

Obesity in K–8 Students — New York City, 2006–07 to 2010–11 School Years

Overweight and obese children are more likely to develop risk factors that can lead to respiratory, metabolic, and cardiovascular illness (1–3). The increase in prevalence of childhood overweight and obesity in the United States since the 1960s has been well documented (4). In New York City, in 1996, an estimated 19.7% of third grade children and 21.2% of sixth grade children in public and private schools were found to be overweight (5); in 2003, an estimated 43% of the city's public elementary school students were found to be overweight, and 24% of these students were obese (6). To update city data on childhood obesity and evaluate public health interventions, the New York City Department of Health and Mental Hygiene analyzed body mass index (BMI) data for public schoolchildren in kindergarten through eighth grade (K–8), using data from the 2006–07 to 2010–11 school years. This report summarizes the results of that analysis, which found that, overall, the prevalence of obesity in grades K–8 decreased 5.5%, from 21.9% in 2006–07 to 20.7% in 2010–11. Obesity decreased significantly among children in all age groups and in all socioeconomic and racial/ethnic populations; however, the decrease was smaller among black (1.9%) and Hispanic (3.4%) children than among Asian/Pacific Islander (7.6%) and white (12.5%) children. Despite the decreases in obesity, continued public health interventions are needed to further reduce the prevalence of obesity and to eliminate disparities among schoolchildren in New York City.

According to the American Community Survey,* approximately 900,000 children attend elementary and middle schools in New York City, and 78% of those attend a public school. In 2005, during physical education classes, the New York City Department of Education (DOE) began annually measuring the BMI (weight [kg] / height [m]²) of public school students in grades K–12 and the fitness of students in grades 4–12 as part of an overall fitness program. Physical education teachers were trained in taking height and weight measurements using

standard protocols developed by DOE. Using these measurements, DOE now provides students and their parents with an annual assessment of the child's BMI and fitness status. The findings in this report are based on analysis by the New York City Department of Health and Mental Hygiene of BMI data obtained from DOE records, including information on student height, weight, race/ethnicity,[†] date of birth, sex, grade, place of birth, language spoken at home, school postal code, and free lunch status (a proxy measure of poverty).

Data were limited to children in grades K–8 who were aged 5–14 years and enrolled in non–alternative and non–special education public schools. During the 5 school years studied, approximately 2 million BMI measurements were completed for 947,765 K–8 students. Among individual students, the number of annual measurements ranged from one to five. Biologically implausible measurements (2%–3% of all measurements), as defined by CDC's BMI percentile-for-sex and age criteria, were excluded from analysis. Children with BMI at or above the 95th percentile were categorized as obese. The percentage of enrolled K–8 students measured as part of the New York City fitness program was 61% in 2006–07, 76% in 2007–08, 86% in 2008–09, 92% in 2009–10, and 93% in 2010–11.

For each school year, observations were weighted to ensure that data were representative of the enrollment population for that year. Weights were calculated using a raking process, with race/ethnicity, a combination of borough and district public

[†] Students were categorized as Asian/Pacific Islander, black, white, or Hispanic. Those categorized as Asian/Pacific Islander, black, or white all were non-Hispanic. Those categorized as Hispanic might be of any race.

* Available at <http://www.census.gov/acs/www>.

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health office (DPHO) neighborhoods (neighborhoods defined by low income and disproportionate rates of morbidity and mortality), free lunch status (free versus not free), grade, sex, age, and school type (elementary versus middle) as population marginal control totals.[§] To test for obesity prevalence trends from 2006–07 to 2010–11, a multivariate model was built that included a linear term for time, along with sex, age, race/ethnicity, school borough, free lunch status, DPHO, place of birth, language spoken at home, and an interaction of age, sex, and race/ethnicity, as covariates. School and student codes were used as cluster variables, and statistical procedures that account for intercluster correlation were used to ensure that variance estimates were calculated correctly. Separate multivariate models were built to test trends for age group, race/ethnicity, and socioeconomic status. The significance level for

[§]The weighting of the data follows procedures similar to those for nonresponse adjustments (or post-stratification) in surveys. In particular, the weighting is similar to that used by the Youth Risk Behavior Survey in New York City. However, the large sample size allowed for adjustment over some additional variables. The control totals are tabulated directly from the DOE enrollment file. An iterative proportional fitting procedure (generally referred to as raking) was used to adjust the observations in the dataset to match the following marginal control totals: EMH (elementary or middle school) by school borough by DPHO status by race/ethnicity, EMH by school borough by DPHO status by grade by sex, EMH by school borough by DPHO status by meal code (free, full, or reduced), and EMH by single year of age (truncated depending on EMH status). Race/ethnicity was a five-level variable (Asian/Pacific Islander, Hispanic, black, white, and other) with groups contributing less than 5% of control total population collapsed into the largest group.

all analyses was set at $p < 0.05$. For presentation of prevalence estimates by school neighborhood poverty, school postal codes were characterized by the percentage of residents living below the federal poverty level (as defined by the 2000 U.S. Census). The percentage of residents living below the poverty level in the school postal code area was categorized as low (<10% of residents), medium (10% to <20%), high (20% to <30%), and very high ($\geq 30\%$).

From 2006–07 to 2010–11, the overall prevalence of obesity in grades K–8 decreased 5.5%, from 21.9% to 20.7% (Table). The prevalence of obesity decreased significantly among children in all age groups, neighborhood poverty levels, and racial/ethnic populations. By age group, the largest decrease was observed among children aged 5–6 years (9.9%, from 20.2% to 18.2%) (Figure 1). Among children in this age group, the largest decrease was among white children (23.6%, from 16.1% to 12.3%), followed by a decrease of 13.5% (from 15.5% to 13.4%) among Asian/Pacific Islanders, 7.0% (from 18.5% to 17.2%) among blacks, and 6.0% (from 24.9% to 23.4%) among Hispanics (Table).

Among children aged 5–6 years, large differences also were observed in obesity reduction by school neighborhood poverty level, with a decrease of 16.7% (from 16.8% to 14.0%) in low poverty areas, compared with a nonsignificant decrease of 2.7% (from 22.2% to 21.6%) in very high poverty areas. Among children in all age groups, the greatest decreases were observed

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TABLE. Prevalence of obesity* among public schoolchildren in grades K–8 who were aged 5–14 years, by school year and selected characteristics — New York City, 2006–07 to 2010–11 school years

