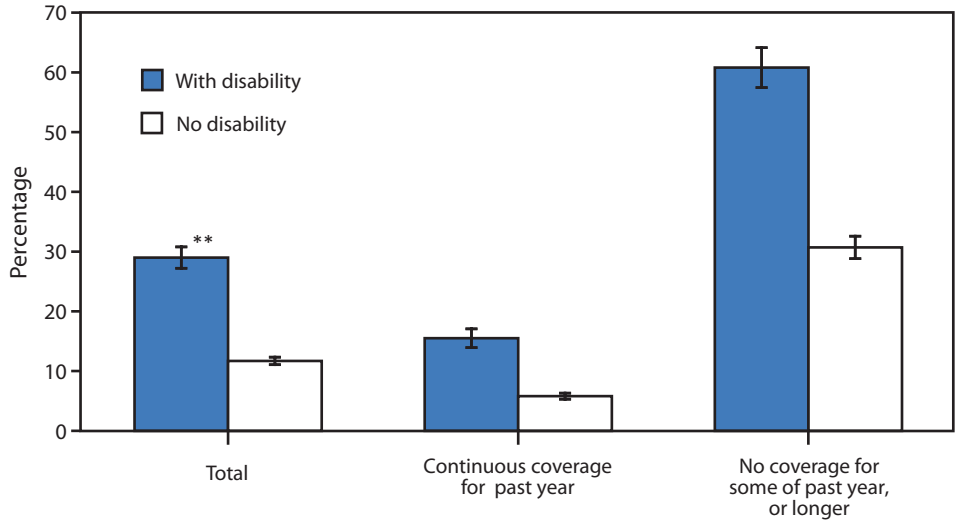
Reference

1. Frieden TR. Antibiotic Resistance and the Threat to Public Health. Testimony Before the Subcomm. on Health of the House Committee on Energy and Commerce, 111th Congress, 2nd Sess. (Apr. 28, 2010). Available at http://www.hhs.gov/asl/testify/2010/04/t20100428b.html. Accessed November 4, 2010.

QuickStats

FROM THE NATIONAL CENTER FOR HEALTH STATISTICS

Delayed or Forgone Medical Care Because of Cost Concerns* Among Adults Aged 18–64 Years,† by Disability§ and Health Insurance Coverage Status¶ — National Health Interview Survey, United States, 2009



* Based on responses to two questions: "During the past 12 months, has [person] delayed seeking medical care because of worry about the cost?" and "During the past 12 months, was there any time when [person] needed medical care but did not get it because [person] could not afford it?" Both questions exclude dental care.
† Estimates are age adjusted to the 2000 U.S. census civilian, noninstitutionalized population.
§ Disability is any difficulty in basic actions, which includes movement, vision, hearing, emotion, and cognition. Of 188,273,000 working age adults, 24.5% reported a difficulty in basic actions.
¶ Insurance coverage includes public and private plans and is stratified by duration of coverage during the year before the interview.
** 95% confidence interval.

During 2009, working-age adults with a disability were approximately 2.5 times more likely than adults without a disability to report delaying or forgoing medical care in the past year because of cost. This difference was found for adults with and without health insurance coverage. Among adults who were continuously insured for the past year, 15.5% of working-age adults with a disability reported delaying or forgoing medical care needs compared with 5.8% of those without a disability. For adults without coverage at any time during the past year or longer, the percentage of adults with a disability (60.8%) who reported delaying or forgoing medical care needs because of cost was twice as high as the percentage of adults without a disability (30.7%). Overall, delayed or forgone medical needs because of cost were highest among adults without insurance, regardless of disability status.

Source: National Health Interview Survey, 2009. Available at http://www.cdc.gov/nchs/nhis.htm.

Notifiable Diseases and Mortality Tables

TABLE I. Provisional cases of infrequently reported notifiable diseases (<1,000 cases reported during the preceding year) — United States, week ending November 6, 2010 (44th week)*

Disease	Current week	Cum 2010	5-year weekly average†	Total cases reported for previous years 2009	2008	2007	2006	2005	States reporting cases during current week (No.)
Anthrax	—	—	—	1	—	1	1	—	
Botulism, total	—	85	2	118	145	144	165	135	
foodborne	—	6	0	10	17	32	20	19	
infant	—	59	1	83	109	85	97	85	
other (wound and unspecified)	—	20	1	25	19	27	48	31	
Brucellosis	—	103	2	115	80	131	121	120	
Chancroid	2	35	1	28	25	23	33	17	TN (2)
Cholera	—	5	0	10	5	7	9	8	
Cyclosporiasis§	1	156	1	141	139	93	137	543	MA (1)
Diphtheria	—	—	—	—	—	—	—	—	
Domestic arboviral diseases§,¶:									
California serogroup virus disease	—	56	1	55	62	55	67	80	
Eastern equine encephalitis virus disease	—	10	—	4	4	4	8	21	
Powassan virus disease	—	5	0	6	2	7	1	1	
St. Louis encephalitis virus disease	—	7	0	12	13	9	10	13	
Western equine encephalitis virus disease	—	—	—	—	—	—	—	—	
Haemophilus influenzae,** invasive disease (age <5 yrs):									
serotype b	—	14	0	35	30	22	29	9	
nonserotype b	2	131	3	236	244	199	175	135	WA (2)
unknown serotype	5	206	3	178	163	180	179	217	VT (1), NY (1), NYC (1), OH (1), FL (1)
Hansen disease§	2	42	2	103	80	101	66	87	FL (1), CA (1)
Hantavirus pulmonary syndrome§	—	16	0	20	18	32	40	26	
Hemolytic uremic syndrome, postdiarrheal§	6	192	5	242	330	292	288	221	MD (1), AR (1), OK (4)
HIV infection, pediatric (age <13 yrs)††	—	—	3	—	—	—	—	380	
Influenza-associated pediatric mortality§,§§	1	58	5	358	90	77	43	45	TX (1)
Listeriosis	5	661	19	851	759	808	884	896	NY (1), OH (1), TN (1), OK (1), CO (1)
Measles¶¶	—	56	0	71	140	43	55	66	
Meningococcal disease, invasive***:									
A, C, Y, and W-135	1	198	5	301	330	325	318	297	WA (1)
serogroup B	—	93	3	174	188	167	193	156	
other serogroup	—	7	1	23	38	35	32	27	
unknown serogroup	5	324	9	482	616	550	651	765	PA (1), OH (1), FL (2), CA (1)
Mumps	4	2,447	19	1,991	454	800	6,584	314	NY (1), FL (1), CA (2)
Novel influenza A virus infections†††	1	2	0	43,774	2	4	NN	NN	PA (1)
Plague	—	2	0	8	3	7	17	8	
Poliomyelitis, paralytic	—	—	—	1	—	—	—	1	
Polio virus Infection, nonparalytic§	—	—	—	—	—	—	NN	NN	
Psittacosis§	—	4	0	9	8	12	21	16	
Q fever, total§,§§§	—	100	3	114	120	171	169	136	
acute	—	76	1	94	106	—	—	—	
chronic	—	24	0	20	14	—	—	—	
Rabies, human	—	1	0	4	2	1	3	2	
Rubella¶¶¶	—	6	0	3	16	12	11	11	
Rubella, congenital syndrome	—	—	—	2	—	—	1	1	
SARS-CoV§,****	—	—	—	—	—	—	—	—	
Smallpox§	—	—	—	—	—	—	—	—	
Streptococcal toxic-shock syndrome§	4	142	1	161	157	132	125	129	CT (4)
Syphilis, congenital (age <1 yr)††††	—	168	8	423	431	430	349	329	
Tetanus	—	6	0	18	19	28	41	27	
Toxic-shock syndrome (staphylococcal)§	1	61	1	74	71	92	101	90	NY (1)
Trichinellosis	—	3	0	13	39	5	15	16	
Tularemia	2	95	1	93	123	137	95	154	MO (1), OK (1)
Typhoid fever	7	351	6	397	449	434	353	324	OH (1), FL (1), CA (5)
Vancomycin-intermediate *Staphylococcus aureus*§	1	78	1	78	63	37	6	2	NY (1)
Vancomycin-resistant *Staphylococcus aureus*§	—	1	0	1	—	2	1	3	
Vibriosis (noncholera *Vibrio* species infections)§	4	674	9	789	588	549	NN	NN	VA (1), FL (2), AZ (1)
Viral hemorrhagic fever§§§§	—	1	—	NN	NN	NN	NN	NN	
Yellow fever	—	—	—	—	—	—	—	—	

See Table I footnotes on next page.

TABLE I. (*Continued*) Provisional cases of infrequently reported notifiable diseases (<1,000 cases reported during the preceding year) — United States, week ending November 6, 2010 (44th week)*

—: No reported cases. N: Not reportable. NN: Not Nationally Notifiable Cum: Cumulative year-to-date counts.

* Case counts for reporting year 2010 are provisional and subject to change. For further information on interpretation of these data, see http://www.cdc.gov/ncphi/disss/nndss/phs/files/ProvisionalNationa%20NotifiableDiseasesSurveillanceData20100927.pdf.

† Calculated by summing the incidence counts for the current week, the 2 weeks preceding the current week, and the 2 weeks following the current week, for a total of 5 preceding years. Additional information is available at http://www.cdc.gov/ncphi/disss/nndss/phs/files/5yearweeklyaverage.pdf.

§ Not reportable in all states. Data from states where the condition is not reportable are excluded from this table except starting in 2007 for the domestic arboviral diseases, STD data, TB data, and influenza-associated pediatric mortality, and in 2003 for SARS-CoV. Reporting exceptions are available at http://www.cdc.gov/ncphi/disss/nndss/phs/infdis.htm.

¶ Includes both neuroinvasive and nonneuroinvasive. Updated weekly from reports to the Division of Vector-Borne Infectious Diseases, National Center for Zoonotic, Vector-Borne, and Enteric Diseases (ArboNET Surveillance). Data for West Nile virus are available in Table II.

** Data for *H. influenzae* (all ages, all serotypes) are available in Table II.

†† Updated monthly from reports to the Division of HIV/AIDS Prevention, National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention. Implementation of HIV reporting influences the number of cases reported. Updates of pediatric HIV data have been temporarily suspended until upgrading of the national HIV/AIDS surveillance data management system is completed. Data for HIV/AIDS, when available, are displayed in Table IV, which appears quarterly.

§§ Updated weekly from reports to the Influenza Division, National Center for Immunization and Respiratory Diseases. Since October 3, 2010, one influenza-associated pediatric death occurred during the 2010–11 influenza season. Since August 30, 2009, a total of 282 influenza-associated pediatric deaths occurring during the 2009–10 influenza season have been reported.

¶¶ No measles cases were reported for the current week.

*** Data for meningococcal disease (all serogroups) are available in Table II.

††† CDC discontinued reporting of individual confirmed and probable cases of 2009 pandemic influenza A (H1N1) virus infections on July 24, 2009. During 2009, four cases of human infection with novel influenza A viruses, different from the 2009 pandemic influenza A (H1N1) strain, were reported to CDC. The two cases of novel influenza A virus infection reported to CDC during 2010 were identified as swine influenza A (H3N2) virus and are unrelated to the 2009 pandemic influenza A (H1N1) virus. Total case counts for 2009 were provided by the Influenza Division, National Center for Immunization and Respiratory Diseases (NCIRD).

§§§ In 2009, Q fever acute and chronic reporting categories were recognized as a result of revisions to the Q fever case definition. Prior to that time, case counts were not differentiated with respect to acute and chronic Q fever cases.

