Clark County Health Status Report 2000-2004 Volume I

Clark County
Health Status Report
Volume I

About this Series of Reports:

The *Clark County Health Status Report* is a series of volumes covering Southern Nevada Health District's reports to the community. Volume I will provide an overview of socio-economic context and population health as well as the communicable disease report covering 2000-2004. Subsequent volumes will cover chronic or non-communicable diseases and conditions in more detail.

Reporting health status helps us understand and interpret the health of our population, and is at the heart of Southern Nevada Health District's mission to protect and promote the health and the well-being of Southern Nevada residents and visitors. It is our hope that this report will inform county residents and visitors about things that affect their health and well-being, and provide information about various diseases and health conditions and the extent to which they occur in our population. The *Clark County Health Status Report* is a tool for planning, as well as for learning. We hope it will stimulate further questions, generate discussions, and guide activities to improve the health status of Clark residents and visitors.

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Data Sources, Strengths and Limitations

National Electronic Telecommunications Systems for Surveillance (NETSS)

The primary source of communicable diseases data is NETSS managed by the Office of Epidemiology at the Southern Nevada Health District (SNHD). NETSS is used for reporting notifiable communicable diseases in Clark County with the exceptions of Sexually Transmitted Diseases (STDs) and Tuberculosis (TB). As an ongoing surveillance system, NETSS provides the Centers for Disease Control and Prevention (CDC) with weekly data regarding cases of notifiable diseases. Since NETSS obtains data primarily from hospital, laboratory and physician reporting, several limitations exist. First, reliance on reporting from health-care providers, even though mandatory, may result in an underestimation of cases of diseases in the 'real world'. One implication of this general caution is that the statistics presented in this report are by their very nature, estimates of what is actually happening in the community, and conclusions drawn from these statistics are always tentative. Secondly, the timeliness of NETSS data is less than ideal due to delays in reporting, an unavoidable problem associated with most surveillance systems. Also of note is the lack of uniformity in the date of event in the NETSS system, as it can be that of disease onset, diagnosis, lab collection and reporting depending on the reporting facility. Even though this limitation also applies to data gathered nationally, particular caution should be exercised in comparisons conducted in this report between county NETSS data and national morbidity data since different reporting schemes are present for some notifiable diseases in the national data. In addition to these general limitations, individual data also have their own limitations. For example, NETSS does not include demographic information for certain notifiable diseases such as rotavirus and respiratory syncytial virus. In this report NETSS county data have been used for all communicable diseases except for STDs and TB. Consistent with CDC's Morbidity and Mortality (MM) Weekly Reports, MM week as recorded in NETSS is the choice of reporting scheme.

Sexually Transmitted Disease - Management Information System (STD-MIS)

STD data, except for HIV and AIDS, were extracted from the STD-MIS system. In this report county level statistics of STDs such as chlamydia, gonorrhea and syphilis were based on STD-MIS data. The general data limitations associated with NETSS also apply here as well as aforementioned cautions. Date reported as recorded in STD-MIS is the reporting scheme used for these STDs.

HIV/AIDS Reporting System (HARS)

HARS is managed by the Office of AIDS of the Clinics and Nursing Division at SNHD. In this report county level HIV/AIDS statistics were provided by the Office of AIDS.

Tuberculosis Data

County level TB statistics in this report were provided by the Nevada State Health Division.

Morbidity and Mortality Weekly Report (MMWR)

http://www.cdc.gov/mmwr/summary.html

Summaries of notifiable diseases provided in MMWRs are the sources of national communicable disease statistics unless otherwise noted. Standard measures such as numbers and rates (cases per 100,000 population) with age, gender, ethnicity and race breakdowns are available in tabular format for selected reportable diseases on an annual basis. This report compared county level statistics with national statistics, if available at the time this report was written.

Healthy People 2010 (HP2010) Database

http://wonder.cdc.gov/DATA2010

The HP2010 database also provided nationwide rates of certain notifiable diseases, which may not match those in MMWRs due to different reporting schemes and data sources utilized. For communicable diseases not included in MMWRs such as campylobacteriosis, national rates reported by the HP2010 database were used. Cautionary notes were provided in such situations.

National STD Surveillance Report

http://www.cdc.gov/std/stats04/default.htm

The 2004 National STD Surveillance Report was the source of nationwide numbers and rates for STDs such as chlamydia, gonorrhea and syphilis.

National TB Surveillance Report

http://www.cdc.gov/nchstp/tb/surv/surv.htm

The 2004 National TB Surveillance Report provided nationwide numbers and rates for TB disease.

Nevada Vital Statistics Database

Health status measures such as life expectancy were estimated using mortality data from the Nevada Vital Statistics Database managed by the Nevada State Health Division, Bureau of Health Planning and Statistics.

Nevada Interactive Health Database System

http://health2k.state.nv.us/nihds/

The Nevada Interactive Health Database System was a source of certain mortality information such as age-adjusted mortality rates for Clark County and Nevada, as was CDC WONDER Online Database (see following section).

State of Nevada Demographer

http://www.nsbdc.org/what/data_statistics/demographer/pubs/

This report used state demographer's population data in rate calculations for communicable diseases at the county level. The demographer's population estimates, as well as adjustments for immigration and migration, were preferred over those of Census 2000, since the true distribution of the county's population was more closely approximated by the former. Comparisons of county level age, gender, ethnicity, race/ethnicity specific disease rates with similar national rates were made if county population breakdowns by such demographic variables were available.

Behavioral Risk Factor Surveillance System (BRFSS)

http://www.cdc.gov/brfss/technical_infodata

The BRFSS is a random digit dial (RDD) telephone survey conducted by all state health departments, the District of Columbia, Puerto Rico, the Virgin Islands, and Guam with assistance from the CDC. The BRFSS is the largest continuously conducted telephone health survey in the world, monitoring chronic disease risk factors, injuries, and infectious diseases. Data are collected through monthly telephone interviews with adults 18 years of age and older using standardized procedures.

National Vital Statistics Reports

http://www.cdc.gov/nchs/

CDC WONDER Online Database

http://wonder.cdc.gov/

U.S. Census Bureau, American Community Survey

http://factfinder.census.gov

Methods

The statistical methods used in this report are primarily descriptive. Statistics presented consist of:

Life Expectancy

Life expectancy estimates were based on county and state mortality data for selected years of 1993 to 2004 using the abridged life table method. 5-year age groupings of both population and mortality rate inputs, as opposed to single-year age breakdowns, were adopted because of their compatibility with the age breakdowns of available vital statistics. Data were aggregated for 1993 to 1994, 1998 to 1999, and 2003 to 2004 to improve the accuracy of estimates.

Crude Incidence Rate (cases per 100,000 per year)

For communicable diseases county population estimates were used as the denominator for calculations of annual crude incidence rates at the county level and the number of cases reported as the numerator. For aforementioned reasons, rates calculated this way are by nature approximations of disease occurrence and are often deflated due to underestimation of cases in the 'real world' and total population being used as the denominator instead of the theoretical population at risk, which is difficult to define and may vary with disease.

Reportable diseases vary by state and across time, making it even harder to obtain denominators for rate calculations at the national level. For this reason disease rates at the national level were not calculated. Instead national rates from aforementioned data sources were used. For most of the reportable diseases included in MMWRs however, incidence rates were based on the same practice using the national resident population as the denominator and the number of cases reported nationally as the numerator. Measures have been taken to correct errors found in the national rates for years where comparisons between county and national rates were made.