Characteristic	% of obesity					Adjusted p value for trend ^f	% decrease 2006–07 to 2010–11
	2006–07	2007–08	2008–09	2009–10	2010–11		
Overall	21.9	21.4	20.9	21.0	20.7	<0.001	5.5
Sex							
Girls	19.5	19.1	18.7	18.9	18.6	<0.001	4.6
Boys	24.2	23.6	23.0	23.1	22.8	<0.001	5.8
Race/Ethnicity^g							
Asian/Pacific Islander	14.5	13.7	13.2	13.5	13.4	<0.001	7.6
Hispanic	26.5	26.0	25.4	25.7	25.6	<0.001	3.4
Black	21.3	21.1	21.2	21.1	20.9	0.015	1.9
White	17.6	16.9	16.1	16.1	15.4	<0.001	12.5
Age group (yrs)							
5–6	20.2	19.4	18.8	18.4	18.2	<0.001	9.9
<i>Race/Ethnicity</i>							
Asian/Pacific Islander	15.5	13.9	13.2	13.6	13.4	0.452	13.5
Hispanic	24.9	24.4	23.7	23.3	23.4	<0.001	6.0
Black	18.5	17.9	17.7	17.2	17.2	<0.001	7.0
White	16.1	14.8	14.0	13.3	12.3	<0.001	23.6
<i>School postal code area</i>							
Low poverty (<10%)	16.8	15.4	13.6	13.7	14.0	<0.001	16.7
Very high poverty (≥30%)	22.2	21.5	21.5	21.4	21.6	0.248	2.7
7–10	22.9	22.7	21.8	22.2	21.8	<0.001	4.8
<i>Race/Ethnicity</i>							
Asian/Pacific Islander	15.9	15.5	14.6	15.0	14.4	0.013	9.4
Hispanic	27.9	27.9	26.8	27.3	27.2	0.003	2.5
Black	21.8	21.6	21.3	21.7	21.5	<0.001	1.4
White	18.2	18.1	16.8	17.3	16.2	<0.001	11.0
<i>School postal code area</i>							
Low poverty (<10%)	19.2	19.1	17.6	17.9	17.1	<0.001	10.9
Very high poverty (≥30%)	25.0	24.8	24.2	24.7	24.9	<0.001	0.4
11–14	21.8	21.0	21.1	21.1	21.1	0.040	3.2
<i>Race/Ethnicity</i>							
Asian/Pacific Islander	11.9	11.3	11.5	11.5	12.1	<0.001	-1.7
Hispanic	25.7	24.7	24.7	25.3	25.1	<0.001	2.3
Black	22.2	22.1	22.7	22.3	22.0	<0.001	0.9
White	18.0	16.8	16.7	16.7	16.8	0.001	6.7
<i>School postal code area</i>							
Low poverty (<10%)	17.2	17.2	17.5	17.3	17.8	0.001	-3.5
Very high poverty (≥30%)	24.9	23.4	23.4	24.0	23.5	0.600	5.6

See table footnotes on page 1676.

among white children (12.5%, from 17.6% to 15.4%) and Asian/Pacific Islander children (7.6%, from 14.5% to 13.4%) (Figure 2). After further stratification by age group, race/ethnicity, and neighborhood poverty level, decreases in the prevalence of obesity were not consistently significant among all children attending school in neighborhoods with high poverty levels (Table).

Reported by

Magdalena Berger, MPH, Kevin Konty, MS, Sophia Day, Lynn D. Silver, MD, Cathy Nonas, MS, Bonnie D. Kerker, PhD, Carolyn Greene, MD, Thomas Farley, MD, New York City Dept of Health and Mental Hygiene; Lindsey Harr, New York City Dept of Education. **Corresponding contributor:** Magdalena Berger, mberger@health.nyc.gov, 347-396-4134.

Editorial Note

The findings in this report indicate that, from 2006–7 to 2010–11, the prevalence of obesity among New York City public elementary and middle school students decreased overall and across all demographic groups. Decreases in obesity prevalence were most notable among children aged 5–6 years and were greater among white and Asian/Pacific Islander children than among Hispanic and black children.

In the last decade, the prevalence of obesity appears to have stabilized nationally among preschool and school-aged children (7,8). Although studies in New York and California have shown recent declines in pediatric obesity (9,10), this report describes the largest documented decline to date in a large city in the United States, using comprehensive K–8 public school data.

TABLE. (Continued) Prevalence of obesity* among public schoolchildren in grades K–8 who were aged 5–14 years, by school year and selected characteristics — New York City, 2006–07 to 2010–11 school years

Characteristic	% of obesity					Adjusted p value for trend [†]	% decrease 2006–07 to 2010–11
	2006–07	2007–08	2008–09	2009–10	2010–11		
Meal code							
Not free	20.1	19.4	18.7	18.5	17.6	<0.001	12.4
Free lunch	23.1	22.7	22.5	22.8	22.6	0.003	2.2
School postal code area							
Low poverty (<10%)	18.0	17.6	16.7	16.8	16.6	<0.001	7.8
Medium poverty (10% to <20%)	20.9	20.5	19.9	20.2	20.0	<0.001	4.3
High poverty (20% to <30%)	22.5	22.2	22.1	21.5	20.9	<0.001	7.1
Very high poverty (≥30%)	24.4	23.6	23.4	23.8	23.7	0.019	2.9
Race and poverty							
Asian/Pacific Islander							
Low poverty	13.4	12.3	11.5	11.6	11.8	<0.001	11.9
Very high poverty	15.1	15.1	13.0	14.5	14.0	0.007	7.3
Hispanic							
Low poverty	23.7	23.3	22.3	22.4	22.0	<0.001	7.2
Very high poverty	27.2	26.3	26.0	26.5	26.5	0.863	2.6
Black							
Low poverty	20.7	21.3	20.2	20.1	20.6	0.001	0.5
Very high poverty	21.6	20.9	21.1	21.2	21.1	<0.001	2.3
White							
Low poverty	16.4	16.0	15.3	15.5	15.1	<0.001	7.9
Very high poverty	19.0	17.9	17.1	17.6	16.6	0.109	12.6

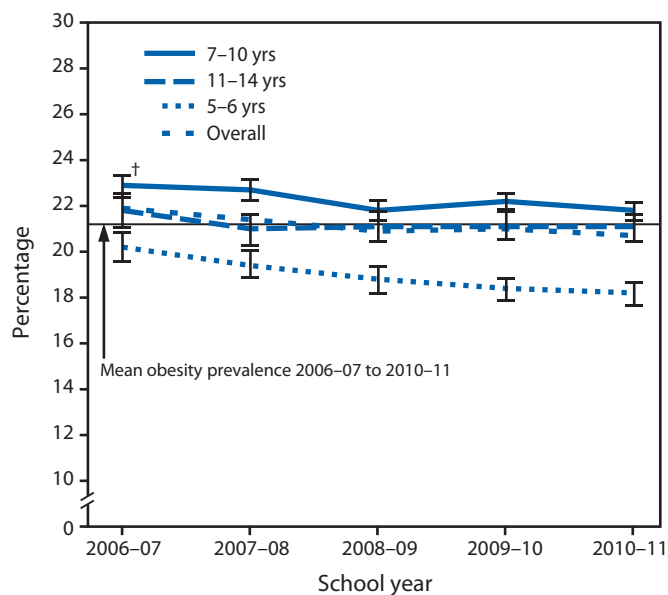
* Obesity prevalence estimates are based on body mass index measurements weighted by race/ethnicity, borough, district public health office neighborhoods (neighborhoods with low income and disproportionate rates of morbidity and mortality), free lunch status, grade, sex, age, and school type (elementary versus middle).

[†] To test for trend over school years, a multivariate model was built that included a linear term for trend, along with sex, age, race/ethnicity, school borough, free lunch status, district public health office, place of birth, language spoken at home, and an interaction by age, sex, and race/ethnicity, as covariates. School and student codes were used as cluster variables.

[§] Persons categorized as Asian/Pacific Islander, black, or white were all non-Hispanic. Persons categorized as Hispanic might be of any race.