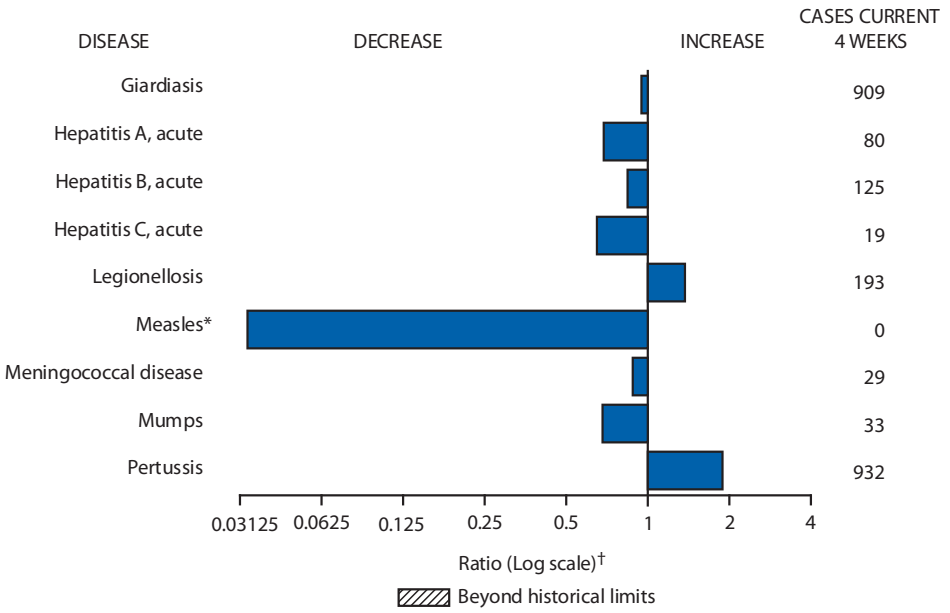
¶¶¶ No rubella cases were reported for the current week.

**** Updated weekly from reports to the Division of Viral and Rickettsial Diseases, National Center for Zoonotic, Vector-Borne, and Enteric Diseases.

†††† Updated weekly from reports to the Division of STD Prevention, National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention.

§§§§ There was one case of viral hemorrhagic fever reported during week 12. The one case report was confirmed as lassa fever. See Table II for dengue hemorrhagic fever.

FIGURE I. Selected notifiable disease reports, United States, comparison of provisional 4-week totals November 6, 2010, with historical data



* No measles cases were reported for the current 4-week period yielding a ratio for week 44 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.

Notifiable Disease Data Team and 122 Cities Mortality Data Team

Patsy A. Hall-Baker
Deborah A. Adams
Willie J. Anderson
Michael S. Wodajo
Rosaline Dhara
Pearl C. Sharp
Lenee Blanton

TABLE II. Provisional cases of selected notifiable diseases, United States, weeks ending November 6, 2010, and November 7, 2009 (44th week)*

Reporting area	*Chlamydia trachomatis* infection					Cryptosporidiosis				
	Current week	Previous 52 weeks		Cum 2010	Cum 2009	Current week	Previous 52 weeks		Cum 2010	Cum 2009
		Med	Max				Med	Max		
United States	9,957	23,384	26,199	1,005,521	1,063,819	50	122	336	6,650	6,461
New England	423	765	1,396	33,454	33,821	3	7	74	409	412
Connecticut	313	216	736	8,730	9,852	—	0	68	68	38
Maine†	—	50	69	1,996	2,048	—	1	7	71	45
Massachusetts	—	401	652	16,701	15,900	2	3	8	143	159
New Hampshire	51	41	114	2,069	1,824	—	1	5	48	76
Rhode Island†	42	64	120	2,899	3,173	—	0	2	13	22
Vermont†	17	23	51	1,059	1,024	1	1	5	66	72
Mid. Atlantic	2,819	3,255	4,766	144,182	134,571	5	14	37	695	728
New Jersey	—	479	691	20,979	20,753	—	0	1	—	47
New York (Upstate)	602	679	2,530	29,178	26,778	1	3	16	184	192
New York City	1,683	1,210	2,741	54,208	49,996	1	1	5	78	73
Pennsylvania	534	902	1,092	39,817	37,044	3	8	26	433	416
E.N. Central	645	3,475	4,127	145,750	170,607	8	29	122	1,802	1,517
Illinois	—	798	1,225	29,826	52,300	—	3	21	245	141
Indiana	—	349	796	15,739	19,237	—	3	10	140	250
Michigan	379	907	1,420	40,719	39,269	—	5	18	283	243
Ohio	134	969	1,085	41,325	41,805	5	7	24	412	337
Wisconsin	132	424	509	18,141	17,996	3	9	55	722	546
W.N. Central	133	1,342	1,565	56,341	60,675	3	23	83	1,201	980
Iowa	12	191	269	8,523	8,221	—	4	24	310	185
Kansas	19	185	235	7,911	9,165	—	2	9	118	93
Minnesota	—	275	331	11,185	12,374	—	0	18	98	294
Missouri	—	495	599	20,430	22,184	2	4	30	346	171
Nebraska†	85	97	237	4,287	4,628	1	3	26	216	105
North Dakota	—	33	89	1,375	1,530	—	0	18	29	11
South Dakota	17	61	77	2,630	2,573	—	2	6	84	121
S. Atlantic	1,364	4,634	5,681	199,916	215,461	9	18	51	869	1,001
Delaware	69	85	220	3,750	4,041	—	0	2	7	8
District of Columbia	—	96	177	4,099	5,828	—	0	1	2	6
Florida	560	1,461	1,732	63,552	63,127	8	7	19	330	399
Georgia	—	541	1,229	21,845	34,576	—	5	31	250	307
Maryland†	—	467	1,031	19,501	19,060	—	1	3	32	38
North Carolina	—	765	1,562	34,310	35,619	—	1	12	69	102
South Carolina†	—	523	788	22,994	23,214	—	1	8	80	54
Virginia†	663	596	902	26,637	26,837	1	2	8	83	72
West Virginia	72	71	112	3,228	3,159	—	0	3	16	15
E.S. Central	780	1,741	2,415	75,079	80,297	4	4	19	277	204
Alabama†	191	491	757	22,345	22,832	—	2	12	131	59
Kentucky	266	277	642	12,562	11,215	3	1	6	76	58
Mississippi	—	384	780	15,872	20,518	—	0	3	19	17
Tennessee†	323	574	729	24,300	25,732	1	1	5	51	70
W.S. Central	861	2,954	4,578	131,654	139,411	2	8	39	379	496
Arkansas†	268	259	392	10,362	12,508	1	0	3	31	50
Louisiana	305	228	1,076	12,456	24,154	—	1	5	53	50
Oklahoma	288	257	1,374	13,015	12,327	1	1	8	76	109
Texas†	—	2,184	3,194	95,821	90,422	—	5	30	219	287
Mountain	762	1,465	1,904	63,326	68,374	5	10	29	482	507
Arizona	265	498	713	21,092	22,288	—	1	3	32	31
Colorado	207	369	577	15,044	16,888	4	2	8	119	129
Idaho†	49	72	200	3,396	3,179	—	2	6	81	81
Montana†	—	60	81	2,526	2,580	1	1	4	44	51
Nevada†	—	171	337	7,842	8,644	—	0	6	31	23
New Mexico†	241	162	453	6,709	7,872	—	2	11	104	136
Utah	—	120	176	5,132	5,244	—	1	5	57	36
Wyoming†	—	37	79	1,585	1,679	—	0	2	14	20
Pacific	2,170	3,643	5,350	155,819	160,602	11	12	28	536	616
Alaska	—	111	148	4,955	4,469	—	0	1	4	6
California	1,915	2,784	4,406	121,008	122,897	9	7	19	307	363
Hawaii	—	112	158	4,705	5,232	—	0	0	—	1
Oregon	—	208	468	9,175	9,536	1	3	13	154	168
Washington	255	384	497	15,976	18,468	1	1	8	71	78
Territories										
American Samoa	—	0	0	—	—	N	0	0	N	N
C.N.M.I.	—	—	—	—	—	—	—	—	—	—
Guam	—	6	31	259	311	—	0	0	—	—
Puerto Rico	254	92	265	4,692	6,402	N	0	0	N	N
U.S. Virgin Islands	—	9	29	323	445	—	0	0	—	—

C.N.M.I.: Commonwealth of Northern Mariana Islands.
U: Unavailable. —: No reported cases. N: Not reportable. NN: Not Nationally Notifiable. Cum: Cumulative year-to-date counts. Med: Median. Max: Maximum.
* Case counts for reporting year 2010 are provisional and subject to change. For further information on interpretation of these data, see http://www.cdc.gov/ncphi/disss/nndss/phs/files/ProvisionalNationa%20NotifiableDiseasesSurveillanceData20100927.pdf. Data for HIV/AIDS, AIDS and TB, when available, are displayed in Table IV, which appears quarterly.
† Contains data reported through the National Electronic Disease Surveillance System (NEDSS).

TABLE II. (*Continued*) Provisional cases of selected notifiable diseases, United States, weeks ending November 6, 2010, and November 7, 2009 (44th week)*

Reporting area	Dengue Virus Infection									
	Dengue Fever†					Dengue Hemorrhagic Fever§				
	Current week	Previous 52 weeks		Cum 2010	Cum 2009	Current week	Previous 52 weeks		Cum 2010	Cum 2009
		Med	Max				Med	Max		
United States	—	5	30	373	NN	—	0	1	4	NN
New England	—	0	2	4	NN	—	0	0	—	NN
Connecticut	—	0	0	—	NN	—	0	0	—	NN
Maine¶	—	0	2	3	NN	—	0	0	—	NN
Massachusetts	—	0	0	—	NN	—	0	0	—	NN
New Hampshire	—	0	0	—	NN	—	0	0	—	NN
Rhode Island¶	—	0	0	—	NN	—	0	0	—	NN
Vermont¶	—	0	1	1	NN	—	0	0	—	NN
Mid. Atlantic	—	1	9	76	NN	—	0	0	—	NN
New Jersey	—	0	0	—	NN	—	0	0	—	NN
New York (Upstate)	—	0	0	—	NN	—	0	0	—	NN
New York City	—	0	7	63	NN	—	0	0	—	NN
Pennsylvania	—	0	2	13	NN	—	0	0	—	NN
E.N. Central	—	0	5	38	NN	—	0	1	1	NN
Illinois	—	0	0	—	NN	—	0	0	—	NN
Indiana	—	0	2	10	NN	—	0	0	—	NN
Michigan	—	0	2	9	NN	—	0	0	—	NN
Ohio	—	0	2	14	NN	—	0	0	—	NN
Wisconsin	—	0	2	5	NN	—	0	1	1	NN
W.N. Central	—	0	2	17	NN	—	0	0	—	NN
Iowa	—	0	1	2	NN	—	0	0	—	NN
Kansas	—	0	1	1	NN	—	0	0	—	NN
Minnesota	—	0	2	13	NN	—	0	0	—	NN
Missouri	—	0	0	—	NN	—	0	0	—	NN
Nebraska¶	—	0	0	—	NN	—	0	0	—	NN
North Dakota	—	0	1	1	NN	—	0	0	—	NN
South Dakota	—	0	0	—	NN	—	0	0	—	NN
S. Atlantic	—	2	16	190	NN	—	0	1	2	NN
Delaware	—	0	0	—	NN	—	0	0	—	NN
District of Columbia	—	0	0	—	NN	—	0	0	—	NN
Florida	—	1	14	157	NN	—	0	1	2	NN
Georgia	—	0	2	9	NN	—	0	0	—	NN
Maryland¶	—	0	0	—	NN	—	0	0	—	NN
North Carolina	—	0	1	4	NN	—	0	0	—	NN
South Carolina¶	—	0	3	9	NN	—	0	0	—	NN
Virginia¶	—	0	3	9	NN	—	0	0	—	NN
West Virginia	—	0	1	2	NN	—	0	0	—	NN
E.S. Central	—	0	2	5	NN	—	0	0	—	NN
Alabama¶	—	0	2	2	NN	—	0	0	—	NN
Kentucky	—	0	1	1	NN	—	0	0	—	NN
Mississippi	—	0	1	1	NN	—	0	0	—	NN
Tennessee¶	—	0	1	1	NN	—	0	0	—	NN
W.S. Central	—	0	1	4	NN	—	0	1	1	NN
Arkansas¶	—	0	0	—	NN	—	0	1	1	NN
Louisiana	—	0	0	—	NN	—	0	0	—	NN
Oklahoma	—	0	1	4	NN	—	0	0	—	NN
Texas¶	—	0	0	—	NN	—	0	0	—	NN
Mountain	—	0	2	16	NN	—	0	0	—	NN
Arizona	—	0	1	6	NN	—	0	0	—	NN
Colorado	—	0	0	—	NN	—	0	0	—	NN
Idaho¶	—	0	1	2	NN	—	0	0	—	NN
Montana¶	—	0	1	3	NN	—	0	0	—	NN
Nevada¶	—	0	1	4	NN	—	0	0	—	NN
New Mexico¶	—	0	1	1	NN	—	0	0	—	NN
Utah	—	0	0	—	NN	—	0	0	—	NN
Wyoming¶	—	0	0	—	NN	—	0	0	—	NN
Pacific	—	0	5	23	NN	—	0	0	—	NN
Alaska	—	0	0	—	NN	—	0	0	—	NN
California	—	0	5	11	NN	—	0	0	—	NN
Hawaii	—	0	0	—	NN	—	0	0	—	NN
Oregon	—	0	0	—	NN	—	0	0	—	NN
Washington	—	0	2	12	NN	—	0	0	—	NN
Territories										
American Samoa	—	0	0	—	NN	—	0	0	—	NN
C.N.M.I.	—	—	—	—	NN	—	—	—	—	NN
Guam	—	0	0	—	NN	—	0	0	—	NN
Puerto Rico	—	97	534	8,701	NN	—	0	3	32	NN
U.S. Virgin Islands	—	0	0	—	NN	—	0	0	—	NN