Age standardization (see following section) was not adopted in the calculation of county level communicable disease incidence rates. Given the county's relatively small population and low occurrence of many communicable diseases, age specific rates (see following section) were often suppressed due to reliability considerations (see following section), making age standardization unfeasible. For the same reason standardization by other demographic variables was also not adopted.

Age, Gender, Ethnicity, Race/Ethnicity Specific Rate (cases per 100,000 per year)

Rates by demographic subgroups at the county level were calculated using aggregated data from 2000 to 2004 to obtain steady rates and to reduce confidentiality risks (see following section). Demographic specific rates are used for comparing rates across demographic subgroups as crude or standardized rates tend to mask important subgroup differences. Comparisons of county rates with 2004 national rates by demographic subgroups were made if data were available. Aggregation of national data was not attempted since obtaining denominators for those reportable diseases which vary by state and across time is not feasible.

Age-Adjusted Rate (Age Standardization)

Age adjustment or standardization is the application of the age-specific rates in a population of interest to a standardized age distribution in order to eliminate the differences in observed rates that result from age differences in the populations being compared. This adjustment is usually done when comparing two or more populations at one point in time or one population at two or more points in time. In this report age adjustment was not adopted in the calculation of communicable disease rates for aforementioned reasons. However, for certain mortality statistics in this report, age-adjusted rates were adopted where applicable to facilitate comparisons across time and geographic areas. For example, this report made use of the Nevada Interactive Health Database System (NIHDS) and CDC WONDER online database to provide death rates by cause of death, where rates were age-adjusted to the Census 2000 US population distribution. The closing date for vital records adopted by NIHDS is far earlier than that by CDC WONDER. Also State Demographer's population estimates were used instead of Census 2000 estimates in calculating age-specific rates by NIHDS, and slightly different age groupings were used by NIHDS than those used by CDC WONDER. Therefore the age-adjusted rates calculated by NIHDS might not be entirely comparable with those provided by CDC WONDER database. Data cautions were provided in such situations.

Confidence Interval

When estimates are based on a small number of events such as the occurrence of many communicable diseases, Poisson approximation to infrequent events is appropriate and often recommended. In this report Poisson confidence intervals were calculated for communicable disease rates where applicable. As a measure of sampling variability, confidence interval calculation is appropriate even when rates are based on population data. This method of calculation is appropriate since all incidence rates for diseases or mortality are based on population estimates and are by their very nature estimates of population parameters. Despite best efforts, population parameters such as the entire county population and exact occurrence of diseases are never obtainable. The accuracy of calculated rates should therefore be properly estimated by confidence intervals. The majority of confidence intervals are presented graphically in this report. While not equivalent to a formal test of statistical significance, rates are considered to be significantly different if the confidence intervals do not overlap.

Of note is that the confidence intervals calculated using BRFSS data do not presume distributions of population parameters. It is a design-based estimation as compared to the model-based approach in the communicable diseases section. They were calculated using standardized SAS procedures and taking into account the weighting of complex survey designs.

Reliability and Confidentiality Issues

The issue of reliability arises when rates and percentages have small numerators. In general, rates based on large numbers provide stable estimates of the population parameter, that is, the true, underlying rate. Conversely, rates based on small numbers may fluctuate dramatically from year to year, or differ considerably across areas and demographic groups, even when there is no meaningful difference. Although provision of confidence intervals helps ensure such small differences will not be exaggerated, as confidence intervals based on small numerators tend to be wider and are more likely to overlap, data suppression has been adopted using five cases as the numerator threshold in rate and percentage calculations for communicable diseases. It is also an appropriate threshold for data suppression due to confidentiality concerns. Typically the risk of confidentiality breach increases when data are tabulated for small subgroups of the population, and data suppression has been recommended when the population size represented in each cell, namely the denominator, becomes smaller than a predefined threshold. In addition, a small count of cases or events, namely the numerator, also poses a risk of violating confidentiality. In this report, confidentiality risk due to small numerator size has been the primary motivation for establishing the confidentiality threshold for data suppression.

Of note is that the above mentioned data suppression techniques apply to population data such as those used in the communicable diseases section, not to survey data based on a proportion of the population such as BRFSS.

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An Overview of Socio-Economic Context & Population Health

Background

It is a major goal of this report to improve public knowledge and understanding of disease prevention and health promotion. There are many factors that contribute to the formidable task of improving our community health, including the growth and diversity of our population, the continued threat of infectious diseases, chronic diseases and conditions, the many people without adequate access to health care, and so forth. Such challenges and associated health issues are presented in the overview of socio-economic context and population health section in this report. Trends and patterns of selected communicable diseases are summarized in the remaining sections.

Key Findings

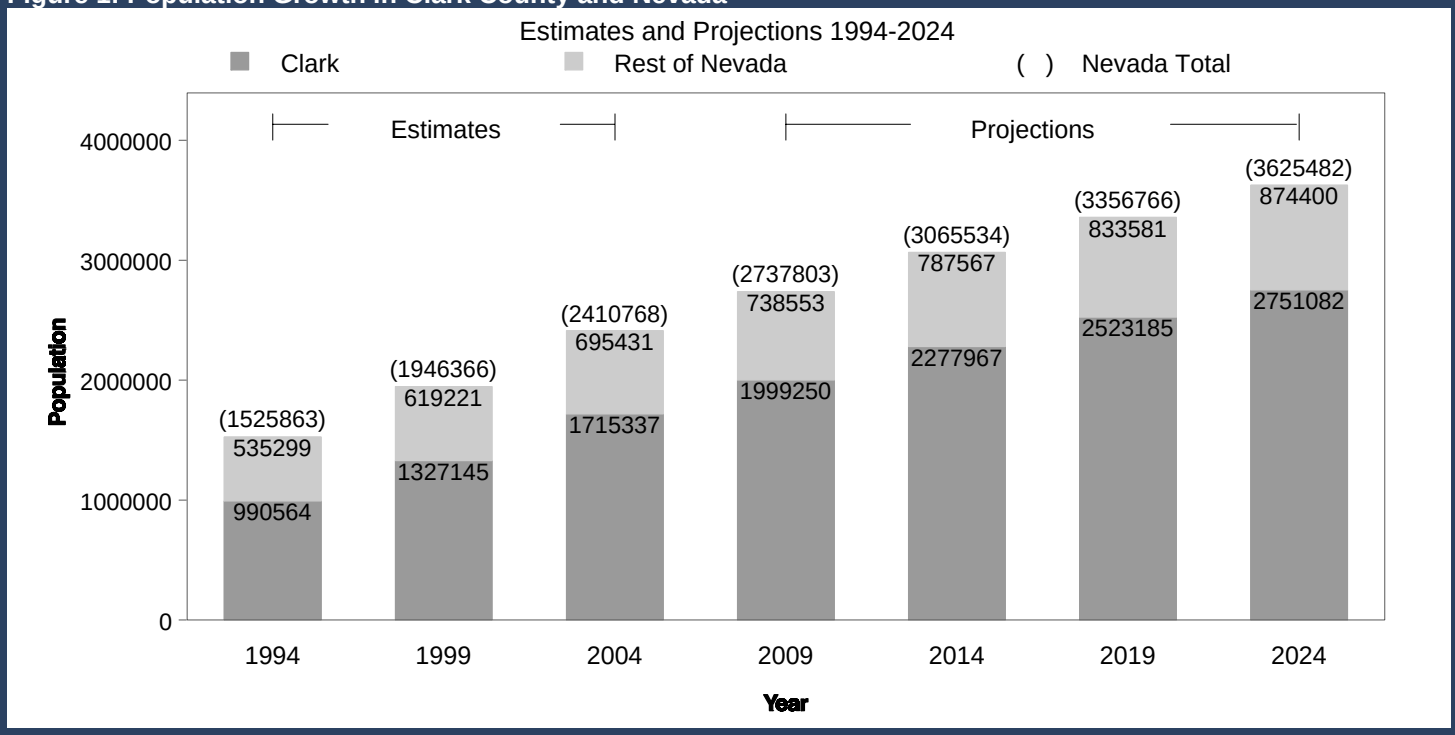
- The estimated percentage of county residents reporting they lack any health insurance coverage is higher than the national median.
- County residents self-report poorer health status than the rest of the nation.
- Infant mortality rates and the percentage of low birth weight babies are highest among Non-Hispanic Blacks.
- County residents have lower life expectancies than Americans in general, with Non-Hispanic Blacks having the lowest life expectancy. In 2003-2004, life expectancy at birth for county residents was 76.7 years, an increase of 1.9 years over the life expectancy of 74.8 years in 1993-1994.
- Seven out of the top fifteen leading causes of death in the county are chronic diseases and conditions. These diseases and conditions account for more than 60% of all deaths among county residents.
- Age-adjusted death rates for cancer, chronic lower respiratory disease, and chronic liver disease and cirrhosis are consistently higher in the county than in the nation.

