improved understanding of TB transmission, and continued collaborative measures with other nations to reduce TB globally. These measures are required for complete implementation of the Institute of Medicine's recommendations for eliminating TB in the United States.[10]

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*A U.S.-born person was defined as someone born in the United States or its associated jurisdictions or someone born in a foreign country but having at least one U.S.-born parent. Persons not meeting this definition were classified as foreign-born.[1] For 2005, patients with unknown origin of birth represented 0.4% (61) of total cases.
†For this report, persons identified as white, black, Asian, American Indian/Alaska Native, native Hawaiian or other Pacific Islander, or of multiple races are all non-Hispanic. Persons identified as Hispanic might be of any race.
‡Defined as resistant to at least isoniazid and rifampin.
§States/jurisdictions reporting decreases in or a stable number of cases in 2005 (2005 case count; case rate per 100,000 population; % change in case rate from 2004 to 2005): California (2,900; 8.0; -3.9%), Texas (1,535; 6.7; -10.3%), New York (1,294; 6.7; -4.7%), Georgia (510; 5.6; -7.0%), North Carolina (329; 3.8; -15.1%), Pennsylvania (325; 2.6; -1.2%), Maryland (283; 5.1; -10.5%), Massachusetts (265; 4.1; -6.2%), Michigan (246; 2.4; -9.7%), Oklahoma (144; 4.1; -19.7%), Kentucky (124; 3.0; -3.1%), Arkansas (114, 4.1; -14.5%), Hawaii (112; 8.8; -4.4%), Missouri (108; 1.9; -15.6%), Mississippi (103; 3.5; -14.0%), Colorado (101; 2.2; -22.2%), Oregon (96; 2.6; -10.7%), Connecticut (95; 2.7; -6.2%), Wisconsin (78; 1.4; -18.4%), Kansas (60; 2.2; -3.6%), DC (56; 10.2; -30.4%). Rhode Island (47; 4.4; -7.5%), New Mexico (39; 2.0; -8.4%), Nebraska (35; 2.0; -10.8%), Utah (29; 1.2; -21.0%), Delaware (27; 3.2; -17.0%), Maine (15; 1.1; -25.4%), Montana (10; 1.1; -34.0%), New Hampshire (four; 0.3; -83.5%), Wyoming (zero; 0.0; -100.0%). Minnesota reported the same number of cases in 2004 and 2005 (199; 3.9; -0.7%).
‖States reporting increases in number of cases in 2005 (2005 case count; case rate per 100,000 population; % change in case rate from 2004 to 2005): Florida (1,094; 6.1; -0.5%), Illinois (596; 4.7; +4.5%), New Jersey (485; 5.6; +0.2%), Virginia (355; 4.7; +6.7%), Tennessee (295; 4.9; +5.3%), Arizona (281; 4.7; -0.2%), South Carolina (261; 6.1; +10.5%), Ohio (260; 2.3; +18.6%), Louisiana (257; 5.7; +2.8%), Washington (256; 4.1; +3.1%), Alabama (216; 4.7; +1.6%), Indiana (146; 2.3; +13.2%), Nevada (112; 4.6; +13.9%), Alaska (60; 9.0; +38.3%), Iowa (55; 1.9; +16.5%), West Virginia (28; 1.5; +16.4%), Idaho (23; 1.6; +104.1%), South Dakota (16; 2.1; +44.5%), Vermont (eight; 1.3; +32.9%), North Dakota (six; 0.9; +49.9%).
¶In 1989, CDC's Advisory Committee for Elimination of TB issued a strategic plan for the elimination of TB, setting an interim target case rate of 3.5 per 100,000 population by year 2000 and ultimately the elimination of TB (<1 case per 1,000,000 population) in the United States by 2010.[8]
#Reporting of official CDC TB statistics for race/ethnicity changed beginning in 2003. A "Native Hawaiian or other Pacific Islanders" category was added to the race/ethnicity reporting options, and multiple races could also be reported for a given patient.
‖Additional information available at http://www.stoptb.org/wg/new_drugs/assets/documents/wgnd%20strategic%20plan%20(final).pdf.

Discontinuation of Spectinomycin

MMWR. 2006;55:370

IN JANUARY 2006, CDC LEARNED THAT Pfizer, Inc. (New York, New York) had discontinued U.S. distribution of spectinomycin (Trobicin®) in November 2005; remaining inventory will expire in May 2006. No other pharmaceutical company manufactures or sells spectinomycin in the United States. Pfizer is continuing to distribute spectinomycin outside the United States for the international market. CDC and the Food and Drug Administration are working with Pfizer to make spectinomycin available again in the United States and will update this information as soon as possible.

Historically, spectinomycin has been used to treat persons infected with *Neisseria gonorrhoeae* who cannot receive one of the two first-line treatments (i.e., fluoroquinolones or third-generation cephalosporins) currently recommended for treatment of uncomplicated gonococcal infection.[1] Relatively few indications exist for which spectinomycin is the preferred treatment option for *N. gonorrhoeae*; these include (1) pregnant women with penicillin or cephalosporin allergy (fluoroquinolones are contraindicated during pregnancy), (2) persons with penicillin or cephalosporin allergies who reside in areas with a high prevalence of quinolone-resistant *N. gonorrhoeae*,[1,2] and (3) men with penicillin or cephalosporin allergies who have sex with men.[3] No acceptable alternatives to spectinomycin therapy are currently available. Persons with penicillin or cephalosporin allergies who cannot receive fluoroquinolones can be desensitized to cephalosporins before treatment.[4] Although 2 grams of azithromycin orally in a single dose is effective against uncomplicated gonococcal infection, no data are available to assess the safety and efficacy of this regimen in pregnant women. Moreover, concerns exist regarding the emergence of antimicrobial resistance if azithromycin is used widely in the treatment of *N. gonorrhoeae*.

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