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† Dengue Fever includes cases that meet criteria for Dengue Fever with hemorrhage, other clinical, and unknown case classifications.
§ DHF includes cases that meet criteria for dengue shock syndrome (DSS), a more severe form of DHF.
¶ Contains data reported through the National Electronic Disease Surveillance System (NEDSS).

TABLE II. (*Continued*) Provisional cases of selected notifiable diseases, United States, weeks ending November 6, 2010, and November 7, 2009 (44th week)*

Reporting area	Ehrlichiosis/Anaplasmosis†														
	Ehrlichia chaffeensis					*Anaplasma phagocytophilum*					Undetermined				
	Current week	Previous 52 weeks		Cum 2010	Cum 2009	Current week	Previous 52 weeks		Cum 2010	Cum 2009	Current week	Previous 52 weeks		Cum 2010	Cum 2009
		Med	Max				Med	Max				Med	Max		
United States	4	8	181	536	868	8	11	309	671	838	—	2	35	95	159
New England	—	0	3	4	50	1	1	8	73	244	—	0	2	7	2
Connecticut	—	0	0	—	—	—	0	5	18	17	—	0	2	5	—
Maine§	—	0	1	2	4	1	0	2	16	12	—	0	0	—	—
Massachusetts	—	0	0	—	9	—	0	2	—	90	—	0	0	—	—
New Hampshire	—	0	1	2	4	—	0	3	15	16	—	0	1	2	1
Rhode Island§	—	0	2	—	32	—	0	7	24	109	—	0	0	—	1
Vermont§	—	0	0	—	1	—	0	0	—	—	—	0	0	—	—
Mid. Atlantic	2	1	15	47	178	7	2	17	180	288	—	0	2	4	44
New Jersey	—	0	2	—	96	—	0	2	1	68	—	0	0	—	—
New York (Upstate)	2	0	15	28	50	7	2	17	176	211	—	0	1	4	6
New York City	—	0	3	18	10	—	0	1	3	8	—	0	0	—	1
Pennsylvania	—	0	2	1	22	—	0	1	—	1	—	0	1	—	37
E.N. Central	—	0	4	32	83	—	3	39	334	265	—	1	6	60	70
Illinois	—	0	2	12	33	—	0	1	2	6	—	0	2	4	3
Indiana	—	0	0	—	—	—	0	0	—	—	—	0	3	28	36
Michigan	—	0	1	2	5	—	0	0	—	—	—	0	1	4	—
Ohio	—	0	3	6	13	—	0	1	2	1	—	0	0	—	2
Wisconsin	—	0	1	12	32	—	3	39	330	258	—	0	4	24	29
W.N. Central	—	1	13	116	152	—	0	261	11	19	—	0	30	11	16
Iowa	—	0	0	—	—	—	0	0	—	—	—	0	0	—	—
Kansas	—	0	1	6	6	—	0	0	—	1	—	0	0	—	—
Minnesota	—	0	6	—	2	—	0	261	—	13	—	0	30	—	3
Missouri	—	1	13	108	142	—	0	3	11	4	—	0	3	11	13
Nebraska§	—	0	1	2	2	—	0	0	—	1	—	0	0	—	—
North Dakota	—	0	0	—	—	—	0	0	—	—	—	0	0	—	—
South Dakota	—	0	0	—	—	—	0	0	—	—	—	0	0	—	—
S. Atlantic	1	4	19	233	242	—	1	7	53	16	—	0	1	6	2
Delaware	—	0	3	17	21	—	0	1	4	2	—	0	0	—	—
District of Columbia	—	0	0	—	—	—	0	0	—	—	—	0	0	—	—
Florida	—	0	2	8	11	—	0	1	3	3	—	0	0	—	—
Georgia	—	0	4	19	18	—	0	1	1	1	—	0	1	1	—
Maryland§	—	0	3	22	38	—	0	2	13	3	—	0	1	2	—
North Carolina	—	2	13	98	60	—	0	4	20	3	—	0	0	—	—
South Carolina§	—	0	2	3	10	—	0	1	1	—	—	0	0	—	—
Virginia§	—	1	13	65	83	—	0	2	11	4	—	0	1	3	2
West Virginia	1	0	0	1	1	—	0	0	—	—	—	0	1	—	—
E.S. Central	1	1	10	83	130	—	0	2	17	3	—	0	1	6	24
Alabama§	1	0	3	11	8	—	0	2	7	1	—	0	0	—	—
Kentucky	—	0	2	14	10	—	0	0	—	—	—	0	0	—	—
Mississippi	—	0	1	3	6	—	0	1	1	—	—	0	0	—	—
Tennessee§	—	1	6	55	106	—	0	2	9	2	—	0	1	6	24
W.S. Central	—	0	141	20	30	—	0	23	3	1	—	0	1	1	—
Arkansas§	—	0	34	2	4	—	0	6	—	—	—	0	0	—	—
Louisiana	—	0	1	1	—	—	0	0	—	—	—	0	0	—	—
Oklahoma	—	0	105	14	24	—	0	16	2	1	—	0	0	—	—
Texas§	—	0	2	3	2	—	0	1	1	—	—	0	1	1	—
Mountain	—	0	0	—	—	—	0	0	—	—	—	0	0	—	1
Arizona	—	0	0	—	—	—	0	0	—	—	—	0	0	—	1
Colorado	—	0	0	—	—	—	0	0	—	—	—	0	0	—	—
Idaho§	—	0	0	—	—	—	0	0	—	—	—	0	0	—	—
Montana§	—	0	0	—	—	—	0	0	—	—	—	0	0	—	—
Nevada§	—	0	0	—	—	—	0	0	—	—	—	0	0	—	—
New Mexico§	—	0	0	—	—	—	0	0	—	—	—	0	0	—	—
Utah	—	0	0	—	—	—	0	0	—	—	—	0	0	—	—
Wyoming§	—	0	0	—	—	—	0	0	—	—	—	0	0	—	—
Pacific	—	0	1	1	3	—	0	0	—	2	—	0	1	—	—
Alaska	—	0	0	—	—	—	0	0	—	—	—	0	0	—	—
California	—	0	1	1	3	—	0	0	—	2	—	0	1	—	—
Hawaii	—	0	0	—	—	—	0	0	—	—	—	0	0	—	—
Oregon	—	0	0	—	—	—	0	0	—	—	—	0	0	—	—
Washington	—	0	0	—	—	—	0	0	—	—	—	0	0	—	—
Territories															
American Samoa	—	0	0	—	—	—	0	0	—	—	—	0	0	—	—
C.N.M.I.	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—
Guam	—	0	0	—	—	—	0	0	—	—	—	0	0	—	—
Puerto Rico	—	0	0	—	—	—	0	0	—	—	—	0	0	—	—
U.S. Virgin Islands	—	0	0	—	—	—	0	0	—	—	—	0	0	—	—

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† Cumulative total *E. ewingii* cases reported for year 2010 = 10.
§ Contains data reported through the National Electronic Disease Surveillance System (NEDSS).

TABLE II. (*Continued*) Provisional cases of selected notifiable diseases, United States, weeks ending November 6, 2010, and November 7, 2009 (44th week)*