Population

The population of Clark County has increased more than 70 percent between 1994 and 2004, and is projected to reach more than 2.7 million in 2024. As of 2004 Clark County comprised 71 percent of the population in Nevada. An increasing representation of the state's population is projected for the next two decades (Figure 1).

An estimated 7.2 percent of people 1 year and older in Clark County lived in a different state 1 year ago, making Clark the most popular county for relocation in the nation. In terms of nativity, Nevada ranked last nationally with an estimated 28.1 percent of the native population born in their state of residence (2004 American Community Survey).

Figure 1: Population Growth in Clark County and Nevada



Source: State Demographer's population estimates and projections as of July 2005 with 2000 prior estimates based on Census 2000 for 1994 and 1999.

Demographic Characteristics

The age-gender distribution of the county population has remained relatively stable for the past decade and is projected to stay essentially unchanged in the next two decades. The percentage of adults aged 40 to 64 years has increased slightly from 28.3 to 30.6 between 1994 and 2004, whereas there has been a decrease in percentage from 25.8 to 22.9 for adults aged 25 to 39 years. As of 2004 the male population exceeded that of female in age groups of one year and older until age 65, at which time women began to outnumber men (Figure 2).

The racial and ethnic composition has shifted more remarkably in Clark County between 1994 and 2004. During the time period, the percentage of the Hispanic population increased from 16.2 to 25, that of the Non-Hispanic Asian/Pacific Islander population increased from 4.8 to 7.1, whereas the percentage of the non-Hispanic White population decreased from 68.5 to 58.1, and that of the Non-Hispanic Black population decreased from 9.7 to 9.1. The percentage of the non-Hispanic Native American population has remained essentially unchanged for the same period. By 2040 the Hispanic population is projected to represent 34.1 percent of the county population, and the non-Hispanic White population 48.2 percent (Figure 3).

Figure 2: County Population by Age and Gender (Percent)

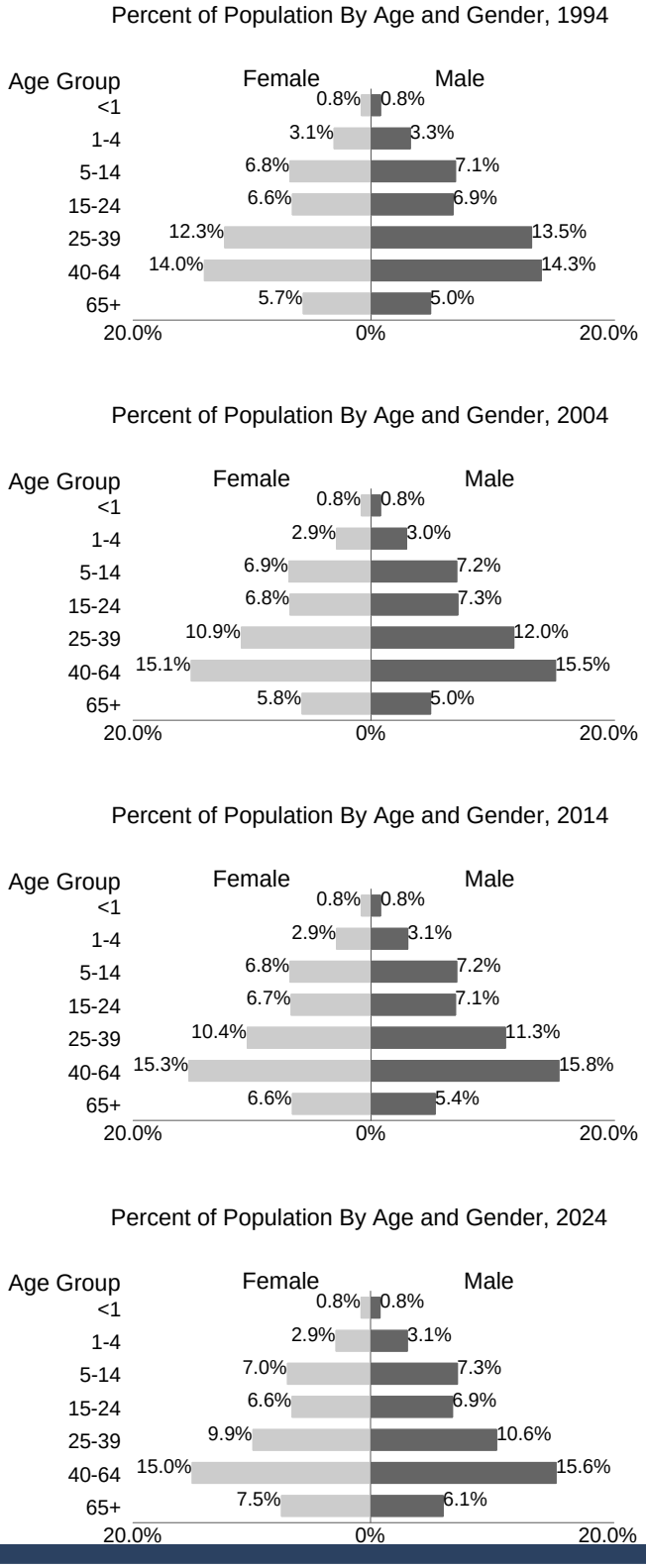
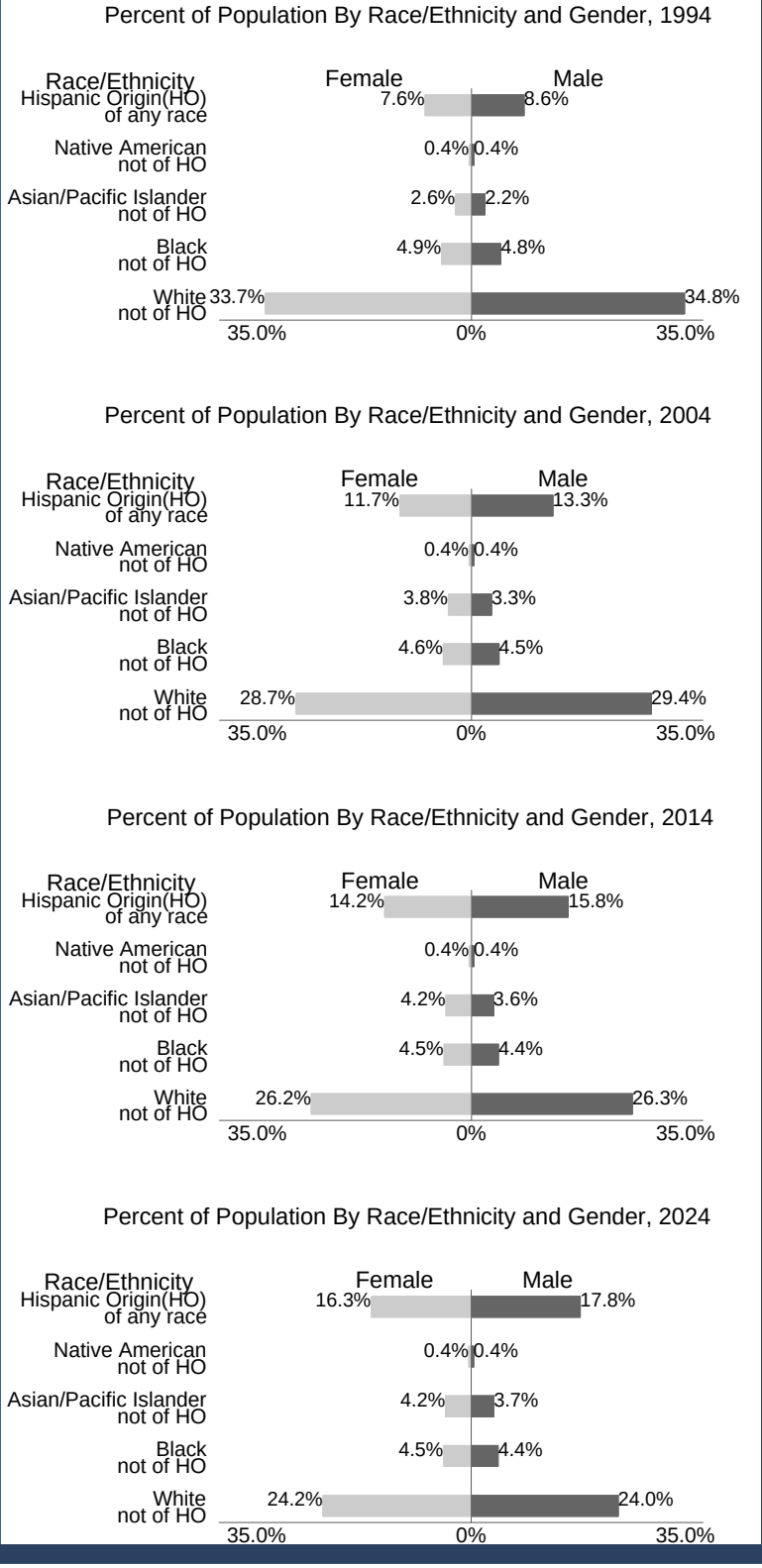