[¶] Within the school postal code area, levels of poverty were classified as low (<10% of residents living below the federal poverty level as defined by the U.S. Census 2000), medium (10 to <20%), high (20 to <30%), and very high (≥30%).

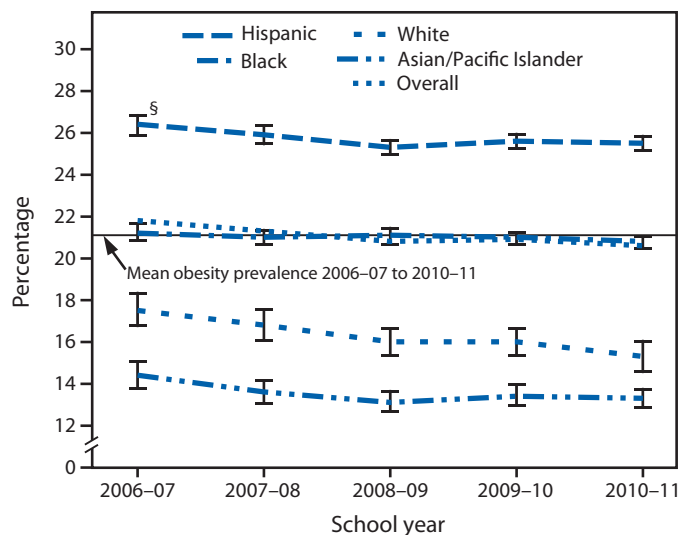
FIGURE 1. Obesity prevalence among public school children in grades K–8 who were aged 5–14 years, by age group and overall — New York City, 2006–07 to 2010–11 school years*



* All trends were significant at p<0.001.

[†] 95% confidence interval.

FIGURE 2. Obesity prevalence among public school children in grades K–8 who were aged 5–14 years, by race/ethnicity* and overall — New York City, 2006–07 to 2010–11 school years[†]



* Hispanics might be of any race. Black, white, and Asian/Pacific Islander children were all non-Hispanic.

[†] All trends except for black children were significant at p<0.001. Trend for black children was significant at p = 0.015.

[§] 95% confidence interval.

What is already known on this topic?

Overweight and obese children are more likely to develop risk factors that can lead to serious illness; since the 1960s, the prevalence of pediatric obesity has increased in the United States.

What is added by this report?

Current estimates in New York City indicate a decrease from the 2006–07 to the 2010–11 school years in the prevalence of obesity among public school children in grades K–8; however, obesity prevalence remains higher among minority children and those living in poor neighborhoods.

What are the implications for public health practice?

Despite the decrease in the prevalence of obesity among New York City public school children, prevalence remains high and warrants continued public health interventions. Improving the food environment both within and outside of school, limiting the marketing of and children's access to calorie-dense and nutrient-poor foods, improving access to and opportunities for physical fitness, and educating students and parents about healthy nutritional and fitness practices are all important public health interventions that need to be expanded and sustained.

During 2003–2009, New York City implemented multiple interventions to address the increase in childhood obesity. These measures included establishment of regulations to require improved nutrition, increased physical activity time and limited screen time (e.g., video game, television, or computer) in group child care, provision of extensive nutrition education training and physical activity equipment to 80% of group child care centers, and provision of on-site nutrition education workers at 300 centers. School nurses were trained to identify and monitor children at high risk for obesity and to know when to notify parents that a problem exists and when to refer children for additional medical care. Nurses also were given information about obesity prevention programs offered at schools and in the community. In schools, substantial improvements in cafeteria food were made, including a shift from whole milk to 1% fat and skim milk in 2005. The number of middle schools in a before-school and after-school physical activity program was expanded from 40 to 225, and nearly 4,000 elementary classroom teachers were trained to provide in-class physical activity breaks. Additionally, individualized BMI and fitness reports were sent to all parents of K–8 public school students beginning in 2005, with guidance on how to help their children maintain a healthy weight.

The findings in this report are subject to at least two limitations. First, although this study uses objectively measured height and weight data collected by trained physical education teachers, which is likely an improved method compared with

surveys using self-reported data, some measurement error is possible. Measurement equipment was not standardized across schools, but obvious measurement errors (i.e., implausible height or weight values, as determined by CDC's BMI percentile-for-age and sex criteria) were excluded from analysis. Second, although DOE sought to assess all eligible children, certain schools that began participating in early, rather than later years might differ in some unmeasured way. However, no evidence indicates that trends were caused by changes in socioeconomic or demographic characteristics of the public school population over time. Additionally, in each year, BMI values for those participating were weighted to be representative of the entire enrollment for that year, thus minimizing selection bias.

The objectives of this study were to create obesity prevalence estimates that are representative of the New York City public school population and to examine trends. Because of the nature of this analysis, a causal relationship cannot be inferred between the BMI and fitness interventions implemented by New York City in schools and the decrease in prevalence of child obesity described in this report. Nevertheless, the trend toward reduced prevalence of obesity is encouraging. The larger decreases in obesity prevalence among children aged 5–6 years suggest that changes in the preschool or home environment might have been particularly important. The smaller reductions among older children might indicate that changes in school-based nutrition and physical activity programs also helped reduce the prevalence of obesity. Nonetheless, the uneven gains among minorities and those with lower incomes highlight the need for further targeted measures to reduce childhood obesity.

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Announcements

Public Health Prevention Service Accepting Applications for 2012 Class and Field Assignments

CDC's Public Health Prevention Service (PHPS) program is accepting applications for the 2012 class. PHPS also is accepting applications from public health organizations for placement of fellows in 2-year field assignments focusing on program management.

PHPS is a 3-year training and service fellowship that focuses on public health program management. This unique program provides experience in program planning, implementation, and evaluation through specialized hands-on training and mentorship at CDC and in state and local health organizations.

Through its 2-year field assignments, PHPS is available to support and supplement state or local health organizations in filling crucial program management needs. The 2-year field assignment provides public health organizations with fellows who can contribute high-quality work in program management, including but not limited to decision making, policy recommendations, budget preparation, workforce planning, project implementation and evaluation, partnerships, and health communication.

Applicants with a master's degree in public health or management-related fields from an accredited college or university and 1 year of paid public health experience are encouraged to apply for acceptance to the PHPS class, which begins in October 2012. Applications must be submitted online by February 1, 2012, and supporting documents must be postmarked by that same day. Additional information regarding the program's eligibility criteria and application process is available at <http://www.cdc.gov/phps>, by telephone at 404-498-6120, or by e-mail at phps@cdc.gov.

The deadline for applications from health organizations to serve as host sites is January 20, 2012. All salaries, benefits, and PHPS-related travel expenses for the 2-year field assignments are covered by CDC. Health organizations are encouraged to take advantage of this opportunity to provide a practical learning experience for PHPS fellows and to address public health priorities of their organizations. Health organization eligibility criteria and application instructions are available online at http://www.cdc.gov/phps/downloads/phps_guideforhealthorganizations.pdf or <http://www.cdc.gov/phps/fieldassignments>.

Health Risk Assessment Recommendations Available Online

Final health risk assessment recommendations, published in *A Framework for Patient-Centered Health Risk Assessments — Providing Health Promotion and Disease Prevention Services to Medicare Beneficiaries*, are now available online at <http://www.cdc.gov/policy/opth/hra>. The framework includes guidance for health-care providers and others in the design and application of health risk assessments and follow-up interventions that research suggests are effective in reducing some high-risk health behaviors. These final recommendations update CDC's previous *Interim Guidance for Health Risk Assessments and Their Modes of Provision for Medicare Beneficiaries*, published March 23, 2011 (1).