Reporting area	Giardiasis					Gonorrhea					*Haemophilus influenzae*, invasive† All ages, all serotypes				
	Current week	Previous 52 weeks		Cum 2010	Cum 2009	Current week	Previous 52 weeks		Cum 2010	Cum 2009	Current week	Previous 52 weeks		Cum 2010	Cum 2009
		Med	Max				Med	Max				Med	Max		
United States	221	347	666	15,153	16,221	2,076	5,440	6,341	235,153	259,060	22	59	171	2,405	2,412
New England	19	32	54	1,387	1,521	52	105	196	4,469	4,167	5	3	21	151	166
Connecticut	—	5	13	236	254	46	42	169	1,944	2,012	4	0	15	34	47
Maine§	9	4	12	196	189	—	3	11	136	115	—	0	2	11	18
Massachusetts	9	13	24	600	653	—	46	81	1,952	1,623	—	2	8	77	77
New Hampshire	—	3	8	128	180	5	3	7	134	91	—	0	2	10	11
Rhode Island§	—	1	7	60	54	1	5	14	256	288	—	0	2	11	8
Vermont§	1	4	10	167	191	—	0	17	47	38	1	0	1	8	5
Mid. Atlantic	43	59	103	2,599	2,974	593	682	1,128	30,516	27,039	3	11	34	465	492
New Jersey	—	5	13	207	377	—	102	161	4,563	4,065	—	2	7	75	108
New York (Upstate)	35	22	84	989	1,134	138	103	422	4,846	5,002	2	3	20	127	127
New York City	3	16	33	758	720	318	229	547	10,508	9,390	1	2	6	91	61
Pennsylvania	5	14	25	645	743	137	239	364	10,599	8,582	—	4	9	172	196
E.N. Central	18	53	80	2,438	2,526	148	923	1,260	39,928	54,536	2	10	20	407	381
Illinois	—	12	26	492	538	—	182	380	7,025	17,354	—	3	9	123	143
Indiana	—	5	13	197	258	—	96	221	4,437	6,182	—	1	6	71	68
Michigan	—	13	23	578	577	58	245	471	11,164	12,807	—	0	4	27	19
Ohio	17	16	29	736	703	45	318	372	13,284	13,714	2	2	6	101	87
Wisconsin	1	8	30	435	450	45	94	155	4,018	4,479	—	2	5	85	64
W.N. Central	14	24	165	1,231	1,466	27	276	357	11,445	12,781	1	3	24	137	139
Iowa	3	5	11	253	258	6	33	53	1,452	1,424	—	0	1	1	—
Kansas	—	4	10	183	136	1	37	83	1,587	2,172	—	0	2	13	13
Minnesota	—	0	135	136	343	—	38	62	1,596	2,005	—	0	17	25	48
Missouri	5	8	25	371	456	—	124	172	5,356	5,584	—	1	6	68	51
Nebraska§	6	3	9	188	155	20	22	50	1,005	1,186	1	0	2	20	21
North Dakota	—	0	7	27	20	—	2	11	94	114	—	0	4	10	6
South Dakota	—	1	7	73	98	—	7	18	355	296	—	0	0	—	—
S. Atlantic	49	72	143	3,193	3,175	338	1,340	1,684	58,097	64,568	4	14	27	635	658
Delaware	—	0	5	28	22	12	18	48	852	825	—	0	1	5	3
District of Columbia	—	1	5	31	66	—	37	65	1,545	2,287	—	0	1	3	4
Florida	41	40	87	1,847	1,656	177	386	493	17,136	18,174	2	3	9	157	195
Georgia	—	10	51	485	642	—	181	421	7,467	11,846	—	3	9	143	130
Maryland§	3	5	11	224	245	—	133	237	5,676	5,211	2	1	6	57	77
North Carolina	N	0	0	N	N	—	246	596	11,490	12,126	—	2	9	107	81
South Carolina§	—	2	9	123	95	—	155	232	6,917	7,295	—	2	7	69	65
Virginia§	5	9	36	416	407	128	160	271	6,548	6,375	—	2	4	72	77
West Virginia	—	0	6	39	42	21	9	20	466	429	—	0	5	22	26
E.S. Central	—	5	15	220	361	211	478	698	20,385	23,117	1	3	12	146	140
Alabama§	—	4	10	163	171	57	145	218	6,461	6,561	—	0	3	22	35
Kentucky	N	0	0	N	N	75	75	156	3,284	3,268	—	0	2	30	19
Mississippi	N	0	0	N	N	—	111	216	4,512	6,390	—	0	2	11	7
Tennessee§	—	1	10	57	190	79	145	195	6,128	6,898	1	2	10	83	79
W.S. Central	5	8	16	329	452	280	782	1,281	35,657	40,810	1	2	20	109	105
Arkansas§	5	2	9	119	136	89	76	133	3,174	3,876	—	0	3	14	18
Louisiana	—	3	9	147	177	98	68	441	3,576	7,865	—	0	3	21	18
Oklahoma	—	2	7	63	139	93	75	359	3,825	3,907	1	1	15	66	65
Texas§	N	0	0	N	N	—	570	964	25,082	25,162	—	0	2	8	4
Mountain	17	30	49	1,377	1,447	78	179	262	7,502	7,981	2	5	15	246	207
Arizona	1	3	8	133	180	32	63	109	2,487	2,684	1	2	10	93	65
Colorado	13	13	27	582	421	22	52	95	2,274	2,405	—	1	5	67	62
Idaho§	1	4	9	181	181	2	2	6	100	89	1	0	2	16	3
Montana§	1	2	7	90	121	—	2	6	87	71	—	0	1	2	1
Nevada§	1	1	11	88	99	—	29	94	1,380	1,479	—	0	2	7	16
New Mexico§	—	2	5	80	109	22	19	41	885	914	—	1	5	35	28
Utah	—	4	11	189	277	—	6	15	261	278	—	0	4	20	29
Wyoming§	—	1	5	34	59	—	0	4	28	61	—	0	2	6	3
Pacific	56	53	133	2,379	2,299	349	601	809	27,154	24,061	3	2	21	109	124
Alaska	—	2	6	85	101	—	23	37	1,054	836	—	0	2	20	17
California	32	33	61	1,482	1,482	311	494	691	22,512	19,789	1	0	18	19	40
Hawaii	—	0	3	24	19	—	14	25	604	557	—	0	2	7	28
Oregon	6	9	20	416	353	—	19	43	830	931	—	1	5	57	36
Washington	18	8	75	372	344	38	50	69	2,154	1,948	2	0	4	6	3
Territories															
American Samoa	—	0	0	—	—	—	0	0	—	—	—	0	0	—	—
C.N.M.I.	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—
Guam	—	0	1	2	3	—	0	4	30	19	—	0	0	—	—
Puerto Rico	—	1	8	58	142	12	5	14	257	208	—	0	1	1	4
U.S. Virgin Islands	—	0	0	—	—	—	2	7	78	109	—	0	0	—	—

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* Case counts for reporting year 2010 are provisional and subject to change. For further information on interpretation of these data, see http://www.cdc.gov/ncphi/disss/nndss/phs/files/ProvisionalNationa%20NotifiableDiseasesSurveillanceData20100927.pdf. Data for HIV/AIDS, AIDS and TB, when available, are displayed in Table IV, which appears quarterly.
† Data for *H. influenzae* (age <5 yrs for serotype b, nonserotype b, and unknown serotype) are available in Table I.
§ Contains data reported through the National Electronic Disease Surveillance System (NEDSS).

TABLE II. (*Continued*) Provisional cases of selected notifiable diseases, United States, weeks ending November 6, 2010, and November 7, 2009 (44th week)*

Reporting area	Hepatitis (viral, acute), by type														
	A					B					C				
	Current week	Previous 52 weeks		Cum 2010	Cum 2009	Current week	Previous 52 weeks		Cum 2010	Cum 2009	Current week	Previous 52 weeks		Cum 2010	Cum 2009
		Med	Max				Med	Max				Med	Max		
United States	21	30	69	1,287	1,704	28	62	204	2,604	2,805	5	14	44	675	639
New England	2	2	5	85	97	—	1	5	47	48	—	1	4	36	58
Connecticut	2	0	3	27	18	—	0	2	18	14	—	0	4	25	45
Maine†	—	0	1	7	1	—	0	2	13	13	—	0	0	—	2
Massachusetts	—	1	5	41	61	—	0	2	8	17	—	0	1	10	10
New Hampshire	—	0	1	2	7	—	0	2	6	4	N	0	0	N	N
Rhode Island†	—	0	4	8	8	U	0	0	U	U	U	0	0	U	U
Vermont†	—	0	0	—	2	—	0	1	2	—	—	0	1	1	1
Mid. Atlantic	1	4	10	173	240	—	5	10	240	291	—	2	6	96	89
New Jersey	—	0	3	12	60	—	1	5	57	87	—	0	2	21	6
New York (Upstate)	—	1	4	53	43	—	1	6	42	47	—	1	4	49	41
New York City	—	1	5	62	76	—	2	4	75	61	—	0	0	—	5
Pennsylvania	1	1	4	46	61	—	1	5	66	96	—	0	3	26	37
E.N. Central	—	4	8	182	261	1	9	17	386	379	—	2	8	96	77
Illinois	—	1	3	40	118	—	1	5	71	105	—	0	1	1	4
Indiana	—	0	2	15	16	—	1	5	47	64	—	0	2	21	18
Michigan	—	1	4	60	63	—	3	6	104	112	—	1	4	58	28
Ohio	—	0	5	42	35	1	2	6	81	77	—	0	1	8	24
Wisconsin	—	0	3	25	29	—	1	8	83	21	—	0	2	8	3
W.N. Central	1	1	13	67	102	—	2	15	100	120	—	0	11	15	21
Iowa	—	0	3	8	32	—	0	2	12	29	—	0	1	—	10
Kansas	—	0	3	11	9	—	0	2	7	6	—	0	1	1	1
Minnesota	—	0	12	14	18	—	0	13	7	23	—	0	9	6	6
Missouri	1	0	2	21	21	—	1	3	62	40	—	0	1	6	—
Nebraska†	—	0	4	12	19	—	0	2	11	19	—	0	1	2	2
North Dakota	—	0	1	—	—	—	0	0	—	—	—	0	1	—	1
South Dakota	—	0	1	1	3	—	0	1	1	3	—	0	0	—	1
S. Atlantic	7	7	14	294	373	10	16	40	749	774	3	4	7	146	142
Delaware	—	0	1	7	3	—	0	2	22	29	U	0	0	U	U
District of Columbia	—	0	1	1	1	—	0	1	3	10	—	0	1	2	1
Florida	7	3	7	120	157	8	5	11	255	248	3	1	5	49	38
Georgia	—	1	3	34	44	—	2	7	127	131	—	0	2	7	30
Maryland†	—	0	3	20	42	—	1	6	60	65	—	0	2	22	21
North Carolina	—	1	5	45	35	—	1	16	85	96	—	0	3	36	20
South Carolina†	—	0	3	22	55	—	1	4	51	49	—	0	1	1	1
Virginia†	—	1	6	43	33	2	1	14	85	85	—	0	2	12	8
West Virginia	—	0	2	2	3	—	0	14	61	61	—	0	5	17	23
E.S. Central	—	1	3	33	35	3	8	13	306	291	—	3	8	126	89
Alabama†	—	0	1	6	9	—	1	5	59	79	—	0	1	5	7
Kentucky	—	0	2	13	8	1	2	8	108	70	—	2	5	87	53
Mississippi	—	0	1	2	8	1	1	3	34	29	U	0	0	U	U
Tennessee†	—	0	2	12	10	1	2	8	105	113	—	1	4	34	29
W.S. Central	2	3	19	118	164	4	10	109	417	493	1	1	14	65	50
Arkansas†	—	0	3	2	8	—	1	4	41	59	—	0	0	—	2
Louisiana	—	0	2	8	6	—	1	4	40	61	—	0	1	7	7
Oklahoma	—	0	3	1	3	2	2	19	81	86	1	0	12	28	12
Texas†	2	2	18	107	147	2	5	87	255	287	—	1	3	30	29
Mountain	1	3	8	122	141	1	2	8	100	116	1	1	5	42	44
Arizona	—	1	5	57	60	—	0	2	27	39	U	0	0	U	U
Colorado	—	1	3	26	46	1	0	3	22	22	1	0	2	8	25
Idaho†	—	0	2	6	4	—	0	1	6	11	—	0	2	9	4
Montana†	—	0	1	4	6	—	0	1	1	1	—	0	0	—	1
Nevada†	1	0	2	14	11	—	0	3	33	28	—	0	1	4	3
New Mexico†	—	0	1	4	7	—	0	1	5	6	—	0	2	11	6
Utah	—	0	1	8	5	—	0	1	5	5	—	0	2	10	5
Wyoming†	—	0	3	3	2	—	0	1	1	4	—	0	0	—	—
Pacific	7	5	16	213	291	9	6	20	259	293	—	1	6	53	69
Alaska	—	0	1	1	2	—	0	1	3	3	U	0	2	U	U
California	6	4	15	176	232	8	4	17	180	205	—	0	4	21	37
Hawaii	—	0	2	3	8	—	0	1	1	6	U	0	0	U	U
Oregon	—	0	2	16	14	—	1	4	34	39	—	0	3	14	16
Washington	1	0	2	17	35	1	1	4	41	40	—	0	6	18	14
Territories															
American Samoa	—	0	0	—	—	—	0	0	—	—	—	0	0	—	—
C.N.M.I.	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—
Guam	—	0	6	18	4	—	1	6	40	50	—	0	7	35	42
Puerto Rico	—	0	2	13	21	—	0	2	16	30	—	0	0	—	—
U.S. Virgin Islands	—	0	0	—	—	—	0	0	—	—	—	0	0	—	—

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U: Unavailable. —: No reported cases. N: Not reportable. NN: Not Nationally Notifiable. Cum: Cumulative year-to-date counts. Med: Median. Max: Maximum.
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TABLE II. (*Continued*) Provisional cases of selected notifiable diseases, United States, weeks ending November 6, 2010, and November 7, 2009 (44th week)*