Figure 3: County Population by Race/Ethnicity and Gender (Percent)



Source: State Demographer's population estimates and projections as of July 2005 with 1994 estimates based on Census 2000.

Socio-Economic Characteristics

Since Clark County accounts for more than 70% of the state's population, the county's socio-economic profile is similar to the state. A downward trend in percent unemployed in civilian labor force was indicated in both

the county and state in 2002-04. The median and mean household incomes of county residents were similar to those of the state and nation. Both the county and state were slightly below the national average of per capita income. In 2004, 12.7% of the county population lived below poverty level, compared to 13.1% in the nation. The percentage of high school graduates or higher in Clark County was similar to that of Nevada, yet significantly below the national level in 2003-04. Both the county and state lagged significantly behind the nation for receipts of a college bachelor's or advanced degree (Table 1).

Table 1: Selected Socio-Economic Status Indicators

		2002	2003	2004
Employment				
Population in labor force	CC	759,291 (744,159~774,423)	793,469 (779,244~807,694)	829,763 (815,961~843,565)
	NV	1,087,663 (1,070,364~1,104,962)	1,134,732 (1,117,060~1,152,404)	1,177,175 (1,157,444~1,196,906)
	US	142,954,724 (142,697,895~143,211,553)	144,022,380 (143,804,029~144,240,731)	145,437,824 (145,239,499~145,636,149)
Employed in civilian labor force (CLF)	CC	688,351 (672,201~704,501)	729,542 (715,840~743,244)	769,119 (753,379~784,859)
	NV	996,084 (977,865~1,014,303)	1,043,195 (1,023,986~1,062,404)	1,090,563 (1,070,683~1,110,443)
	US	131,659,263 (131,372,767~131,945,759)	132,422,387 (132,198,493~132,646,281)	134,259,460 (134,022,806~134,496,114)
Percent (%) unemployed in CLF	CC	8.7 (7.7~9.7)	7.7 (6.7~8.6)	6.7 (5.7~7.7)
	NV	7.8 (7.0~8.6)	7.6 (6.8~8.4)	6.7 (5.9~7.5)
	US	7.4 (7.2~7.6)	7.6 (7.6~7.7)	7.2 (7.1~7.3)
Income				
Median household income ($)	CC	43,765 (41,856~45,674)	45,605 (43,952~47,258)	44,281 (42,458~46,104)
	NV	43,928 (42,002~45,854)	45,395 (43,901~46,889)	44,646 (42,935~46,357)
	US	43,057 (42,836~43,278)	43,564 (43,336~43,792)	44,684 (44,470~44,898)
Mean household income ($)	CC	56,396 (54,383~58,409)	58,477 (56,403~60,552)	60,318 (57,565~63,071)
	NV	56,456 (54,361~58,552)	58,307 (56,366~60,248)	59,825 (57,761~61,889)
	US	57,208 (56,987~57,429)	58,036 (57,827~58,245)	60,070 (59,830~60,310)
Per capita income ($)	CC	22,354 (21,605~23,103)	22,584 (21,852~23,316)	23,805 (22,791~24,819)
	NV	22,419 (21,662~23,176)	22,830 (22,184~23,476)	23,938 (23,152~24,724)
	US	22,759 (22,677~22,842)	23,110 (23,030~23,190)	24,020 (23,929~24,111)
Poverty				
People below poverty in past 12 months (%)	CC	12.4 (10.8~14.1)	11.6 (10.1~13.2)	12.7 (11.0~14.4)
	NV	11.8 (10.6~13.0)	11.5 (10.4~12.6)	12.6 (11.1~14.1)
	US	12.4 (12.2~12.6)	12.7 (12.6~12.9)	13.1 (12.9~13.3)
Education				
High school graduate or higher (%)	CC	81.7 (80.2~83.2)	80.5 (79.2~81.9)	82.1 (81.1~83.1)
	NV	83.0 (82.0~84.0)	82.1 (81.0~83.1)	83.0 (82.2~83.8)
	US	82.6 (82.3~82.9)	83.6 (83.5~83.8)	83.9 (83.8~84.0)
Bachelor's degree or higher (%)	CC	17.7 (16.4~19.0)	18.4 (17.2~19.6)	18.4 (17.3~19.5)
	NV	18.6 (17.6~19.6)	19.5 (18.3~20.7)	19.3 (18.2~20.4)
	US	25.9 (25.6~26.2)	26.5 (26.3~26.7)	27.0 (26.8~27.2)

Source: U.S. Census Bureau, American Community Survey (not available at county level until 2002).
Note: Numbers are estimates with 90% confidence intervals in parentheses.

Health Care Coverage

The percentage of people in both the county and state regarding themselves as lacking any health care coverage has been hovering above the national medians between 2000 and 2004. For most years this percentage has been slightly lower for the county than for the state (Table 2).