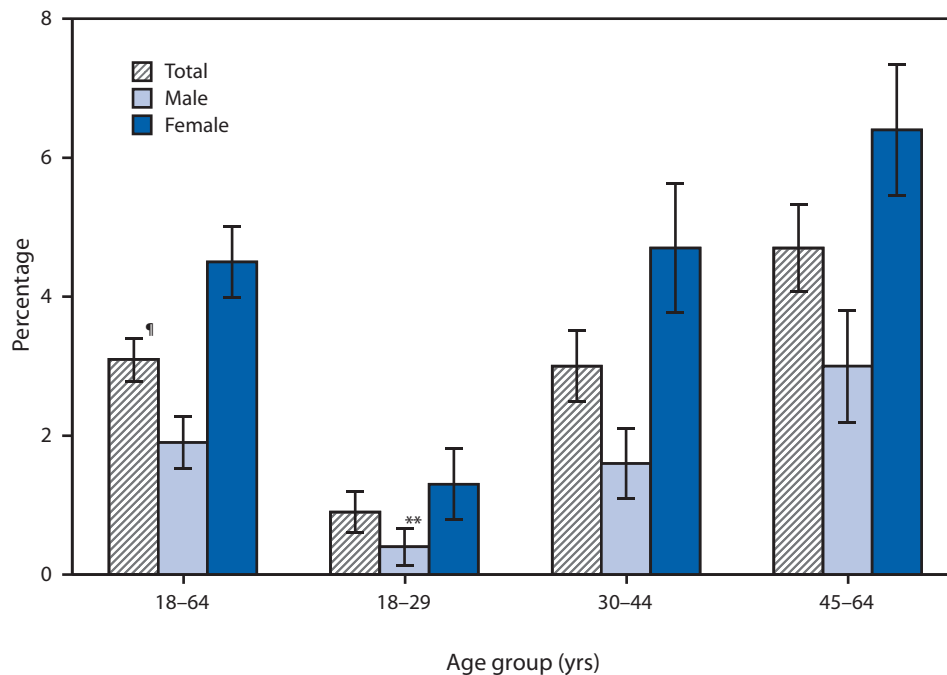
Reference

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QuickStats

FROM THE NATIONAL CENTER FOR HEALTH STATISTICS

Percentage of Employed Adults* Aged 18–64 Years Who Had Carpal Tunnel Syndrome[†] in the Past 12 Months, by Sex and Age Group — National Health Interview Survey, 2010[§]



* Employed adults are persons who worked at a job or business any time in the 12 months before the interview (either full-time or part-time).

[†] Adults were defined as having carpal tunnel syndrome if they answered “yes” to the following two questions: “Have you ever been told by a doctor or other health professional that you have a condition affecting the wrist and hand called carpal tunnel syndrome?” and “During the past 12 months, have you had carpal tunnel syndrome?”

[§] Estimates are based on household interviews of a sample of the civilian, noninstitutionalized U.S. population and are derived from the National Health Interview Survey sample adult component.

[¶] 95% confidence interval.

** Estimate has a relative standard error >30% and ≤50% and should be interpreted with caution because it does not meet standards of reliability or precision.

In 2010, an estimated 3.1% of employed adults aged 18–64 years had carpal tunnel syndrome in the past 12 months. The percentage of employed adults with carpal tunnel syndrome increased with each age group. Employed women were more likely than employed men to have carpal tunnel syndrome in the past 12 months, a pattern identified for each age group.

Source: National Health Interview Survey, 2010 data. 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 December 10, 2011 (49th week)*

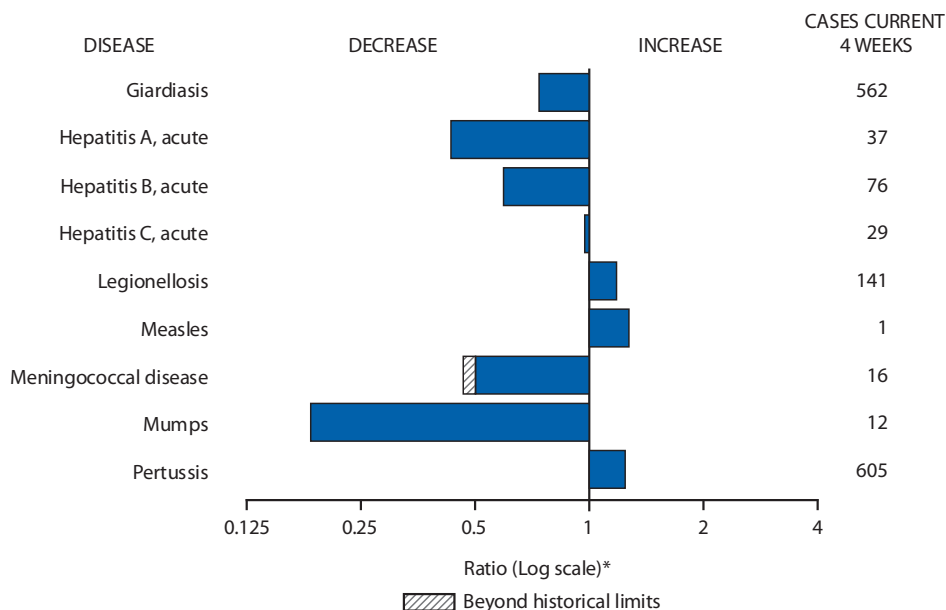
Disease	Current week	Cum 2011	5-year weekly average [†]	Total cases reported for previous years					States reporting cases during current week (No.)
				2010	2009	2008	2007	2006	
Anthrax	—	1	0	—	1	—	1	1	
Arboviral diseases ^{§, ¶} :									
California serogroup virus disease	—	125	0	75	55	62	55	67	
Eastern equine encephalitis virus disease	—	4	—	10	4	4	4	8	
Powassan virus disease	—	14	0	8	6	2	7	1	
St. Louis encephalitis virus disease	—	4	0	10	12	13	9	10	
Western equine encephalitis virus disease	—	—	—	—	—	—	—	—	
Babesiosis	3	623	0	NN	NN	NN	NN	NN	NY (3)
Botulism, total	—	107	3	112	118	145	144	165	
foodborne	—	8	0	7	10	17	32	20	
infant	—	70	2	80	83	109	85	97	
other (wound and unspecified)	—	29	1	25	25	19	27	48	
Brucellosis	—	72	2	115	115	80	131	121	
Chancroid	—	27	1	24	28	25	23	33	
Cholera	—	29	0	13	10	5	7	9	
Cyclosporiasis [§]	1	147	1	179	141	139	93	137	FL (1)
Diphtheria	—	—	—	—	—	—	—	—	
<i>Haemophilus influenzae</i> ,** invasive disease (age <5 yrs):									
serotype b	—	7	1	23	35	30	22	29	
nonsensory type b	—	102	4	200	236	244	199	175	
unknown serotype	1	214	4	223	178	163	180	179	ID (1)
Hansen disease [§]	—	43	1	98	103	80	101	66	
Hantavirus pulmonary syndrome [§]	—	20	1	20	20	18	32	40	
Hemolytic uremic syndrome, postdiarrheal [§]	2	191	3	266	242	330	292	288	NY (1), MO (1)
Influenza-associated pediatric mortality ^{§, ††}	—	118	2	61	358	90	77	43	
Listeriosis	3	701	14	821	851	759	808	884	FL (1), AR (1), CA (1)
Measles ^{§§}	—	212	1	63	71	140	43	55	
Meningococcal disease, invasive ^{¶¶} :									
A, C, Y, and W-135	—	169	6	280	301	330	325	318	
serogroup B	1	97	3	135	174	188	167	193	WA (1)
other serogroup	—	12	0	12	23	38	35	32	
unknown serogroup	5	360	9	406	482	616	550	651	MD (1), LA (1), TX (1), ID (1), CA (1)
Novel influenza A virus infections ^{***}	—	8	0	4	43,774	2	4	NN	
Plague	—	2	—	2	8	3	7	17	
Poliomyelitis, paralytic	—	—	—	—	1	—	—	—	
Polio virus Infection, nonparalytic [§]	—	—	—	—	—	—	—	NN	
Psittacosis [§]	—	2	0	4	9	8	12	21	
Q fever, total [§]	1	102	1	131	113	120	171	169	
acute	1	77	1	106	93	106	—	—	OH (1)
chronic	—	25	0	25	20	14	—	—	
Rabies, human	—	2	0	2	4	2	1	3	
Rubella ^{†††}	—	5	0	5	3	16	12	11	
Rubella, congenital syndrome	—	—	—	—	2	—	—	1	
SARS-CoV [§]	—	—	—	—	—	—	—	—	
Smallpox [§]	—	—	—	—	—	—	—	—	
Streptococcal toxic-shock syndrome [§]	2	110	2	142	161	157	132	125	NY (1), NC (1)
Syphilis, congenital (age <1 yr) ^{§§§}	—	222	8	377	423	431	430	349	
Tetanus	—	8	1	26	18	19	28	41	
Toxic-shock syndrome (staphylococcal) [§]	2	67	1	82	74	71	92	101	NY (1), MI (1)
Trichinellosis	—	10	0	7	13	39	5	15	
Tularemia	—	139	1	124	93	123	137	95	
Typhoid fever	1	329	5	467	397	449	434	353	MD (1)
Vancomycin-intermediate <i>Staphylococcus aureus</i> [§]	1	61	1	91	78	63	37	6	OH (1)
Vancomycin-resistant <i>Staphylococcus aureus</i> [§]	—	—	0	2	1	—	2	1	
Vibriosis (noncholera <i>Vibrio</i> species infections) [§]	2	707	7	846	789	588	549	NN	VA (1), WA (1)
Viral hemorrhagic fever ^{¶¶¶}	—	—	—	1	NN	NN	NN	NN	
Yellow fever	—	—	—	—	—	—	—	—	