Reporting area	Legionellosis					Lyme disease					Malaria				
	Current week	Previous 52 weeks		Cum 2010	Cum 2009	Current week	Previous 52 weeks		Cum 2010	Cum 2009	Current week	Previous 52 weeks		Cum 2010	Cum 2009
		Med	Max				Med	Max				Med	Max		
United States	24	59	113	2,715	3,025	127	406	2,336	23,856	33,629	14	27	89	1,230	1,203
New England	2	3	15	210	178	18	125	468	7,081	11,537	—	2	4	65	53
Connecticut	2	0	6	43	48	—	40	200	2,257	3,892	—	0	1	1	5
Maine†	—	0	4	12	8	15	11	76	642	791	—	0	1	5	2
Massachusetts	—	1	8	103	88	—	41	200	2,639	4,960	—	1	3	45	34
New Hampshire	—	0	5	20	12	2	22	67	1,093	1,299	—	0	2	4	4
Rhode Island†	—	0	4	23	15	—	1	40	146	223	—	0	1	7	5
Vermont†	—	0	2	9	7	1	4	27	304	372	—	0	1	3	3
Mid. Atlantic	3	17	37	726	1,066	74	168	712	11,004	14,666	4	7	17	330	355
New Jersey	—	2	9	78	195	—	43	202	2,818	4,728	—	0	4	1	91
New York (Upstate)	2	5	19	251	316	51	53	577	2,602	3,587	3	1	6	67	42
New York City	—	2	10	121	212	—	2	17	67	969	—	4	14	213	175
Pennsylvania	1	6	17	276	343	23	75	379	5,517	5,382	1	1	3	49	47
E.N. Central	4	12	41	619	649	1	16	240	1,999	2,826	2	2	9	129	153
Illinois	—	1	15	118	117	—	1	16	110	135	—	1	7	44	65
Indiana	1	2	6	96	56	—	1	7	66	80	—	0	2	8	20
Michigan	1	3	20	155	148	—	1	14	90	95	1	0	4	29	26
Ohio	2	4	15	204	257	—	0	5	21	49	1	0	5	38	33
Wisconsin	—	0	11	46	71	1	12	215	1,712	2,467	—	0	1	10	9
W.N. Central	—	2	19	103	107	—	2	1,395	113	220	—	1	11	62	61
Iowa	—	0	2	13	21	—	0	10	78	106	—	0	2	11	10
Kansas	—	0	2	10	7	—	0	1	6	18	—	0	2	10	7
Minnesota	—	0	16	27	12	—	0	1,380	—	88	—	0	11	3	24
Missouri	—	0	4	32	53	—	0	1	1	3	—	0	3	20	12
Nebraska†	—	0	2	8	11	—	0	2	9	4	—	0	2	15	7
North Dakota	—	0	1	6	1	—	0	15	18	—	—	0	1	—	—
South Dakota	—	0	2	7	2	—	0	1	1	1	—	0	2	3	1
S. Atlantic	2	10	27	448	503	25	58	171	3,314	3,952	4	6	38	338	315
Delaware	—	0	3	15	18	1	11	32	551	910	—	0	1	2	5
District of Columbia	—	0	4	15	19	—	0	4	21	60	—	0	2	9	16
Florida	1	3	9	147	156	3	2	10	90	97	3	2	7	111	82
Georgia	—	1	4	41	53	—	0	2	10	38	—	0	4	31	64
Maryland†	—	2	8	98	133	9	25	99	1,453	1,848	—	1	18	74	61
North Carolina	—	0	7	50	54	—	1	9	78	89	—	0	13	45	28
South Carolina†	—	0	2	10	9	—	0	3	27	35	—	0	1	4	4
Virginia†	1	1	6	61	53	11	16	79	971	722	1	1	5	59	53
West Virginia	—	0	3	11	8	1	0	32	113	153	—	0	2	3	2
E.S. Central	1	2	10	114	127	—	1	4	40	35	1	0	3	27	30
Alabama†	—	0	2	15	17	—	0	1	2	3	1	0	1	7	9
Kentucky	—	0	4	26	46	—	0	1	4	1	—	0	3	6	9
Mississippi	—	0	3	9	4	—	0	0	—	—	—	0	2	2	3
Tennessee†	1	1	6	64	60	—	1	4	34	31	—	0	2	12	9
W.S. Central	1	3	14	124	107	1	2	44	90	194	—	2	31	75	57
Arkansas†	—	0	2	13	7	—	0	0	—	—	—	0	1	2	5
Louisiana	—	0	3	8	13	—	0	1	2	—	—	0	1	4	5
Oklahoma	1	0	4	13	6	—	0	2	—	—	—	0	1	5	1
Texas†	—	2	10	90	81	1	2	42	88	194	—	1	30	64	46
Mountain	3	3	10	146	123	—	0	3	21	53	—	1	4	54	45
Arizona	2	1	7	57	38	—	0	1	2	6	—	0	2	22	8
Colorado	—	1	5	31	24	—	0	1	2	1	—	0	3	18	26
Idaho†	1	0	1	6	5	—	0	2	6	15	—	0	1	3	2
Montana†	—	0	1	4	6	—	0	1	3	3	—	0	1	2	5
Nevada†	—	0	2	19	12	—	0	1	1	12	—	0	1	5	—
New Mexico†	—	0	2	7	9	—	0	2	5	5	—	0	1	1	—
Utah	—	0	3	17	25	—	0	1	2	9	—	0	1	3	4
Wyoming†	—	0	2	5	4	—	0	1	—	2	—	0	0	—	—
Pacific	8	5	19	225	165	8	4	11	194	146	3	3	19	150	134
Alaska	—	0	2	2	1	—	0	1	6	6	—	0	1	3	2
California	4	4	19	188	124	6	3	9	128	94	3	2	13	103	99
Hawaii	—	0	1	1	1	N	0	0	N	N	—	0	1	1	1
Oregon	—	0	3	12	16	1	1	4	47	36	—	0	3	12	11
Washington	4	0	4	22	23	1	0	3	13	10	—	0	5	31	21
Territories															
American Samoa	—	0	0	—	—	N	0	0	N	N	—	0	0	—	—
C.N.M.I.	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—
Guam	—	0	1	1	—	—	0	0	—	—	—	0	0	—	—
Puerto Rico	—	0	1	—	2	N	0	0	N	N	—	0	2	4	5
U.S. Virgin Islands	—	0	0	—	—	—	0	0	—	—	—	0	0	—	—

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TABLE II. (*Continued*) Provisional cases of selected notifiable diseases, United States, weeks ending November 6, 2010, and November 7, 2009 (44th week)*

Reporting area	Meningococcal disease, invasive† All groups					Pertussis					Rabies, animal				
	Current week	Previous 52 weeks		Cum 2010	Cum 2009	Current week	Previous 52 weeks		Cum 2010	Cum 2009	Current week	Previous 52 weeks		Cum 2010	Cum 2009
		Med	Max				Med	Max				Med	Max		
United States	6	15	43	622	796	225	309	1,756	16,192	13,214	23	66	140	2,857	4,562
New England	—	0	3	16	29	1	8	22	410	569	3	4	15	208	300
Connecticut	—	0	2	2	3	—	1	8	95	46	—	0	14	59	132
Maine§	—	0	1	3	4	—	0	5	39	77	1	1	4	56	49
Massachusetts	—	0	2	6	14	1	5	13	224	323	—	0	0	—	—
New Hampshire	—	0	0	—	3	—	0	2	15	72	1	0	5	13	29
Rhode Island§	—	0	0	—	4	—	0	9	26	40	—	1	4	31	38
Vermont§	—	0	1	5	1	—	0	4	11	11	1	1	5	49	52
Mid. Atlantic	1	1	4	53	89	32	25	64	1,274	1,023	11	18	41	880	512
New Jersey	—	0	2	9	16	—	3	8	103	213	—	0	0	—	—
New York (Upstate)	—	0	3	11	17	14	8	27	457	188	11	9	19	450	394
New York City	—	0	2	14	16	2	0	9	75	83	—	2	12	120	18
Pennsylvania	1	0	2	19	40	16	10	40	639	539	—	5	24	310	100
E.N. Central	1	2	8	110	144	77	77	173	4,011	2,754	—	2	27	218	215
Illinois	—	0	4	19	37	—	12	29	615	565	—	1	11	112	81
Indiana	—	0	3	23	32	—	9	26	468	326	—	0	0	—	25
Michigan	—	0	2	18	19	6	23	53	1,131	749	—	1	5	63	63
Ohio	1	1	2	29	35	71	25	69	1,416	959	—	0	12	43	46
Wisconsin	—	0	2	21	21	—	6	19	381	155	—	0	0	—	—
W.N. Central	—	1	6	42	68	22	30	627	1,882	1,928	1	4	16	211	350
Iowa	—	0	3	9	10	—	9	26	427	207	—	0	2	7	31
Kansas	—	0	2	6	13	—	3	9	136	217	—	1	4	56	69
Minnesota	—	0	2	2	11	—	0	601	692	419	—	0	9	26	56
Missouri	—	0	3	18	21	17	8	33	371	897	—	1	6	64	64
Nebraska§	—	0	2	5	8	5	2	13	189	130	1	1	4	45	77
North Dakota	—	0	1	2	1	—	0	30	41	17	—	0	7	13	4
South Dakota	—	0	1	—	4	—	1	5	26	41	—	0	2	—	49
S. Atlantic	2	3	7	116	143	6	27	78	1,304	1,438	8	21	73	946	1,889
Delaware	—	0	1	2	2	—	0	4	11	13	—	0	0	—	—
District of Columbia	—	0	0	—	—	—	0	1	5	6	—	0	0	—	—
Florida	2	1	5	53	45	3	5	28	272	466	—	0	60	72	161
Georgia	—	0	2	9	29	—	3	18	202	209	—	0	13	—	357
Maryland§	—	0	1	7	10	1	3	8	115	130	4	7	14	325	352
North Carolina	—	0	2	14	27	—	0	32	124	180	—	0	10	—	427
South Carolina§	—	0	1	10	11	—	5	19	294	228	—	0	0	—	—
Virginia§	—	0	2	19	14	1	5	15	196	178	—	10	25	480	487
West Virginia	—	0	2	2	5	1	1	13	85	28	4	1	7	69	105
E.S. Central	—	1	4	38	26	5	14	33	644	701	—	3	7	133	133
Alabama§	—	0	2	6	7	—	4	8	169	271	—	0	4	45	—
Kentucky	—	0	2	17	4	5	4	13	229	204	—	0	4	19	45
Mississippi	—	0	1	5	3	—	1	7	58	62	—	0	1	1	4
Tennessee§	—	0	2	10	12	—	4	11	188	164	—	1	4	68	84
W.S. Central	—	1	9	70	79	20	57	753	2,416	2,812	—	1	30	61	832
Arkansas§	—	0	1	5	8	—	3	29	159	311	—	0	7	21	38
Louisiana	—	0	4	12	17	—	1	4	31	138	—	0	0	—	—
Oklahoma	—	0	7	15	12	1	0	41	55	41	—	0	30	40	32
Texas§	—	1	7	38	42	19	48	681	2,171	2,322	—	0	19	—	762
Mountain	—	1	6	47	55	30	23	56	1,175	842	—	1	8	76	99
Arizona	—	0	2	12	12	—	7	16	353	221	—	0	5	—	—
Colorado	—	0	4	15	18	30	4	16	228	197	—	0	0	—	—
Idaho§	—	0	2	7	7	—	3	19	174	69	—	0	2	11	8
Montana§	—	0	1	1	5	—	1	12	67	53	—	0	3	16	25
Nevada§	—	0	1	8	4	—	0	7	30	24	—	0	2	7	6
New Mexico§	—	0	1	3	3	—	2	11	114	62	—	0	2	11	25
Utah	—	0	1	1	2	—	4	14	199	194	—	0	2	10	12
Wyoming§	—	0	1	—	4	—	0	2	10	22	—	0	4	21	23
Pacific	2	3	16	130	163	32	40	207	3,076	1,147	—	3	12	124	232
Alaska	—	0	1	1	6	—	0	6	37	44	—	0	2	12	11
California	1	2	13	85	104	6	27	179	2,335	582	—	2	12	100	210
Hawaii	—	0	1	1	5	—	0	6	39	37	—	0	0	—	—
Oregon	—	1	2	27	35	1	6	16	292	238	—	0	2	12	11
Washington	1	0	7	16	13	25	5	38	373	246	—	0	0	—	—
Territories															
American Samoa	—	0	0	—	—	—	0	0	—	—	N	0	0	N	N
C.N.M.I.	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—
Guam	—	0	0	—	—	—	0	2	—	—	—	0	0	—	—
Puerto Rico	—	0	1	—	—	—	0	1	2	1	—	1	3	38	39
U.S. Virgin Islands	—	0	0	—	—	—	0	0	—	—	—	0	0	—	—

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† Data for meningococcal disease, invasive caused by serogroups A, C, Y, and W-135; serogroup B; other serogroup; and unknown serogroup are available in Table I.
§ Contains data reported through the National Electronic Disease Surveillance System (NEDSS).

