reducing contamination and illness related to ground beef.\textsuperscript{5,6}

Consumers can reduce their risk for foodborne illness by following safe food-handling recommendations and by avoiding consumption of unpasteurized milk and unpasteurized milk products, raw or undercooked oysters, raw or undercooked eggs, raw or undercooked ground beef, and undercooked poultry (additional information on food safety for consumers is available at http://www.fightbac.org). Other effective prevention measures, such as pasteurization of in-shell eggs, irradiation of ground meat, and pressure treatment of oysters, can also decrease the risk for foodborne illness.

REFERENCES


\textcopyright{} 2006 American Medical Association. All rights reserved.

\textbf{Trends in Tuberculosis—United States, 2005}

\textit{MMWR}. 2006;55:305-308

2 figures, 1 table omitted

For 2005, a total of 14,093 tuberculosis (TB) cases (4.8 cases per 100,000 population) were reported in the United States, representing a 3.8% decline in the rate from 2004. This report summarizes provisional 2005 data from the national TB surveillance system and describes trends since 1993. The findings indicate that although the 2005 TB rate was the lowest recorded since national reporting began in 1953, the decline has slowed from an average of 7.1% per year (1993-2000) to an average of 3.8% per year (2001-2005). In 2005, the TB rate in foreign-born persons in the United States was 8.7 times that of U.S.-born persons.\textsuperscript{8,9} In addition, Hispanics,\textsuperscript{8} blacks, and Asians had TB rates 7.3, 8.3, and 19.6 times higher than whites, respectively. Moreover, the number of multidrug-resistant (MDR) TB cases in the United States increased 13.3%, with 128 cases (up from 113 in 2003) of MDR TB in 2004, the most recent year for which complete drug-susceptibility data are available. The deceleration of the decline in the overall national TB rate, the persistent disparities in TB rates between U.S.-born and foreign-born persons and between whites and racial/ethnic minorities, and the increase in MDR TB cases all threaten progress toward the goal of TB elimination in the United States. Effective TB control and prevention in the United States require sufficient resources, continued collaborative measures with other countries to reduce TB globally, and interventions targeted to U.S. populations with the highest TB rates.

Health departments in the 50 states and the District of Columbia (DC) electronically report to CDC any TB cases that meet the CDC/Council of State and Territorial Epidemiologists case definition (available at http://www.cdc.gov/epo/dphsi/casedef/tuberculosis_current.htm). Reports include the patient’s race, ethnicity (i.e., Hispanic or non-Hispanic), treatment information, and, when available, drug-susceptibility test results. CDC calculated national and state TB rates\textsuperscript{7,3} and rates for foreign-born and U.S.-born persons\textsuperscript{4,6} and racial/ethnic populations\textsuperscript{7} by using current U.S. census population estimates for the years 1993 through 2005. In 2005, a total of 29 states\textsuperscript{8} and DC had fewer TB cases than in 2004. Twenty states\textsuperscript{8} collectively reported 282 more cases for 2005 than for 2004. The top five states reporting additional cases were Ohio (+41), Illinois (+28), South Carolina (+28), Virginia (+26), and Florida (+20). Seven states (California, Florida, Georgia, Illinois, New Jersey, New York, and Texas) reported more than 400 cases each for 2005; combined, these seven states accounted for 59.7% (8,414 cases) of the national total.

TB rates in reporting jurisdictions ranged from 0.0 (Wyoming) to 10.2 (DC) cases per 100,000 population in 2005 (median: 3.5 cases). Thirty-two states and DC had lower rates in 2005 than in 2004; 18 states had higher rates. In 2005, for the first time since national reporting began, more than half of the states (26 [52.0%]) had TB rates of 3.5% or less; however, eight (30.8%) of the 26 had higher TB rates in 2005 than in 2004.

During 2005, a total of 6,376 cases (45.2%) were reported among U.S.-born persons, a decrease of 63.4% compared with 1993. The 2005 TB rate for U.S.-born persons was 2.5, representing a 66.3% decline from the 1993 rate of 7.4.

Among foreign-born persons in the United States, 7,656 cases (54.3%) were reported for 2005. Although the total foreign-born population in the United States has increased 61.6% since 1993, the number of TB cases reported in this population has not changed substantially, resulting in a decline of 36.0% in the TB rate among foreign-born persons (from 34.0 in 1993 to 21.8 in 2005). The rate ratio of TB in foreign-born
persons to U.S.-born persons increased an average of 6.6% per year during 1993-2002 but increased an average of 0.5% per year during 2003-2005. More than half (56.0%) of the foreign-born cases in 2005 were reported in persons from Mexico (1,930), the Philippines (826), Vietnam (576), India (563), and China (389).

For 2005, and for the second consecutive year, more TB cases were reported among Hispanics than any other racial/ethnic population. Among persons of a racial/ethnic minority whose country of birth was known, 3,034 (95.9%) of 3,164 Asians, 3,021 (75.4%) of 4,005 Hispanics, and 1,049 (26.7%) of 3,927 blacks with TB were foreign-born. During 2003-2005, TB rates declined in almost all racial/ethnic populations; the decrease in rates was greatest in American Indians/Alaska Natives (14.4%) and Asians (14.1%).