See Table 1 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 December 10, 2011 (49th week)*

—: No reported cases. N: Not reportable. NN: Not Nationally Notifiable. Cum: Cumulative year-to-date counts.
 * Case counts for reporting year 2011 are provisional and subject to change. For further information on interpretation of these data, see http://www.cdc.gov/osels/ph_surveillance/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/osels/ph_surveillance/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 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/osels/ph_surveillance/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 weekly from reports to the Influenza Division, National Center for Immunization and Respiratory Diseases. Since October 2, 2011, no influenza-associated pediatric deaths occurring during the 2011-12 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 four cases of novel influenza A virus infection reported to CDC during 2010, and the eight cases reported during 2011, were identified as swine influenza A (H3N2) virus and are unrelated to the 2009 pandemic influenza A (H1N1) virus. Total case counts are provided by the Influenza Division, National Center for Immunization and Respiratory Diseases (NCIRD).
 ††† No rubella cases were reported for the current week.
 §§§ 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 of 2010. 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 December 10, 2011, with historical data



* Ratio of current 4-week total to mean of 15 4-week totals (from previous, comparable, and subsequent 4-week periods for the past 5 years). The point where the hatched area begins is based on the mean and two standard deviations of these 4-week totals.

Notifiable Disease Data Team and 122 Cities Mortality Data Team

Jennifer Ward	Deborah A. Adams
Willie J. Anderson	Lenee Blanton
Rosaline Dhara	Diana Harris Onweh
Pearl C. Sharp	Michael S. Wodajo

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TABLE II. (Continued) Provisional cases of selected notifiable diseases, United States, weeks ending December 10, 2011, and December 11, 2010 (49th week)*

Reporting area	Dengue Virus Infection†									
	Dengue Fever‡					Dengue Hemorrhagic Fever¶				
	Current week	Previous 52 weeks		Cum 2011	Cum 2010	Current week	Previous 52 weeks		Cum 2011	Cum 2010
	Med	Max				Med	Max			
United States	—	3	16	199	679	—	0	1	2	10
New England	—	0	1	2	10	—	0	0	—	—
Connecticut	—	0	0	—	—	—	0	0	—	—
Maine**	—	0	0	—	6	—	0	0	—	—
Massachusetts	—	0	0	—	—	—	0	0	—	—
New Hampshire	—	0	0	—	—	—	0	0	—	—
Rhode Island**	—	0	0	—	1	—	0	0	—	—
Vermont**	—	0	1	2	3	—	0	0	—	—
Mid. Atlantic	—	1	6	55	220	—	0	0	—	5
New Jersey	—	0	0	—	29	—	0	0	—	—
New York (Upstate)	—	0	1	—	30	—	0	0	—	2
New York City	—	0	4	40	140	—	0	0	—	3
Pennsylvania	—	0	2	15	21	—	0	0	—	—
E.N. Central	—	0	2	14	67	—	0	1	1	1
Illinois	—	0	2	4	21	—	0	1	1	—
Indiana	—	0	1	2	14	—	0	0	—	—
Michigan	—	0	1	2	9	—	0	0	—	—
Ohio	—	0	1	2	16	—	0	0	—	—
Wisconsin	—	0	2	4	7	—	0	0	—	1
W.N. Central	—	0	2	11	32	—	0	0	—	1
Iowa	—	0	1	3	2	—	0	0	—	—
Kansas	—	0	1	1	4	—	0	0	—	—
Minnesota	—	0	1	5	14	—	0	0	—	—
Missouri	—	0	1	1	4	—	0	0	—	—
Nebraska**	—	0	0	—	7	—	0	0	—	—
North Dakota	—	0	1	1	1	—	0	0	—	—
South Dakota	—	0	0	—	—	—	0	0	—	1
S. Atlantic	—	1	8	78	236	—	0	1	1	2
Delaware	—	0	2	2	—	—	0	0	—	—
District of Columbia	—	0	0	—	—	—	0	0	—	—
Florida	—	1	7	58	188	—	0	0	—	2
Georgia	—	0	1	3	11	—	0	0	—	—
Maryland**	—	0	2	5	—	—	0	0	—	—
North Carolina	—	0	1	2	8	—	0	0	—	—
South Carolina**	—	0	1	1	13	—	0	0	—	—
Virginia**	—	0	1	7	14	—	0	1	1	—
West Virginia	—	0	0	—	2	—	0	0	—	—
E.S. Central	—	0	3	8	7	—	0	0	—	—
Alabama**	—	0	1	2	4	—	0	0	—	—
Kentucky	—	0	1	3	2	—	0	0	—	—
Mississippi	—	0	0	—	—	—	0	0	—	—
Tennessee**	—	0	2	3	1	—	0	0	—	—
W.S. Central	—	0	2	9	28	—	0	0	—	1
Arkansas**	—	0	0	—	—	—	0	0	—	1
Louisiana	—	0	1	3	4	—	0	0	—	—
Oklahoma	—	0	0	—	5	—	0	0	—	—
Texas**	—	0	1	6	19	—	0	0	—	—
Mountain	—	0	1	4	24	—	0	0	—	—
Arizona	—	0	1	2	12	—	0	0	—	—
Colorado	—	0	0	—	—	—	0	0	—	—
Idaho**	—	0	0	—	3	—	0	0	—	—
Montana**	—	0	0	—	4	—	0	0	—	—
Nevada**	—	0	1	1	4	—	0	0	—	—
New Mexico**	—	0	0	—	1	—	0	0	—	—
Utah	—	0	1	1	—	—	0	0	—	—
Wyoming**	—	0	0	—	—	—	0	0	—	—
Pacific	—	0	4	18	55	—	0	0	—	—
Alaska	—	0	0	—	1	—	0	0	—	—
California	—	0	2	5	36	—	0	0	—	—
Hawaii	—	0	4	5	—	—	0	0	—	—
Oregon	—	0	0	—	—	—	0	0	—	—
Washington	—	0	1	8	18	—	0	0	—	—
Territories										
American Samoa	—	0	0	—	—	—	0	0	—	—
C.N.M.I.	—	—	—	—	—	—	—	—	—	—
Guam	—	0	0	—	—	—	0	0	—	—
Puerto Rico	—	0	62	107	10,541	—	0	0	—	237
U.S. Virgin Islands	—	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 2011 are provisional and subject to change. For further information on interpretation of these data, see http://www.cdc.gov/osels/ph_surveillance/nndss/phps/files/ProvisionalNationa%20NotifiableDiseasesSurveillanceData20100927.pdf. Data for TB 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).