TABLE II. (*Continued*) Provisional cases of selected notifiable diseases, United States, weeks ending November 6, 2010, and November 7, 2009 (44th week)*

Reporting area	Salmonellosis					Shiga toxin-producing *E. coli* (STEC)†					Shigellosis				
	Current week	Previous 52 weeks		Cum 2010	Cum 2009	Current week	Previous 52 weeks		Cum 2010	Cum 2009	Current week	Previous 52 weeks		Cum 2010	Cum 2009
		Med	Max				Med	Max				Med	Max		
United States	527	901	1,694	43,062	41,776	63	82	205	4,002	3,988	104	275	527	11,534	13,441
New England	6	31	444	2,021	1,972	1	3	52	179	237	—	4	62	287	314
Connecticut	—	0	428	428	430	—	0	52	52	67	—	0	57	57	43
Maine§	1	2	7	113	113	—	0	3	17	17	—	0	1	5	5
Massachusetts	5	23	54	1,126	1,002	1	2	8	74	92	—	4	16	201	217
New Hampshire	—	3	10	148	239	—	0	2	18	35	—	0	2	12	21
Rhode Island§	—	2	17	140	129	—	0	26	2	1	—	0	3	11	23
Vermont§	—	1	5	66	59	—	0	2	16	25	—	0	1	1	5
Mid. Atlantic	35	89	218	4,945	4,837	5	9	31	447	384	7	33	53	1,352	2,506
New Jersey	—	18	56	890	997	—	1	5	54	94	—	6	16	257	543
New York (Upstate)	20	25	78	1,268	1,141	5	3	15	177	132	3	4	19	205	185
New York City	2	25	56	1,186	1,118	—	1	7	65	54	—	6	14	260	406
Pennsylvania	13	28	82	1,601	1,581	—	3	13	151	104	4	15	35	630	1,372
E.N. Central	17	83	238	4,509	4,565	3	10	39	652	653	7	26	238	1,478	2,274
Illinois	—	28	114	1,579	1,298	—	2	8	105	156	—	9	228	725	535
Indiana	—	9	54	379	540	—	1	9	66	83	—	1	5	33	63
Michigan	2	15	48	800	862	—	2	16	147	125	2	5	9	210	204
Ohio	15	24	47	1,175	1,263	3	2	11	127	119	5	6	23	270	1,006
Wisconsin	—	11	44	576	602	—	3	17	207	170	—	4	21	240	466
W.N. Central	11	47	98	2,154	2,318	8	11	39	586	661	10	48	88	1,867	919
Iowa	1	9	34	471	362	—	3	16	153	145	1	1	5	48	49
Kansas	—	8	18	388	347	—	1	6	62	51	—	5	14	226	178
Minnesota	—	0	32	178	486	—	0	13	31	191	—	0	4	14	69
Missouri	5	13	44	724	572	4	3	27	222	123	7	42	75	1,518	588
Nebraska§	5	4	13	220	312	4	1	6	69	80	2	1	10	54	27
North Dakota	—	0	39	47	59	—	0	10	17	7	—	0	5	—	4
South Dakota	—	3	8	126	180	—	1	4	32	64	—	0	2	7	4
S. Atlantic	221	268	596	12,892	12,078	11	13	30	605	590	27	43	97	2,145	2,075
Delaware	2	3	11	161	126	—	0	2	6	12	—	1	10	39	116
District of Columbia	—	1	6	64	87	—	0	1	5	2	—	0	4	22	22
Florida	194	127	227	5,412	5,404	3	4	13	209	149	25	14	53	946	397
Georgia	—	39	129	2,268	2,103	—	1	15	92	65	—	13	39	647	570
Maryland§	14	16	52	890	686	8	1	6	85	84	1	3	8	114	341
North Carolina	—	29	197	1,637	1,612	—	1	10	63	99	—	2	18	168	341
South Carolina§	—	20	93	1,345	941	—	0	3	19	27	—	1	5	60	108
Virginia§	11	18	68	968	926	—	2	15	110	126	1	2	15	123	172
West Virginia	—	2	16	147	193	—	0	4	16	26	—	0	11	26	8
E.S. Central	40	52	177	3,381	2,740	6	4	11	218	191	4	12	40	611	718
Alabama§	16	15	49	855	799	1	1	4	42	42	—	3	10	148	139
Kentucky	7	9	31	499	405	—	1	6	59	64	—	4	28	202	193
Mississippi	4	17	67	1,087	831	—	0	2	15	6	—	1	4	43	43
Tennessee§	13	14	53	940	705	5	2	7	102	79	4	5	13	218	343
W.S. Central	50	115	547	5,267	5,098	7	5	68	260	267	12	51	251	2,118	2,514
Arkansas§	15	10	43	707	555	1	1	5	45	37	1	1	9	61	277
Louisiana	—	20	48	1,044	1,051	—	0	1	15	22	—	4	13	216	163
Oklahoma	14	11	46	577	549	6	0	27	31	30	1	6	96	237	250
Texas§	21	74	477	2,939	2,943	—	3	41	169	178	10	36	144	1,604	1,824
Mountain	15	48	105	2,355	2,663	6	9	33	502	514	2	15	32	686	1,033
Arizona	2	18	42	829	921	4	1	9	70	57	2	8	19	372	744
Colorado	13	10	23	488	553	1	2	18	156	156	—	2	6	100	88
Idaho§	—	3	9	139	156	1	1	7	89	85	—	0	3	23	8
Montana§	—	2	7	77	101	—	1	5	37	33	—	0	1	6	11
Nevada§	—	4	22	258	225	—	0	5	28	33	—	1	6	43	65
New Mexico§	—	6	15	269	332	—	1	5	35	33	—	2	9	105	95
Utah	—	5	17	257	286	—	1	7	73	104	—	0	4	37	18
Wyoming§	—	1	9	38	89	—	0	2	14	13	—	0	2	—	4
Pacific	132	113	299	5,538	5,505	16	10	46	553	491	35	20	64	990	1,088
Alaska	—	1	5	74	62	—	0	1	2	1	—	0	2	1	2
California	94	84	227	4,194	4,097	9	5	35	246	230	31	16	51	820	874
Hawaii	—	4	14	177	293	—	0	4	18	9	—	0	3	17	38
Oregon	1	8	48	453	392	1	2	8	97	73	1	1	4	53	45
Washington	37	15	61	640	661	6	3	19	190	178	3	2	20	99	129
Territories															
American Samoa	—	0	1	2	—	—	0	0	—	—	—	1	1	4	3
C.N.M.I.	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—
Guam	—	0	2	7	11	—	0	0	—	—	—	0	3	1	10
Puerto Rico	—	10	39	437	484	—	0	0	—	—	—	0	1	4	12
U.S. Virgin Islands	—	0	0	—	—	—	0	0	—	—	—	0	0	—	—

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† Includes *E. coli* O157:H7; Shiga toxin-positive, serogroup non-O157; and Shiga toxin-positive, not serogrouped.
§ Contains data reported through the National Electronic Disease Surveillance System (NEDSS).

TABLE II. (*Continued*) Provisional cases of selected notifiable diseases, United States, weeks ending November 6, 2010, and November 7, 2009 (44th week)*

Reporting area	Spotted Fever Rickettsiosis (including RMSF)†									
	Confirmed					Probable				
	Current week	Previous 52 weeks		Cum 2010	Cum 2009	Current week	Previous 52 weeks		Cum 2010	Cum 2009
		Med	Max				Med	Max		
United States	—	2	13	144	139	1	17	421	1,332	1,198
New England	—	0	0	—	2	—	0	1	3	10
Connecticut	—	0	0	—	—	—	0	0	—	—
Maine§	—	0	0	—	—	—	0	1	2	5
Massachusetts	—	0	0	—	1	—	0	1	—	5
New Hampshire	—	0	0	—	—	—	0	1	1	—
Rhode Island§	—	0	0	—	—	—	0	0	—	—
Vermont§	—	0	0	—	1	—	0	0	—	—
Mid. Atlantic	—	0	2	16	12	1	1	4	54	90
New Jersey	—	0	0	—	2	—	0	2	—	58
New York (Upstate)	—	0	1	2	—	1	0	3	17	13
New York City	—	0	1	1	1	—	0	4	25	6
Pennsylvania	—	0	2	13	9	—	0	1	12	13
E.N. Central	—	0	2	6	9	—	1	9	85	79
Illinois	—	0	1	4	1	—	0	5	27	47
Indiana	—	0	1	2	3	—	0	5	43	10
Michigan	—	0	0	—	4	—	0	1	1	1
Ohio	—	0	0	—	—	—	0	2	13	17
Wisconsin	—	0	0	—	1	—	0	1	1	4
W.N. Central	—	0	4	17	18	—	4	21	292	249
Iowa	—	0	0	—	1	—	0	1	4	4
Kansas	—	0	1	2	1	—	0	0	—	—
Minnesota	—	0	1	—	1	—	0	1	—	1
Missouri	—	0	4	13	7	—	4	20	284	240
Nebraska§	—	0	1	2	8	—	0	1	3	4
North Dakota	—	0	0	—	—	—	0	1	1	—
South Dakota	—	0	0	—	—	—	0	0	—	—
S. Atlantic	—	1	9	69	64	—	7	60	451	362
Delaware	—	0	1	1	—	—	0	3	19	17
District of Columbia	—	0	0	—	—	—	0	1	—	—
Florida	—	0	1	3	—	—	0	2	11	6
Georgia	—	0	6	47	50	—	0	0	—	—
Maryland§	—	0	1	2	3	—	1	4	49	35
North Carolina	—	0	3	11	7	—	1	48	235	238
South Carolina§	—	0	1	1	3	—	0	2	16	15
Virginia§	—	0	2	4	1	—	1	12	121	49
West Virginia	—	0	0	—	—	—	0	0	—	2
E.S. Central	—	0	4	20	9	—	4	29	355	251
Alabama§	—	0	1	5	3	—	1	8	71	61
Kentucky	—	0	2	6	1	—	0	0	—	—
Mississippi	—	0	0	—	—	—	0	2	10	9
Tennessee§	—	0	3	9	5	—	3	20	274	181
W.S. Central	—	0	3	6	9	—	1	408	80	133
Arkansas§	—	0	2	2	—	—	0	110	37	67
Louisiana	—	0	0	—	—	—	0	1	2	2
Oklahoma	—	0	3	3	7	—	0	287	22	45
Texas§	—	0	1	1	2	—	0	11	19	19
Mountain	—	0	1	2	15	—	0	2	12	24
Arizona	—	0	1	—	9	—	0	1	2	12
Colorado	—	0	0	—	1	—	0	1	1	—
Idaho§	—	0	0	—	—	—	0	1	5	1
Montana§	—	0	1	2	4	—	0	1	1	6
Nevada§	—	0	0	—	—	—	0	0	—	1
New Mexico§	—	0	0	—	—	—	0	1	1	1
Utah	—	0	0	—	—	—	0	1	1	1
Wyoming§	—	0	0	—	1	—	0	1	1	2
Pacific	—	0	2	8	1	—	0	0	—	—
Alaska	N	0	0	N	N	N	0	0	N	N
California	—	0	2	7	1	—	0	0	—	—
Hawaii	N	0	0	N	N	N	0	0	N	N
Oregon	—	0	1	1	—	—	0	0	—	—
Washington	—	0	0	—	—	—	0	0	—	—
Territories										
American Samoa	N	0	0	N	N	N	0	0	N	N
C.N.M.I.	—	—	—	—	—	—	—	—	—	—
Guam	N	0	0	N	N	N	0	0	N	N
Puerto Rico	N	0	0	N	N	N	0	0	N	N
U.S. Virgin Islands	—	0	0	—	—	—	0	0	—	—

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† Illnesses with similar clinical presentation that result from Spotted fever group rickettsia infections are reported as Spotted fever rickettsioses. Rocky Mountain spotted fever (RMSF) caused by *Rickettsia rickettsii*, is the most common and well-known spotted fever.
§ Contains data reported through the National Electronic Disease Surveillance System (NEDSS).