Table 2: Self-Assessed Health Insurance Coverage among Adults 18 Years and Older

		2000	2001	2002	2003	2004
Currently lacking any health care coverage (%)	CC	12.9 (10.2~15.7)	18.9 (15.2~22.6)	20.6 (17.1~24.0)	19.1 (16.0~22.2)	19.5 (16.3~22.7)
	NV	13.6 (11.6~15.6)	17.5 (14.9~20.1)	22.4 (20.0~24.9)	20.5 (18.2~22.8)	21.6 (19.3~24.0)
	US	11.8	13.3	14.1	14.5	14.9

Source: Behavioral Risk Factors Surveillance System (BRFSS).
Note: For Clark County and Nevada numbers are estimates with 95% confidence intervals in parentheses. For U.S., numbers are median percentages among participating states.

General Health of Individuals

Between 2000 and 2004 county residents' self-assessed health status was similar to that of Nevada. Both the county and state lagged behind the nation in the percent of people reporting good/better health. Likewise the percent reporting fair/poor health in Clark and Nevada exceeded national medians (Table 3).

Table 3: Self-Assessed Health Status among Adults 18 Years and Older

		2000	2001	2002	2003	2004
Good or better health (%)	CC	82.8 (79.2~86.4)	86.7 (84.2~89.2)	83.5 (80.7~86.2)	82.9 (80.1~85.7)	81.9 (79.0~84.8)
	NV	84.2 (81.7~86.8)	86.4 (84.6~88.2)	82.8 (80.8~84.8)	82.5 (80.4~84.6)	81.9 (79.8~84.0)
	US	N/A	N/A	85.2	85.0	84.8
Fair or poor health (%)	CC	17.2 (13.6~20.8)	13.3 (10.7~15.8)	16.5 (13.8~19.3)	17.1 (14.3~19.9)	18.1 (15.2~21.0)
	NV	15.8 (13.2~18.3)	13.6 (11.8~15.4)	17.2 (15.2~19.2)	17.5 (15.4~19.6)	18.1 (16.0~20.2)
	US	N/A	N/A	14.8	15.0	15.1

Source & Note: Same as in Table 2.

Maternal and Infant Health

Live Births and First Trimester Prenatal Care

For each of the selected racial/ethnic groups, the percentage of births with prenatal care beginning in first trimester (PCB1T) in both Clark County and Nevada was substantially below the national level between 1999 and 2004 (Table 4). Hispanic mothers were least likely to enter prenatal care in the first trimester among the selected racial/ethnic groups in both the county and state, whereas Blacks not of Hispanic origin experienced the lowest percent births with PCB1T in the nation (Figure 4).

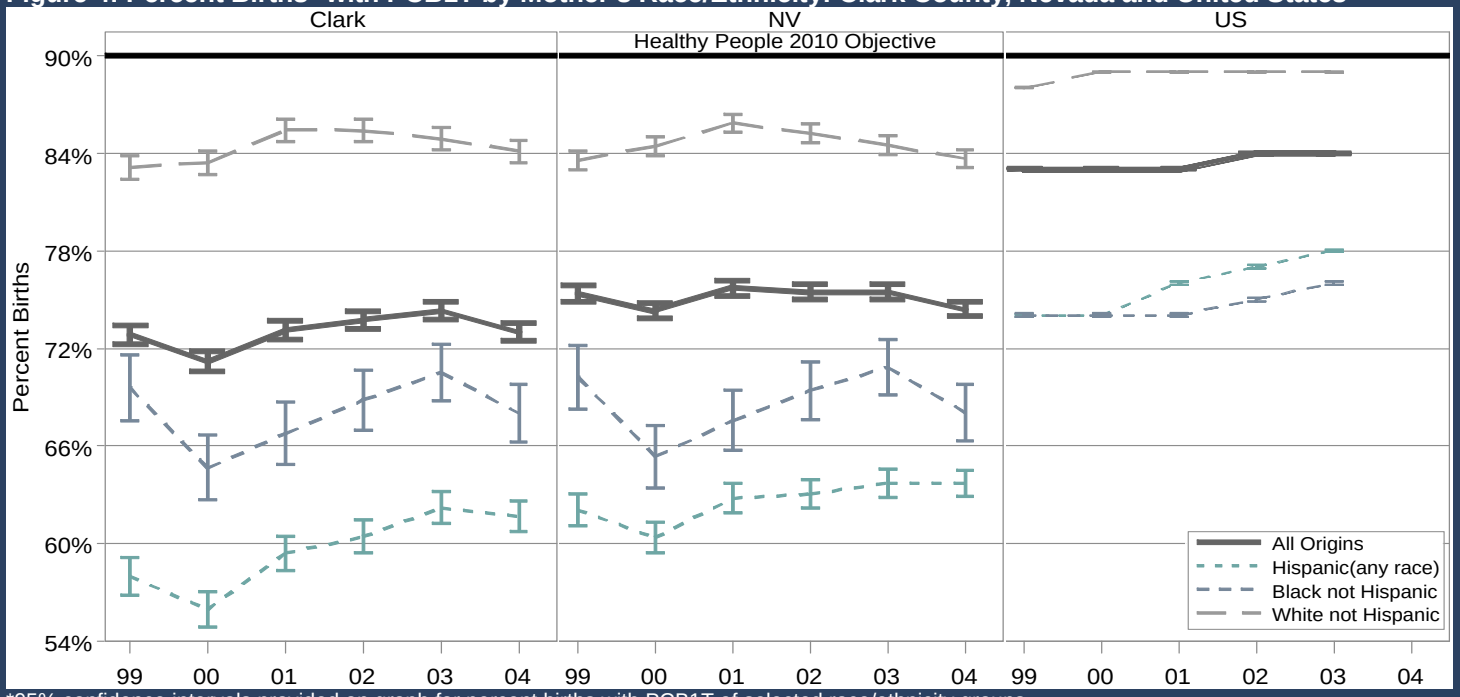
Table 4: Number of Live Births and Percent Births with Prenatal Care Beginning in 1st Trimester (PCB1T) by Mother's Race/Ethnicity for Selected Racial/Ethnic Groups: Clark County, Nevada and United States

	Clark								NV								US							
	All Origins*		Hispanic, Any Race		Black Not Hispanic		White Not Hispanic		All Origins*		Hispanic, Any Race		Black Not Hispanic		White Not Hispanic		All Origins*		Hispanic, Any Race		Black Not Hispanic		White Not Hispanic	
'99	20806	73%	7084	58%	1947	70%	10002	83%	28911	75%	9153	62%	2077	70%	15244	84%	3959417	83%	764339	74%	588981	74%	2346450	88%
'00	21970	71%	7843	56%	2148	65%	10072	83%	30130	74%	10007	60%	2255	65%	15303	84%	4058814	83%	815868	74%	604346	74%	2362968	89%
'01	22861	73%	8472	59%	2261	67%	9972	85%	31297	76%	10831	63%	2389	68%	15264	86%	4025933	83%	851851	76%	589917	74%	2326578	89%
'02	23756	74%	8851	60%	2383	69%	10144	85%	32423	75%	11340	63%	2512	69%	15337	85%	4021726	84%	876642	77%	578335	75%	2298156	89%
'03	24766	74%	9612	62%	2578	71%	10248	85%	33605	75%	12192	64%	2732	71%	15541	85%	4089950	84%	912329	78%	576033	76%	2321904	89%
'04	26122	73%	10395	62%	2621	68%	10592	84%	35147	74%	13037	64%	2787	68%	15992	84%	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A

*Includes origins other than the selected racial/ethnic groups.