‡ 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).

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TABLE II. (Continued) Provisional cases of selected notifiable diseases, United States, weeks ending December 10, 2011, and December 11, 2010 (49th week)*

Reporting area	Hepatitis (viral, acute), by type														
	A					B					C				
	Current week	Previous 52 weeks		Cum 2011	Cum 2010	Current week	Previous 52 weeks		Cum 2011	Cum 2010	Current week	Previous 52 weeks		Cum 2011	Cum 2010
	Med	Max				Med	Max				Med	Max			
United States	15	22	74	1,109	1,546	16	48	167	2,350	3,080	11	17	39	912	786
New England	—	1	5	65	93	—	1	8	74	52	—	1	5	57	54
Connecticut	—	0	3	17	28	—	0	4	15	20	—	0	4	37	37
Maine†	—	0	2	6	7	—	0	2	8	13	—	0	2	4	2
Massachusetts	—	0	3	31	48	—	1	6	49	12	—	0	2	11	13
New Hampshire	—	0	1	—	1	—	0	1	2	5	N	0	0	N	N
Rhode Island†	—	0	1	5	9	U	0	0	U	U	U	0	0	U	U
Vermont†	—	0	2	6	—	—	0	0	—	2	—	0	1	5	2
Mid. Atlantic	2	4	8	190	264	4	5	12	258	267	2	1	5	86	101
New Jersey	—	1	3	29	72	—	1	4	56	73	—	0	2	7	28
New York (Upstate)	1	1	4	45	55	3	1	9	52	48	2	1	4	47	44
New York City	—	1	5	62	85	—	1	5	75	77	—	0	0	—	3
Pennsylvania	1	1	3	54	52	1	2	4	75	69	—	0	4	32	26
E.N. Central	2	3	8	171	200	—	5	37	309	461	—	3	9	140	91
Illinois	—	1	4	52	48	—	1	6	59	128	—	0	2	7	1
Indiana	—	0	3	12	11	—	1	3	55	69	—	0	5	55	27
Michigan	—	1	6	62	73	—	1	6	79	118	—	1	4	70	44
Ohio	2	1	3	39	46	—	1	30	89	93	—	0	1	6	9
Wisconsin	—	0	1	6	22	—	0	3	27	53	—	0	1	2	10
W.N. Central	—	1	25	38	75	1	2	16	121	112	—	0	6	8	20
Iowa	—	0	1	7	11	—	0	1	10	14	—	0	0	—	—
Kansas	—	0	2	3	11	—	0	2	12	11	—	0	1	3	2
Minnesota	—	0	22	9	15	—	0	15	9	8	—	0	6	2	10
Missouri	—	0	1	12	20	1	1	5	77	65	—	0	0	—	6
Nebraska†	—	0	1	5	14	—	0	3	12	12	—	0	1	3	2
North Dakota	—	0	3	—	3	—	0	0	—	—	—	0	0	—	—
South Dakota	—	0	2	2	1	—	0	1	1	2	—	0	0	—	—
S. Atlantic	8	4	12	225	322	8	12	56	642	839	2	4	11	222	180
Delaware	—	0	1	2	7	—	0	2	13	24	U	0	0	U	U
District of Columbia	—	0	0	—	1	—	0	0	—	3	—	0	0	—	2
Florida	4	1	7	78	132	6	4	7	191	283	1	1	3	55	55
Georgia	—	1	5	47	36	—	2	7	107	159	—	0	3	33	31
Maryland†	1	0	4	25	21	1	1	4	52	66	—	0	3	32	23
North Carolina	2	0	3	27	45	1	2	12	102	96	—	1	7	56	39
South Carolina†	—	0	2	10	25	—	1	3	32	56	—	0	1	1	1
Virginia†	1	0	3	28	47	—	1	6	66	90	—	0	3	19	12
West Virginia	—	0	5	8	8	—	0	43	79	62	1	0	6	26	17
E.S. Central	—	1	6	46	46	1	9	14	409	359	1	3	8	171	154
Alabama†	—	0	2	7	8	—	2	6	105	64	—	0	3	16	6
Kentucky	—	0	2	9	24	—	2	6	98	126	—	1	7	81	104
Mississippi	—	0	1	7	2	—	1	3	42	33	U	0	0	U	U
Tennessee†	—	0	5	23	12	1	4	8	164	136	1	1	5	74	44
W.S. Central	3	3	15	126	141	2	6	67	288	543	4	2	11	83	65
Arkansas†	—	0	1	1	2	—	1	4	48	60	—	0	0	—	1
Louisiana	—	0	2	5	11	—	1	4	29	49	—	0	2	5	3
Oklahoma	—	0	4	3	2	—	1	16	81	93	3	1	10	47	30
Texas†	3	2	11	117	126	2	3	45	130	341	1	0	3	31	31
Mountain	—	1	5	55	140	—	1	4	71	131	—	1	5	62	60
Arizona	—	0	2	16	61	—	0	3	15	25	U	0	0	U	U
Colorado	—	0	2	18	35	—	0	2	15	44	—	0	3	17	16
Idaho†	—	0	1	6	7	—	0	1	2	6	—	0	2	10	10
Montana†	—	0	1	2	4	—	0	0	—	—	—	0	1	3	3
Nevada†	—	0	3	5	14	—	0	3	26	40	—	0	2	10	7
New Mexico†	—	0	1	5	5	—	0	2	8	5	—	0	2	12	14
Utah	—	0	2	1	10	—	0	1	5	8	—	0	2	8	10
Wyoming†	—	0	1	2	4	—	0	0	—	3	—	0	1	2	—
Pacific	—	4	13	193	265	—	3	25	178	316	2	2	12	83	61
Alaska	—	0	1	2	4	—	0	1	4	5	U	0	0	U	U
California	—	3	12	150	218	—	2	22	113	223	1	1	4	38	27
Hawaii	—	0	2	8	7	—	0	1	6	6	U	0	0	U	U
Oregon	—	0	2	9	16	—	0	4	29	39	—	0	3	13	15
Washington	—	0	4	24	20	—	0	4	26	43	1	0	5	32	19
Territories															
American Samoa	—	0	0	—	—	—	0	0	—	—	—	0	0	—	—
C.N.M.I.	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—
Guam	—	0	5	8	7	—	2	8	28	77	—	0	4	10	61
Puerto Rico	—	0	2	7	19	—	0	2	8	26	N	0	0	N	N
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 2011 are provisional and subject to change. For further information on interpretation of these data, see http://www.cdc.gov/osels/ph_surveillance/nndss/pdfs/files/ProvisionalNationalNotifiableDiseasesSurveillanceData20100927.pdf. Data for TB 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 December 10, 2011, and December 11, 2010 (49th week)*