TABLE II. (*Continued*) Provisional cases of selected notifiable diseases, United States, weeks ending November 6, 2010, and November 7, 2009 (44th week)*

Reporting area	*Streptococcus pneumoniae*,† invasive disease										Syphilis, primary and secondary				
	All ages					Age <5									
	Current week	Previous 52 weeks		Cum 2010	Cum 2009	Current week	Previous 52 weeks		Cum 2010	Cum 2009	Current week	Previous 52 weeks		Cum 2010	Cum 2009
		Med	Max				Med	Max				Med	Max		
United States	159	214	495	11,801	2,484	27	49	156	1,821	1,988	67	244	413	10,351	11,947
New England	18	9	99	644	46	4	1	24	84	65	3	9	22	387	271
Connecticut	13	0	91	288	—	3	0	22	27	—	1	1	10	81	49
Maine§	2	2	6	104	16	—	0	1	8	7	—	0	3	23	2
Massachusetts	—	1	5	58	3	—	1	4	39	40	—	5	15	229	195
New Hampshire	—	0	7	59	—	—	0	1	3	11	2	0	2	21	13
Rhode Island§	—	0	35	68	15	—	0	2	2	3	—	1	4	31	12
Vermont§	3	1	6	67	12	1	0	1	5	4	—	0	2	2	—
Mid. Atlantic	20	23	56	1,114	169	5	7	48	298	250	21	33	45	1,443	1,517
New Jersey	—	1	8	86	—	—	1	5	45	50	—	4	12	196	195
New York (Upstate)	5	3	12	135	68	4	2	19	97	111	3	2	11	113	99
New York City	7	8	28	481	14	—	1	24	108	74	18	18	31	824	927
Pennsylvania	8	8	22	412	87	1	1	5	48	15	—	7	16	310	296
E.N. Central	30	46	98	2,405	557	4	8	18	305	335	1	28	47	1,100	1,323
Illinois	—	1	7	83	—	—	2	5	76	58	—	8	23	352	643
Indiana	—	7	24	450	211	—	1	6	39	70	—	3	14	147	135
Michigan	2	11	27	578	24	—	2	6	71	62	1	4	12	177	202
Ohio	25	18	49	994	322	4	2	6	86	107	—	9	18	387	303
Wisconsin	3	6	22	300	—	—	1	4	33	38	—	1	3	37	40
W.N. Central	2	8	182	633	161	1	2	12	114	159	—	6	19	275	262
Iowa	—	0	0	—	—	—	0	0	—	—	—	0	3	16	21
Kansas	—	1	7	77	52	—	0	2	13	18	—	0	3	18	28
Minnesota	—	0	179	287	39	—	0	10	44	73	—	2	9	107	61
Missouri	2	2	10	95	59	1	1	3	34	42	—	3	10	124	143
Nebraska§	—	2	7	108	2	—	0	2	13	11	—	0	1	6	5
North Dakota	—	0	11	50	7	—	0	1	2	5	—	0	0	—	4
South Dakota	—	0	3	16	2	—	0	2	8	10	—	0	1	4	—
S. Atlantic	27	49	144	2,706	1,120	4	12	28	451	477	18	57	218	2,534	2,862
Delaware	1	0	3	32	18	—	0	0	—	3	—	0	2	4	25
District of Columbia	—	0	4	23	19	—	0	2	7	5	—	2	21	139	150
Florida	18	22	89	1,230	653	2	3	18	168	167	1	20	45	903	894
Georgia	—	10	28	437	334	—	3	12	121	133	—	13	167	546	681
Maryland§	6	7	31	422	4	1	1	6	46	67	—	6	13	258	261
North Carolina	—	0	0	—	—	—	0	0	—	—	—	7	31	296	474
South Carolina§	—	6	25	413	—	—	1	4	44	42	—	2	7	128	107
Virginia§	1	0	4	48	—	1	1	4	46	41	17	4	22	255	266
West Virginia	1	2	21	101	92	—	0	4	19	19	—	0	2	5	4
E.S. Central	17	20	50	1,051	227	3	2	8	103	123	9	17	39	781	981
Alabama§	—	0	0	—	—	—	0	0	—	—	3	5	11	212	380
Kentucky	3	3	16	160	64	—	0	2	13	8	6	2	13	117	55
Mississippi	—	1	6	47	45	—	0	2	10	22	—	4	17	186	184
Tennessee§	14	15	44	844	118	3	2	7	80	93	—	6	17	266	362
W.S. Central	31	24	91	1,530	102	4	5	41	241	297	5	38	62	1,574	2,419
Arkansas§	6	3	9	145	47	1	0	3	15	37	3	3	13	150	231
Louisiana	—	1	8	78	55	—	0	3	21	24	2	7	26	354	677
Oklahoma	—	1	5	40	—	—	1	5	40	52	—	2	7	72	80
Texas§	25	20	83	1,267	—	3	3	34	165	184	—	25	34	998	1,431
Mountain	13	24	82	1,466	99	2	4	12	195	254	2	9	23	417	463
Arizona	5	10	51	665	—	2	1	7	84	107	—	3	7	124	206
Colorado	6	8	20	437	—	—	1	4	55	41	—	2	8	112	84
Idaho§	—	0	2	12	—	—	0	2	6	7	—	0	1	2	3
Montana§	—	0	2	18	—	—	0	1	2	—	—	0	1	2	2
Nevada§	1	1	4	69	36	—	0	1	5	7	—	1	9	101	86
New Mexico§	1	2	9	127	—	—	0	4	15	32	2	1	4	42	53
Utah	—	2	9	127	53	—	0	3	25	58	—	1	4	34	26
Wyoming§	—	0	1	11	10	—	0	1	3	2	—	0	0	—	3
Pacific	1	5	14	252	3	—	0	7	30	28	8	42	60	1,840	1,849
Alaska	—	2	9	98	—	—	0	5	18	19	—	0	1	1	—
California	1	3	12	154	—	—	0	2	12	—	5	35	54	1,594	1,646
Hawaii	—	0	0	—	3	—	0	1	—	9	—	0	3	27	33
Oregon	—	0	0	—	—	—	0	0	—	—	—	1	6	52	44
Washington	—	0	0	—	—	—	0	0	—	—	3	3	10	166	126
Territories															
American Samoa	—	0	0	—	—	—	0	0	—	—	—	0	0	—	—
C.N.M.I.	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—
Guam	—	0	0	—	—	—	0	0	—	—	—	0	0	—	—
Puerto Rico	—	0	0	—	—	—	0	0	—	—	3	3	15	193	192
U.S. Virgin Islands	—	0	0	—	—	—	0	0	—	—	—	0	0	—	—

C.N.M.I.: Commonwealth of Northern Mariana Islands.
U: Unavailable. —: No reported cases. N: Not reportable. NN: Not Nationally Notifiable. Cum: Cumulative year-to-date counts. Med: Median. Max: Maximum.
* Case counts for reporting year 2010 are provisional and subject to change. For further information on interpretation of these data, see http://www.cdc.gov/ncphi/disss/nndss/phs/files/ProvisionalNationa%20NotifiableDiseasesSurveillanceData20100927.pdf. Data for HIV/AIDS, AIDS and TB, when available, are displayed in Table IV, which appears quarterly.
† Includes drug resistant and susceptible cases of invasive *Streptococcus pneumoniae* disease among children <5 years and among all ages. Case definition: Isolation of *S. pneumoniae* from a normally sterile body site (e.g., blood or cerebrospinal fluid).
§ Contains data reported through the National Electronic Disease Surveillance System (NEDSS).

TABLE II. (*Continued*) Provisional cases of selected notifiable diseases, United States, weeks ending November 6, 2010, and November 7, 2009 (44th week)*

Reporting area	Varicella (chickenpox)§					West Nile virus disease†									
						Neuroinvasive					Nonneuroinvasive¶				
	Current week	Previous 52 weeks		Cum 2010	Cum 2009	Current week	Previous 52 weeks		Cum 2010	Cum 2009	Current week	Previous 52 weeks		Cum 2010	Cum 2009
		Med	Max				Med	Max				Med	Max		
United States	184	301	547	12,036	17,941	—	0	69	566	384	—	1	52	365	334
New England	11	15	36	632	944	—	0	3	13	—	—	0	1	2	—
Connecticut	—	6	20	256	431	—	0	2	6	—	—	0	1	1	—
Maine§	4	4	15	195	205	—	0	0	—	—	—	0	0	—	—
Massachusetts	—	0	1	2	4	—	0	2	6	—	—	0	1	1	—
New Hampshire	—	2	8	114	182	—	0	1	1	—	—	0	0	—	—
Rhode Island§	2	1	12	31	34	—	0	0	—	—	—	0	0	—	—
Vermont§	5	0	10	34	88	—	0	0	—	—	—	0	0	—	—
Mid. Atlantic	34	30	62	1,350	1,803	—	0	19	123	9	—	0	13	62	1
New Jersey	—	8	30	448	385	—	0	3	14	3	—	0	6	15	—
New York (Upstate)	N	0	0	N	N	—	0	9	57	3	—	0	7	30	1
New York City	—	0	0	—	—	—	0	7	32	3	—	0	4	8	—
Pennsylvania	34	21	39	902	1,418	—	0	3	20	—	—	0	3	9	—
E.N. Central	62	101	176	4,025	5,620	—	0	14	67	9	—	0	6	28	4
Illinois	—	23	49	1,007	1,383	—	0	10	35	5	—	0	4	15	—
Indiana§	—	6	35	355	392	—	0	1	4	2	—	0	2	6	2
Michigan	18	31	62	1,199	1,650	—	0	6	25	1	—	0	1	4	—
Ohio	44	29	56	1,165	1,680	—	0	1	3	—	—	0	1	1	2
Wisconsin	—	7	22	299	515	—	0	0	—	1	—	0	1	2	—
W.N. Central	7	15	40	678	1,121	—	0	7	28	26	—	0	11	68	75
Iowa	N	0	0	N	N	—	0	1	2	—	—	0	2	4	5
Kansas§	—	6	22	231	478	—	0	1	3	4	—	0	2	10	9
Minnesota	—	0	0	—	—	—	0	1	4	1	—	0	3	4	3
Missouri	6	7	23	370	534	—	0	1	3	4	—	0	0	—	1
Nebraska§	N	0	0	N	N	—	0	3	10	11	—	0	7	27	41
North Dakota	—	0	26	37	57	—	0	2	2	—	—	0	2	7	1
South Dakota	1	0	6	40	52	—	0	2	4	6	—	0	3	16	15
S. Atlantic	24	35	98	1,826	2,305	—	0	4	32	16	—	0	4	19	2
Delaware§	—	0	3	19	11	—	0	0	—	—	—	0	0	—	—
District of Columbia	—	0	4	17	29	—	0	1	1	2	—	0	1	1	—
Florida§	10	15	57	881	1,044	—	0	2	8	2	—	0	1	3	1
Georgia	N	0	0	N	N	—	0	1	4	4	—	0	3	8	—
Maryland§	N	0	0	N	N	—	0	3	16	—	—	0	2	7	1
North Carolina	N	0	0	N	N	—	0	0	—	—	—	0	0	—	—
South Carolina§	—	0	35	75	111	—	0	1	1	3	—	0	0	—	—
Virginia§	6	11	34	443	661	—	0	1	2	5	—	0	0	—	—
West Virginia	8	8	26	391	449	—	0	0	—	—	—	0	0	—	—
E.S. Central	1	6	22	258	491	—	0	1	8	36	—	0	3	9	27
Alabama§	1	5	22	251	486	—	0	1	1	—	—	0	1	2	—
Kentucky	N	0	0	N	N	—	0	1	2	3	—	0	1	1	—
Mississippi	—	0	2	7	5	—	0	1	3	29	—	0	2	4	22
Tennessee§	N	0	0	N	N	—	0	1	2	4	—	0	2	2	5
W.S. Central	36	46	285	2,354	4,367	—	0	15	90	117	—	0	3	15	35
Arkansas§	—	2	32	122	440	—	0	3	6	6	—	0	1	1	—
Louisiana	—	1	5	40	119	—	0	3	14	10	—	0	1	6	11
Oklahoma	N	0	0	N	N	—	0	0	—	8	—	0	0	—	2
Texas§	36	41	272	2,192	3,808	—	0	15	70	93	—	0	2	8	22
Mountain	9	20	36	866	1,197	—	0	18	145	77	—	0	15	126	123
Arizona	—	0	0	—	—	—	0	13	98	12	—	0	9	59	8
Colorado§	6	8	18	354	464	—	0	5	26	36	—	0	11	55	67
Idaho§	N	0	0	N	N	—	0	0	—	9	—	0	1	1	29
Montana§	3	3	17	174	143	—	0	0	—	2	—	0	0	—	3
Nevada§	N	0	0	N	N	—	0	0	—	7	—	0	1	2	5
New Mexico§	—	2	8	88	104	—	0	5	18	6	—	0	2	4	2
Utah	—	5	17	237	486	—	0	1	1	1	—	0	1	1	1
Wyoming§	—	0	3	13	—	—	0	1	2	4	—	0	1	4	8
Pacific	—	1	5	47	93	—	0	7	60	94	—	0	5	36	67
Alaska	—	0	5	36	55	—	0	0	—	—	—	0	0	—	—
California	—	0	0	—	—	—	0	7	60	67	—	0	5	36	45
Hawaii	—	0	2	11	38	—	0	0	—	—	—	0	0	—	—
Oregon	N	0	0	N	N	—	0	0	—	1	—	0	0	—	10
Washington	N	0	0	N	N	—	0	0	—	26	—	0	0	—	12
Territories															
American Samoa	N	0	0	N	N	—	0	0	—	—	—	0	0	—	—
C.N.M.I.	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—
Guam	—	0	3	15	26	—	0	0	—	—	—	0	0	—	—
Puerto Rico	—	9	30	494	480	—	0	0	—	—	—	0	0	—	—
U.S. Virgin Islands	—	0	0	—	—	—	0	0	—	—	—	0	0	—	—