Source: For Clark County and Nevada, number and percentages were based on vital statistics of selected years from Nevada State Health Division, Bureau of Health Planning & Statistics; National statistics were from National Vital Statistics reports.
Note: Births of unspecified prenatal care status in the county and state are prorated according to the distribution of births of known prenatal care status.

Figure 4: Percent Births* with PCB1T by Mother's Race/Ethnicity: Clark County, Nevada and United States



*95% confidence intervals provided on graph for percent births with PCB1T of selected race/ethnicity groups.

Live Births of Low and Very Low Birth Weight

In Clark County and Nevada, the percentages of live births with low birth weight (LBW) and very low birth weight (VLBW) were substantially higher for Blacks not of Hispanic origin than other selected racial/ethnic groups between 1999 to 2004 (Table 5). Similar patterns have been observed nationally (Figure 5).

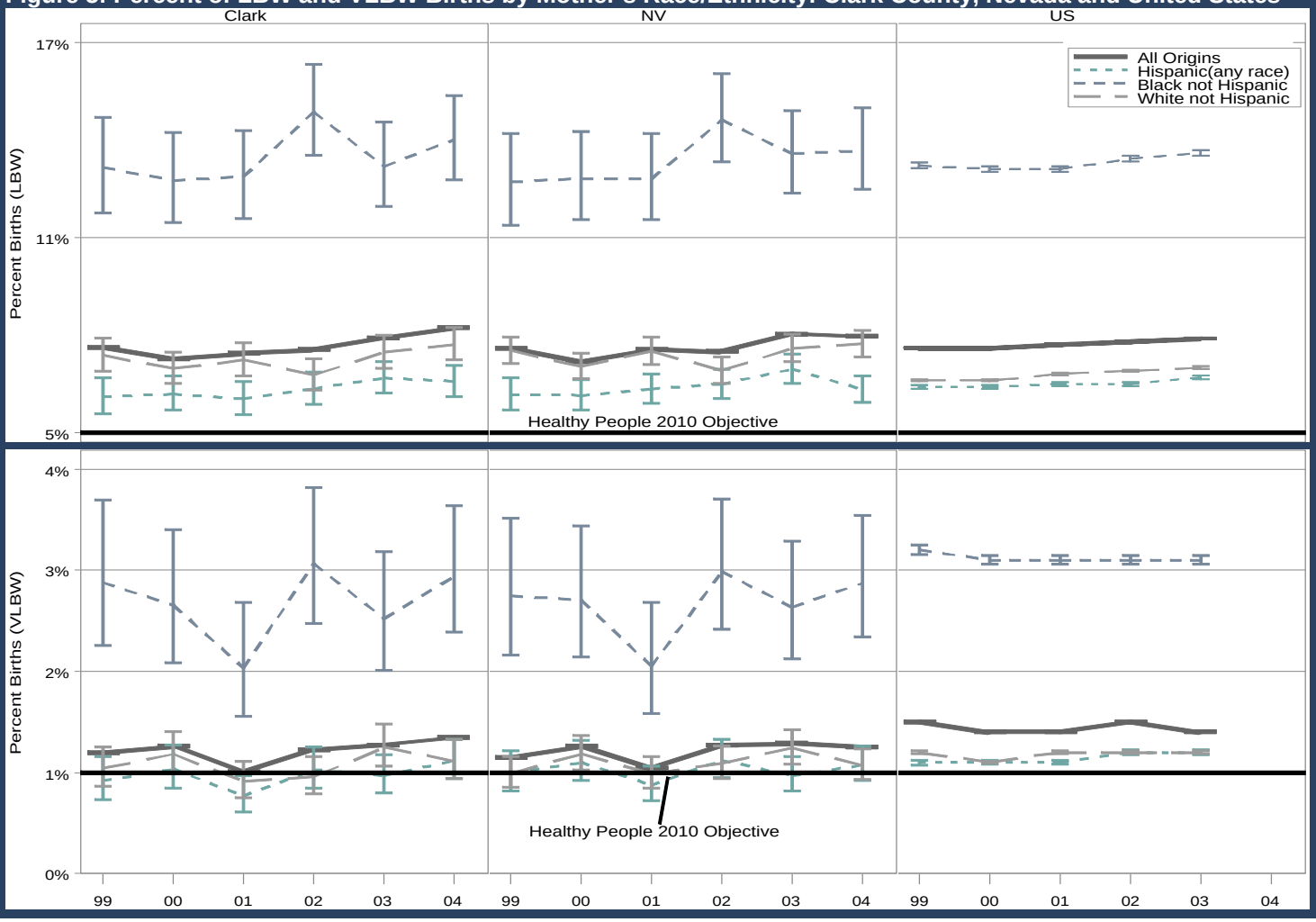
Table 5: Number (Num) and Percent (Pct) of Low Birth Weight (LBW)[1] Births and Very LBW (VLBW)[2] Births by Mother's Race/Ethnicity: Clark County, Nevada and United States

		Clark								NV								US							
		All Origins*		Hispanic, Any Race		Black Not Hispanic		White Not Hispanic		All Origins*		Hispanic, Any Race		Black Not Hispanic		White Not Hispanic		All Origins*		Hispanic, Any Race		Black Not Hispanic		White Not Hispanic	
		Num	Pct	Num	Pct	Num	Pct	Num	Pct	Num	Pct	Num	Pct	Num	Pct	Num	Pct	Num	Pct	Num	Pct	Num	Pct	Num	Pct
LBW	'99	1585	7.6	433	6.1	256	13.1	739	7.4	2196	7.6	566	6.2	264	12.7	1148	7.5	300916	7.6	48918	6.4	77745	13.2	154866	6.6
	'00	1600	7.3	486	6.2	274	12.8	703	7	2170	7.2	616	6.2	289	12.8	1078	7	308470	7.6	52216	6.4	79169	13.1	155956	6.6
	'01	1703	7.4	512	6	291	12.9	722	7.2	2371	7.6	688	6.4	306	12.8	1146	7.5	309997	7.7	55370	6.5	77279	13.1	158207	6.8
	'02	1796	7.6	563	6.4	354	14.9	687	6.8	2436	7.5	737	6.5	367	14.6	1061	6.9	313695	7.8	56982	6.5	77497	13.4	158573	6.9
	'03	1963	7.9	643	6.7	340	13.2	767	7.5	2704	8	849	7	371	13.6	1181	7.6	323106	7.9	61126	6.7	78340	13.6	162533	7
	'04	2150	8.2	684	6.6	367	14	818	7.7	2799	8	826	6.3	381	13.7	1236	7.7	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
VLBW	'99	249	1.2	65	0.9	56	2.9	104	1	333	1.2	91	1	57	2.7	151	1	59391	1.5	8408	1.1	18847	3.2	28157	1.2
	'00	277	1.3	81	1	57	2.7	119	1.2	380	1.3	110	1.1	61	2.7	181	1.2	56823	1.4	8975	1.1	18735	3.1	25993	1.1
	'01	230	1	65	0.8	46	2	91	0.9	328	1	95	0.9	49	2.1	151	1	56363	1.4	9370	1.1	18287	3.1	27919	1.2
	'02	291	1.2	91	1	73	3.1	97	1	411	1.3	127	1.1	75	3	167	1.1	60326	1.5	10520	1.2	17928	3.1	27578	1.2
	'03	316	1.3	93	1	65	2.5	128	1.2	432	1.3	118	1	72	2.6	193	1.2	57259	1.4	10948	1.2	17857	3.1	27863	1.2
	'04	353	1.4	116	1.1	77	2.9	118	1.1	441	1.3	140	1.1	80	2.9	171	1.1	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A

[1]Birth weight of less than 2,500 grams (5 lb 8 oz). [2]Birth weight of less than 1,500 grams (3 lb 4 oz).
*Includes origins other than the selected racial/ethnic groups.