Reporting area	Legionellosis					Lyme disease					Malaria				
	Current week	Previous 52 weeks		Cum 2011	Cum 2010	Current week	Previous 52 weeks		Cum 2011	Cum 2010	Current week	Previous 52 weeks		Cum 2011	Cum 2010
		Med	Max				Med	Max				Med	Max		
United States	36	54	168	3,647	3,180	200	412	1,972	30,542	29,283	7	26	114	1,272	1,615
New England	4	5	39	387	258	1	72	489	6,550	8,764	—	2	20	85	101
Connecticut	—	1	10	72	50	—	29	226	2,485	3,006	—	0	20	10	2
Maine†	—	0	3	18	11	1	14	66	902	688	—	0	2	6	6
Massachusetts	4	3	24	235	124	—	19	106	1,354	3,244	—	1	6	56	70
New Hampshire	—	0	3	23	22	—	15	84	1,082	1,299	—	0	1	2	5
Rhode Island†	—	0	9	28	42	—	1	31	140	180	—	0	2	5	15
Vermont†	—	0	2	11	9	—	6	67	587	347	—	0	1	6	3
Mid. Atlantic	12	15	82	1,214	903	152	221	1,216	18,887	10,568	2	7	13	310	499
New Jersey	—	2	16	180	148	—	97	590	8,070	3,623	—	0	2	8	101
New York (Upstate)	6	5	27	363	280	62	42	213	3,607	2,503	1	1	4	50	75
New York City	—	3	14	196	159	—	1	12	110	713	—	4	10	197	265
Pennsylvania	6	5	37	475	316	90	85	509	7,100	3,729	1	1	5	55	58
E.N. Central	8	12	51	786	660	2	15	143	1,445	3,796	—	3	10	149	158
Illinois	—	2	11	121	145	—	1	18	163	135	—	1	5	55	60
Indiana	1	2	7	110	55	—	1	15	100	78	—	0	2	9	15
Michigan	—	3	15	186	174	1	1	13	107	94	—	0	4	30	29
Ohio	7	5	34	368	224	1	1	6	50	39	—	1	4	41	40
Wisconsin	—	0	1	1	62	—	12	101	1,025	3,450	—	0	2	14	14
W.N. Central	1	1	8	79	121	—	1	13	127	2,083	—	0	45	36	68
Iowa	—	0	2	11	15	—	0	12	80	85	—	0	3	22	14
Kansas	—	0	2	11	12	—	0	2	14	10	—	0	2	9	11
Minnesota	—	0	4	—	35	—	0	3	—	1,952	—	0	45	—	3
Missouri	1	1	5	47	36	—	0	0	—	4	—	0	1	—	21
Nebraska†	—	0	1	6	9	—	0	2	8	8	—	0	1	4	15
North Dakota	—	0	1	2	5	—	0	10	21	23	—	0	0	—	1
South Dakota	—	0	1	2	9	—	0	2	4	1	—	0	1	1	3
S. Atlantic	9	10	29	549	533	42	53	172	3,291	3,718	4	8	24	418	434
Delaware	—	0	4	24	16	4	12	48	804	636	—	0	3	7	2
District of Columbia	—	0	3	9	17	—	0	3	31	40	—	0	1	5	12
Florida	2	4	13	177	164	7	2	7	123	78	—	2	7	98	131
Georgia	—	1	3	38	63	—	0	5	25	10	—	1	5	73	68
Maryland†	7	1	14	127	108	17	18	114	1,200	1,592	2	2	14	121	98
North Carolina	—	1	7	71	60	1	0	12	67	77	1	0	6	37	51
South Carolina†	—	0	5	22	16	—	0	6	33	29	—	0	1	6	6
Virginia†	—	1	6	75	75	13	15	76	931	1,136	1	1	8	71	63
West Virginia	—	0	2	6	14	—	0	14	77	120	—	0	0	—	3
E.S. Central	—	2	10	147	131	1	1	5	59	42	1	0	4	32	31
Alabama†	—	0	2	26	21	1	0	2	21	2	—	0	3	6	9
Kentucky	—	1	3	35	27	—	0	1	2	5	—	0	1	7	8
Mississippi	—	0	3	13	12	—	0	1	3	—	—	0	1	1	2
Tennessee†	—	1	8	73	71	—	0	4	33	35	1	0	3	18	12
W.S. Central	1	2	13	126	167	—	1	29	48	107	—	0	18	28	92
Arkansas†	1	0	2	14	19	—	0	0	—	—	—	0	1	5	4
Louisiana	—	0	3	16	11	—	0	1	1	3	—	0	1	1	5
Oklahoma	—	0	3	9	13	—	0	0	—	—	—	0	1	5	5
Texas†	—	2	11	87	124	—	1	29	47	104	—	0	17	17	78
Mountain	—	2	8	101	164	1	0	4	36	28	—	1	4	59	62
Arizona	—	1	4	42	63	—	0	2	10	2	—	0	4	22	25
Colorado	—	0	1	6	31	—	0	1	1	3	—	0	3	21	21
Idaho†	—	0	1	8	7	—	0	2	4	9	—	0	1	2	3
Montana†	—	0	1	1	4	—	0	3	9	4	—	0	1	2	3
Nevada†	—	0	2	15	19	—	0	1	4	2	—	0	2	8	6
New Mexico†	—	0	2	10	9	—	0	2	5	5	—	0	1	3	1
Utah	—	0	2	15	23	—	0	1	1	3	—	0	1	1	3
Wyoming†	—	0	2	4	8	1	0	1	2	—	—	0	0	—	—
Pacific	1	5	21	258	243	1	2	11	99	177	—	3	11	155	170
Alaska	—	0	0	—	2	—	0	2	12	7	—	0	2	5	4
California	—	4	15	216	199	1	1	9	60	117	—	2	8	105	113
Hawaii	—	0	1	2	2	N	0	0	N	N	—	0	1	7	4
Oregon	—	0	3	19	16	—	0	2	12	39	—	0	4	17	14
Washington	1	0	6	21	24	—	0	6	15	14	—	0	3	21	35
Territories															
American Samoa	N	0	0	N	N	N	0	0	N	N	—	0	1	1	—
C.N.M.I.	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—
Guam	—	0	0	—	1	—	0	0	—	—	—	0	0	—	—
Puerto Rico	—	0	1	—	2	N	0	0	N	N	—	0	0	—	5
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.