C.N.M.I.: Commonwealth of Northern Mariana Islands.
U: Unavailable. —: No reported cases. N: Not reportable. NN: Not Nationally Notifiable. Cum: Cumulative year-to-date counts. Med: Median. Max: Maximum.
* Case counts for reporting year 2010 are provisional and subject to change. For further information on interpretation of these data, see http://www.cdc.gov/ncphi/disss/nndss/phs/files/ProvisionalNationa%20NotifiableDiseasesSurveillanceData20100927.pdf. Data for HIV/AIDS, AIDS and TB, when available, are displayed in Table IV, which appears quarterly.
† Updated weekly from reports to the Division of Vector-Borne Infectious Diseases, National Center for Zoonotic, Vector-Borne, and Enteric Diseases (ArboNET Surveillance). Data for California serogroup, eastern equine, Powassan, St. Louis, and western equine diseases are available in Table I.
§ Contains data reported through the National Electronic Disease Surveillance System (NEDSS).
¶ Not reportable in all states. Data from states where the condition is not reportable are excluded from this table, except starting in 2007 for the domestic arboviral diseases and influenza-associated pediatric mortality, and in 2003 for SARS-CoV. Reporting exceptions are available at http://www.cdc.gov/ncphi/disss/nndss/phs/infdis.htm.

TABLE III. Deaths in 122 U.S. cities,* week ending November 6, 2010 (44th week)

Reporting area	All causes, by age (years)						P&I†
	All Ages	≥65	45–64	25–44	1–24	<1	Total
New England	525	379	102	23	9	12	62
Boston, MA	135	83	43	4	2	3	19
Bridgeport, CT	23	17	4	2	—	—	1
Cambridge, MA	6	5	1	—	—	—	—
Fall River, MA	22	19	3	—	—	—	2
Hartford, CT	50	36	7	3	2	2	4
Lowell, MA	24	21	2	1	—	—	3
Lynn, MA	8	7	—	1	—	—	—
New Bedford, MA	26	22	2	1	1	—	3
New Haven, CT	52	31	13	1	2	5	6
Providence, RI	50	37	10	1	—	2	2
Somerville, MA	2	1	—	—	1	—	—
Springfield, MA	35	26	6	2	1	—	—
Waterbury, CT	23	18	4	1	—	—	2
Worcester, MA	69	56	7	6	—	—	20
Mid. Atlantic	2,001	1,373	451	98	40	38	108
Albany, NY	53	32	13	5	2	1	3
Allentown, PA	13	11	1	—	1	—	2
Buffalo, NY	81	55	21	1	2	2	8
Camden, NJ	26	16	3	2	4	1	2
Elizabeth, NJ	22	17	5	—	—	—	—
Erie, PA	53	44	8	1	—	—	3
Jersey City, NJ	27	19	6	2	—	—	3
New York City, NY	1,034	729	230	47	17	10	48
Newark, NJ	26	7	15	4	—	—	—
Paterson, NJ	19	9	8	—	1	1	4
Philadelphia, PA	356	210	96	24	8	18	12
Pittsburgh, PA§	27	20	7	—	—	—	3
Reading, PA	26	23	2	—	—	1	1
Rochester, NY	66	46	8	6	2	4	6
Schenectady, NY	24	22	2	—	—	—	—
Scranton, PA	20	15	4	1	—	—	—
Syracuse, NY	77	59	15	2	1	—	12
Trenton, NJ	19	14	2	1	2	—	—
Utica, NY	20	16	3	1	—	—	1
Yonkers, NY	12	9	2	1	—	—	—
E.N. Central	1,902	1,291	456	97	35	23	129
Akron, OH	41	33	7	1	—	—	6
Canton, OH	40	28	11	—	—	1	1
Chicago, IL	209	132	59	14	4	—	25
Cincinnati, OH	85	44	31	5	3	2	7
Cleveland, OH	263	188	63	6	4	2	15
Columbus, OH	203	138	41	17	2	5	15
Dayton, OH	129	80	37	9	2	1	12
Detroit, MI	145	87	41	14	2	1	7
Evansville, IN	37	29	6	1	—	1	4
Fort Wayne, IN	81	57	21	—	2	1	4
Gary, IN	19	9	9	1	—	—	—
Grand Rapids, MI	38	28	7	2	1	—	2
Indianapolis, IN	145	97	27	9	4	8	13
Lansing, MI	64	50	10	2	1	1	2
Milwaukee, WI	85	56	25	3	1	—	4
Peoria, IL	57	37	11	6	3	—	5
Rockford, IL	45	36	6	1	2	—	2
South Bend, IN	49	33	13	1	2	—	1
Toledo, OH	106	76	24	5	1	—	2
Youngstown, OH	61	53	7	—	1	—	2
W.N. Central	633	412	151	36	18	16	48
Des Moines, IA	36	18	13	2	1	2	1
Duluth, MN	26	20	5	—	1	—	1
Kansas City, KS	27	13	9	3	1	1	3
Kansas City, MO	101	57	34	7	2	1	9
Lincoln, NE	49	37	10	1	1	—	1
Minneapolis, MN	50	29	15	3	2	1	7
Omaha, NE	88	60	21	4	—	3	10
St. Louis, MO	118	66	24	14	8	6	8
St. Paul, MN	62	48	11	—	1	2	5
Wichita, KS	76	64	9	2	1	—	3
S. Atlantic	1,312	839	316	89	38	30	85
Atlanta, GA	133	72	36	14	11	—	4
Baltimore, MD	108	64	33	4	4	3	13
Charlotte, NC	146	96	32	12	3	3	11
Jacksonville, FL	168	112	37	10	3	6	11
Miami, FL	186	116	54	9	3	4	14
Norfolk, VA	48	30	12	3	2	1	3
Richmond, VA	66	41	18	6	1	—	7
Savannah, GA	60	40	11	6	—	3	5
St. Petersburg, FL	51	37	8	4	—	2	3
Tampa, FL	241	162	53	17	7	2	9
Washington, D.C.	95	62	20	4	3	6	3
Wilmington, DE	10	7	2	—	1	—	2
E.S. Central	847	539	216	49	22	21	51
Birmingham, AL	186	108	51	15	6	6	16
Chattanooga, TN	72	45	17	5	3	2	2
Knoxville, TN	94	64	24	5	—	1	1
Lexington, KY	80	54	18	6	2	—	2
Memphis, TN	190	121	54	6	3	6	12
Mobile, AL	58	37	11	4	4	2	2
Montgomery, AL	44	25	14	2	2	1	4
Nashville, TN	123	85	27	6	2	3	12
W.S. Central	1,397	859	361	90	54	33	66
Austin, TX	80	45	21	8	6	—	3
Baton Rouge, LA	72	54	11	3	3	1	—
Corpus Christi, TX	70	48	16	2	1	3	11
Dallas, TX	210	116	64	15	8	7	15
El Paso, TX	120	82	24	6	5	3	3
Fort Worth, TX	U	U	U	U	U	U	U
Houston, TX	388	206	125	35	13	9	17
Little Rock, AR	64	47	11	4	1	1	—
New Orleans, LA	U	U	U	U	U	U	U
San Antonio, TX	241	163	51	10	10	7	11
Shreveport, LA	17	11	3	—	2	1	1
Tulsa, OK	135	87	35	7	5	1	5
Mountain	1,017	668	241	65	27	15	71
Albuquerque, NM	117	78	34	3	2	—	9
Boise, ID	58	39	11	5	—	3	3
Colorado Springs, CO	62	37	18	5	2	—	5
Denver, CO	93	60	20	8	1	4	6
Las Vegas, NV	215	134	63	11	5	2	18
Ogden, UT	29	21	3	3	1	1	3
Phoenix, AZ	163	92	44	16	8	3	10
Pueblo, CO	40	34	5	—	1	—	—
Salt Lake City, UT	114	84	16	9	3	2	10
Tucson, AZ	126	89	27	5	4	—	7
Pacific	1,481	1,047	314	60	26	34	119
Berkeley, CA	20	13	5	1	1	—	2
Fresno, CA	123	83	27	9	—	4	10
Glendale, CA	45	40	5	—	—	—	11
Honolulu, HI	88	66	13	3	3	3	2
Long Beach, CA	69	50	15	1	2	1	6
Los Angeles, CA	235	154	55	12	8	6	30
Pasadena, CA	22	21	—	—	—	1	1
Portland, OR	109	70	31	5	2	1	9
Sacramento, CA	139	105	24	5	—	5	9
San Diego, CA	29	16	5	1	—	7	3
San Francisco, CA	104	69	27	4	1	3	9
San Jose, CA	185	137	36	8	4	—	9
Santa Cruz, CA	30	24	4	1	1	—	1
Seattle, WA	98	56	30	8	1	3	4
Spokane, WA	63	43	16	2	2	—	7
Tacoma, WA	122	100	21	—	1	—	6
Total¶	**11,115**	**7,407**	**2,608**	**607**	**269**	**222**	**739**

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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