Source: Same as in Table 4.

Figure 5: Percent of LBW and VLBW Births by Mother's Race/Ethnicity: Clark County, Nevada and United States



Infant Mortality

Little change has occurred in the infant mortality rate (per 1,000 live births) in both Clark County and Nevada between 1999 and 2004 (Table & Figure 6). For most years the county and state had lower infant mortality rates (IMR) than the nation. In both the county and state, Blacks not of Hispanic origin experienced significantly higher IMR than the other selected racial/ethnic groups, whereas Hispanics had lowest IMR among the selected groups in recent years. Similar patterns have been observed nationally.

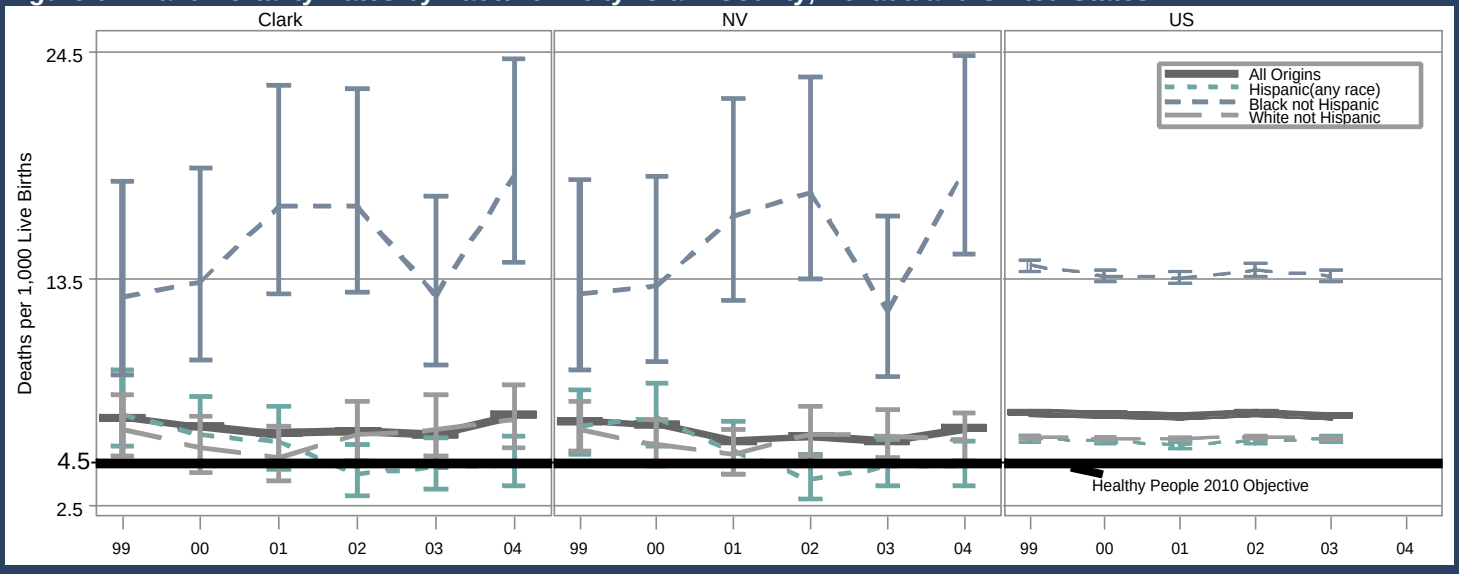
Table 6: Number of Infant Deaths (Num) and Infant Mortality Rates (IMR) per 1,000 live births by Selected Characteristics and Race/Ethnicity: Clark County, Nevada and United States

		Clark								NV								US							
		All Origins*		Hispanic Any Race		Black Not Hispanic		White Not Hispanic		All Origins*		Hispanic Any Race		Black Not Hispanic		White Not Hispanic		All Origins*		Hispanic Any Race		Black Not Hispanic		White Not Hispanic	
		Num	IMR	Num	IMR	Num	IMR	Num	IMR	Num	IMR	Num	IMR	Num	IMR	Num	IMR	Num	IMR	Num	IMR	Num	IMR	Num	IMR
Neonatal	'99	81	3.89	33	4.57	14	7.05	34	3.33	113	3.91	40	4.3	15	7.1	54	3.48	18609	4.7	2981	3.9	5654	9.6	8917	3.8
	'00	85	3.87	32	4.03	12	5.52	37	3.63	121	4.02	44	4.35	13	5.71	57	3.69	18671	4.6	3100	3.8	5560	9.2	8979	3.8
	'01	73	3.19	26	3.03	22	9.59	25	2.47	92	2.94	31	2.83	22	9.1	39	2.52	18117	4.5	3067	3.6	5309	9	8841	3.8
	'02	91	3.83	22	2.45	25	10.36	40	3.89	120	3.7	28	2.43	27	10.59	59	3.79	18902	4.7	3331	3.8	5379	9.3	8963	3.9
	'03	88	3.55	23	2.37	19	7.3	40	3.86	115	3.42	31	2.52	19	6.88	58	3.69	18814	4.6	3558	3.9	5357	9.3	8823	3.8
	'04	121	4.63	29	2.76	31	11.72	52	4.86	147	4.18	38	2.89	33	11.73	66	4.09	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Post-neonatal	'99	60	2.88	17	2.35	11	5.54	29	2.84	78	2.7	19	2.04	12	5.68	42	2.71	9107	2.3	1376	1.8	2709	4.6	4458	1.9
	'00	54	2.46	15	1.89	17	7.82	17	1.67	73	2.42	24	2.37	17	7.46	27	1.75	9335	2.3	1469	1.8	2659	4.4	4490	1.9
	'01	64	2.8	22	2.56	17	7.41	24	2.37	85	2.72	25	2.28	18	7.44	38	2.46	9260	2.3	1533	1.8	2655	4.5	4420	1.9
	'02	54	2.27	14	1.56	16	6.63	21	2.04	70	2.16	15	1.3	18	7.06	34	2.18	9250	2.3	1578	1.8	2660	4.6	4366	1.9
	'03	59	2.38	19	1.96	14	5.38	24	2.32	74	2.2	23	1.87	14	5.07	34	2.16	8998	2.2	1551	1.7	2477	4.3	4412	1.9
	'04	59	2.26	18	1.72	18	6.8	19	1.78	72	2.05	20	1.52	20	7.11	26	1.61	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Total	'99	141	6.78	50	6.92	25	12.59	63	6.18	191	6.61	59	6.34	27	12.79	96	6.19	27716	7	4357	5.7	8305	14.1	13609	5.8
	'00	139	6.33	47	5.92	29	13.35	54	5.3	194	6.44	68	6.73	30	13.17	84	5.43	28006	6.9	4569	5.6	8219	13.6	13469	5.7
	'01	137	5.99	48	5.58	39	17	49	4.84	177	5.66	56	5.11	40	16.54	77	4.98	27376	6.8	4600	5.4	7964	13.5	13261	5.7
	'02	145	6.1	36	4.02	41	16.99	61	5.94	190	5.86	43	3.74	45	17.65	93	5.97	28152	7	4909	5.6	8039	13.9	13329	5.8
	'03	147	5.94	42	4.33	33	12.67	64	6.18	189	5.62	54	4.38	33	11.95	92	5.86	27812	6.8	5200	5.7	7834	13.6	13235	5.7
	'04	180	6.89	47	4.48	49	18.52	71	6.64	219	6.23	58	4.41	53	18.83	92	5.7	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A

*Includes origins other than the selected racial/ethnic groups.