For 2004, the most recent year for which complete drug-susceptibility data are available, 128 cases of MDR TB were identified, representing 1.2% of the 10,846 cases for which drug-susceptibility test results were reported. This marks a 13.3% increase from the 113 MDR TB cases reported for 2003, the largest 1-year increase since 1993. In 2004, 0.6% (31) of U.S.-born and 1.6% (97) of foreign-born patients had MDR TB. Approximately one half of the foreign-born MDR TB patients were from Mexico (25), the Philippines (11), and Vietnam (10). California accounted for 30.5% (39) of the MDR cases but 20.6% (2,993 of 14,516) of the total cases.

The recommended length of drug therapy for most types of TB is 6-9 months. In 2002, the latest year for which treatment data are complete, the percentage of patients for whom ≤1 year of treatment is indicated and who completed therapy within 1 year was 81.8% for U.S.-born patients and 81.2% for foreign-born patients.

CDC Editorial Note: After the unprecedented 1985-1992 resurgence in TB in the United States, the annual TB rate steadily decreased during 1993-2005; however, the decline has recently decelerated, raising concerns that the progress toward eliminating TB is slowing. The proportion of cases contributed by foreign-born persons has increased each year since 1993. If immigration patterns continue, foreign-born persons will likely account for an increasing percentage of TB cases in the United States.

From 2003 to 2004, the number of MDR TB cases increased 13.3%, marking the largest 1-year increase in MDR TB cases since 1993. A greater percentage of foreign-born than U.S.-born patients had MDR TB, likely reflecting exposure to TB in countries where rates of MDR TB are higher than in the United States. In 2002, the percentages of both U.S.-born and foreign-born patients for whom ≤1 year of treatment is indicated and who completed therapy within 1 year were similar but fell short of the Healthy People 2010 target of 90% (objective 14-12).

For the first time in 50 years, six new TB drugs will soon be tested in humans.1 These drugs might reduce the duration of therapy by 30%-70%, making treatment completion more likely and might increase the probability of cure. If proven to be safe and efficacious, they will also provide additional options in the treatment of MDR TB.

To address the high rate of TB among foreign-born persons in the United States and the increasing proportion of cases they represent, CDC is collaborating with other national and international public health organizations to (1) survey foreign-born TB patients in the United States to determine opportunities for improving prevention and control interventions, (2) test recent arrivals from high-incidence countries for latent TB infection and treat them to completion, (3) optimize coordination of TB-control activities between the United States and Mexico to ensure completion of treatment among TB patients who travel back and forth across the U.S.-Mexican border, (4) strengthen the current notification system that alerts local health departments about the arrival of immigrants or refugees who have suspected TB, (5) enhance TB diagnostic, laboratory, and treatment capacities in host countries and sites where migrant populations are screened, and (6) improve overseas screening of immigrants and refugees by systematically monitoring, evaluating, and updating screening regulations, guidelines, and operations. CDC also continues to collaborate with international partners, including the Stop TB Partnership (http://www.stoptb.org), to strengthen TB control in countries with high TB incidence.

A disproportionately large number of TB cases are reported among blacks, most of whom were born in the United States.9 To address the high rate of TB in blacks in the United States, during 2002-2005, CDC funded three demonstration projects (in Chicago, Illinois; Georgia; and South Carolina), in collaboration with state and local health departments, that identified innovative strategies for improving TB diagnosis, screening, and treatment adherence in communities with black persons at high risk. CDC is also conducting a formative research and intervention study in collaboration with the Research Triangle Institute to (1) examine barriers to health-seeking behaviors and treatment adherence for blacks with TB or at risk for TB, (2) determine barriers to TB-guideline adherence among health-care providers who serve this population, (3) develop and test interventions to overcome identified barriers, and (4) improve partnerships and collaborations among TB programs and providers and organizations serving this population.

Despite these targeted measures to control TB, the recent deceleration of the decline in the TB rate indicates a need for improved case management and contact investigation, intensified testing of populations at high risk, better treatments and diagnostic tools,
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

Acknowledgments

The findings in this report are based, in part, on data contributed by state and local TB-control officials.

REFERENCES


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 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; -12.1%), 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; -16.6%), 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; +13.1%), Alabama (216; 4.7; +1.6%), Indiana (146; 2.3; +13.2%), Nevada (112; 4.6; +13.9%), Alaska (69; 9.0; +38.3%), Iowa (95; 19; +16.5%), West Virginia (28; 1.5; +16.4%), Idaho (23; 1.6; +104.1%), South Dakota (216; 2.2; +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. 1

#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.


Discontinuation of Specinomycin

MMWR. 2006;55:370

IN JANUARY 2006, CDC LEARNED THAT Pfizer, Inc. (New York, New York) had discontinued U.S. distribution of specinomycin (Trobicin®) in November 2005; remaining inventory will expire in May 2006. No other pharmaceutical company manufactures or sells specinomycin 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, 1,4 and (3) men with penicillin or cephalosporin allergies who have sex with men. 6 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.

REFERENCES


©2006 American Medical Association. All rights reserved.

(Reprinted) JAMA, May 17, 2006—Vol 295, No. 19 2245