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TABLE II. (Continued) Provisional cases of selected notifiable diseases, United States, weeks ending December 10, 2011, and December 11, 2010 (49th week)*

Reporting area	Meningococcal disease, invasive [†] All serogroups					Mumps					Pertussis				
	Current week	Previous 52 weeks		Cum 2011	Cum 2010	Current week	Previous 52 weeks		Cum 2011	Cum 2010	Current week	Previous 52 weeks		Cum 2011	Cum 2010
		Med	Max				Med	Max				Med	Max		
United States	6	13	53	638	748	5	7	47	317	2,532	177	279	2,925	13,629	23,385
New England	—	0	3	29	20	—	0	2	10	25	11	13	32	678	498
Connecticut	—	0	1	3	3	—	0	0	—	11	—	1	5	55	105
Maine [§]	—	0	1	5	5	—	0	2	2	2	3	2	19	196	47
Massachusetts	—	0	2	14	6	—	0	1	4	9	2	4	10	222	269
New Hampshire	—	0	1	1	—	—	0	0	—	3	—	2	12	130	20
Rhode Island [§]	—	0	1	1	1	—	0	2	3	—	—	0	4	28	40
Vermont [§]	—	0	3	5	5	—	0	1	1	—	6	0	7	47	17
Mid. Atlantic	—	1	6	74	76	—	1	23	34	2,111	38	30	125	1,598	1,743
New Jersey	—	0	1	5	21	—	0	2	10	351	—	3	10	168	162
New York (Upstate)	—	0	4	22	12	—	0	3	11	663	25	12	81	716	584
New York City	—	0	3	27	18	—	0	22	10	1,039	—	0	36	74	82
Pennsylvania	—	0	2	20	25	—	0	8	3	58	13	12	67	640	915
E.N. Central	—	2	6	94	125	2	2	7	84	77	20	63	152	2,927	5,383
Illinois	—	0	3	28	22	—	1	5	54	28	—	16	46	801	986
Indiana	—	0	2	19	29	—	0	1	1	4	—	4	17	230	718
Michigan	—	0	2	11	22	1	0	2	11	18	3	12	41	618	1,458
Ohio	—	0	2	23	31	1	0	5	14	23	16	13	67	714	1,693
Wisconsin	—	0	2	13	21	—	0	1	4	4	1	11	25	564	528
W.N. Central	—	1	3	50	55	—	0	4	32	81	11	21	501	1,105	2,333
Iowa	—	0	1	13	10	—	0	1	5	38	—	4	15	185	664
Kansas	—	0	1	4	7	—	0	1	4	4	2	2	10	108	174
Minnesota	—	0	2	—	8	—	0	4	1	4	—	0	469	326	648
Missouri	—	0	3	18	23	—	0	3	12	10	9	6	28	354	563
Nebraska [§]	—	0	2	11	5	—	0	1	6	23	—	1	7	51	205
North Dakota	—	0	1	1	2	—	0	3	4	—	—	0	10	51	50
South Dakota	—	0	1	3	—	—	0	0	—	2	—	0	7	30	29
S. Atlantic	1	2	8	124	128	2	0	4	36	55	18	26	106	1,313	1,810
Delaware	—	0	1	1	1	—	0	0	—	—	—	0	5	22	14
District of Columbia	—	0	1	1	1	—	0	0	—	3	1	0	2	6	14
Florida	—	1	5	49	57	1	0	2	10	8	4	6	17	305	300
Georgia	—	0	1	14	12	—	0	2	5	5	5	3	8	166	236
Maryland [§]	1	0	1	13	9	1	0	1	2	11	5	2	8	111	132
North Carolina	—	0	3	14	13	—	0	2	9	9	—	2	35	163	333
South Carolina [§]	—	0	1	9	12	—	0	1	1	4	—	2	25	136	357
Virginia [§]	—	0	2	16	21	—	0	4	9	13	—	7	41	341	299
West Virginia	—	0	3	7	2	—	0	0	—	2	3	0	41	63	125
E.S. Central	—	0	2	22	42	—	0	1	4	10	4	7	25	344	802
Alabama [§]	—	0	2	10	7	—	0	1	1	6	—	2	11	128	198
Kentucky	—	0	2	2	17	—	0	0	—	1	2	1	16	78	285
Mississippi	—	0	1	3	5	—	0	1	3	—	—	0	3	37	103
Tennessee [§]	—	0	2	7	13	—	0	0	—	3	2	2	10	101	216
W.S. Central	2	1	12	57	85	1	1	15	64	112	19	20	297	875	2,910
Arkansas [§]	—	0	2	12	6	—	0	2	3	5	—	1	16	56	216
Louisiana	1	0	2	12	15	—	0	0	—	8	—	0	3	17	44
Oklahoma	—	0	2	10	16	—	0	2	4	—	—	0	92	52	91
Texas [§]	1	0	10	23	48	1	1	14	57	99	19	18	187	750	2,559
Mountain	1	1	4	46	55	—	0	2	8	20	25	38	100	1,893	1,752
Arizona	—	0	1	11	13	—	0	0	—	5	1	14	28	655	492
Colorado	—	0	1	9	21	—	0	1	3	7	12	8	63	402	458
Idaho [§]	1	0	1	7	5	—	0	2	2	1	12	2	11	172	185
Montana [§]	—	0	2	4	2	—	0	0	—	—	—	1	32	130	106
Nevada [§]	—	0	1	5	8	—	0	0	—	1	—	0	5	31	33
New Mexico [§]	—	0	1	2	3	—	0	2	2	2	—	3	21	243	142
Utah	—	0	2	8	1	—	0	0	—	3	—	5	16	251	324
Wyoming [§]	—	0	1	—	2	—	0	1	1	1	—	0	1	9	12
Pacific	2	3	26	142	162	—	0	11	45	41	31	60	1,710	2,896	6,154
Alaska	—	0	1	3	1	—	0	1	1	1	—	0	4	25	41
California	1	2	17	99	107	—	0	11	36	26	—	39	1,569	1,887	5,339
Hawaii	—	0	1	4	1	—	0	1	2	4	—	1	9	78	63
Oregon	—	0	3	21	31	—	0	1	4	3	—	5	23	287	271
Washington	1	0	8	15	22	—	0	1	2	7	31	11	131	619	440
Territories	—	0	0	—	—	—	0	0	—	—	—	0	0	—	—
American Samoa	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—
C.N.M.I.	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—
Guam	—	0	0	—	—	—	0	3	12	484	—	1	14	31	3
Puerto Rico	—	0	0	—	2	—	0	1	1	1	—	0	1	2	4
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.

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