Source: Same as in Table 4.
Note: Births of unspecified racial/ethnic origin in the county and state are prorated according to the distribution of births of known racial/ethnic origin.

Figure 6: Infant Mortality Rates by Race/Ethnicity: Clark County, Nevada and United States

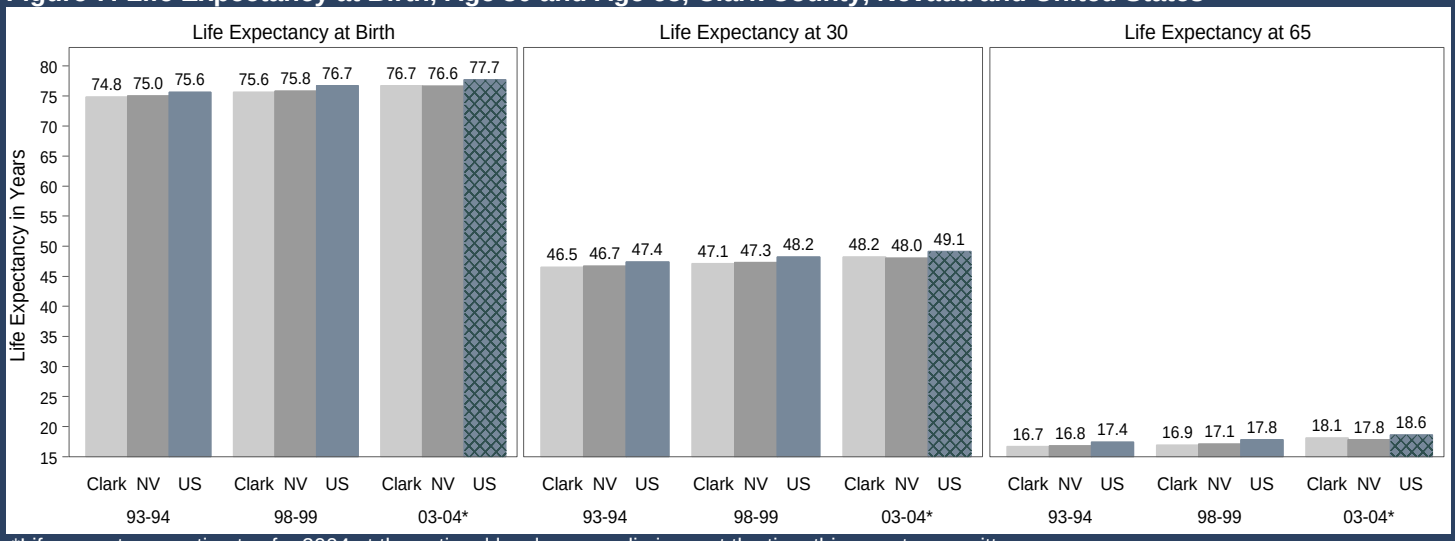


Life Expectancy

Generally defined as the number of years one would be expected to live if the current age-specific mortality

rates remain constant, life expectancy provides both a summary measure of population health status and of mortality. Life expectancy at birth, age 30, and 65 has improved gradually in the past decade in both the county and state. Clark was slightly behind the state in life expectancies at selected ages early in the decade. The trend reversed in 2003 to 2004. In 2003-04, life expectancy in Clark County at birth was 76.7 years, at age 30 48.2 years, and at age 65 18.1 years, slightly above the state level in all three measures. However, both the county and state were slightly below the national level of life expectancy at birth and selected ages (Figure 7). Of note is that the national estimates have been based on a slightly changed methodology since 1997 and are thus not completely comparable (National Vital Statistics Reports, 2005).

Figure 7: Life Expectancy at Birth, Age 30 and Age 65, Clark County, Nevada and United States



*Life expectancy estimates for 2004 at the national level were preliminary at the time this report was written.

Source: For Clark and Nevada, life expectancies were estimated using vital statistics of selected years from Nevada State Health Division, Bureau of Health Planning & Statistics; National life expectancy estimates were from National Vital Statistics reports (final for 2003 and prior, unavailable prior to 1993).

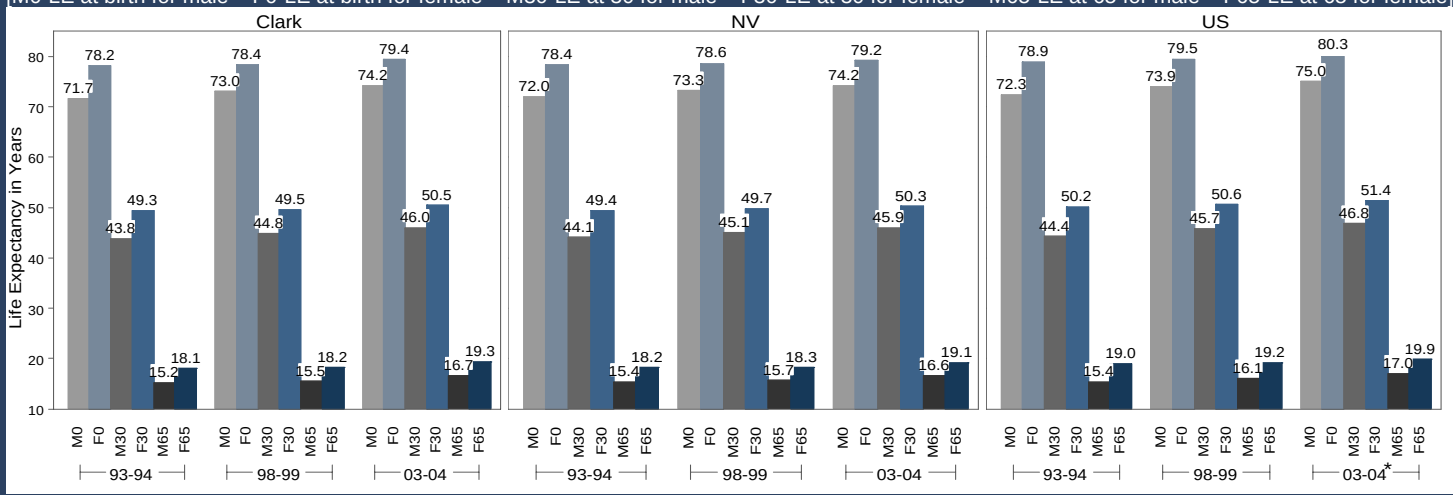
Note: Aggregation of population and death data of 1993-94, 1998-99 and 2003-04 were used in the estimation of county and state life expectancies to obtain steady estimates. Life expectancies at the national level were single year estimates averaged across the two year period.

Gender and Race/Ethnicity Variations

In 1993-94, life expectancy in Clark County at birth was 71.7 years for males and 78.2 years for females. Whereas a male could expect to live 74.2 years and a female 79.4 years in the 2003-04 period. The difference in male and female life expectancies slightly decreased during this period, from 6.5 years higher for females in 1993-94 to 5.2 years in 2003-04. In both the state and nation, the gender gap has also slightly declined during the period (Figure 8).

Figure 8: Life Expectancy (LE) by Gender at Birth, Age 30 and Age 65, Clark County, Nevada and United States

[M0-LE at birth for male F0-LE at birth for female M30-LE at 30 for male F30-LE at 30 for female M65-LE at 65 for male F65-LE at 65 for female]

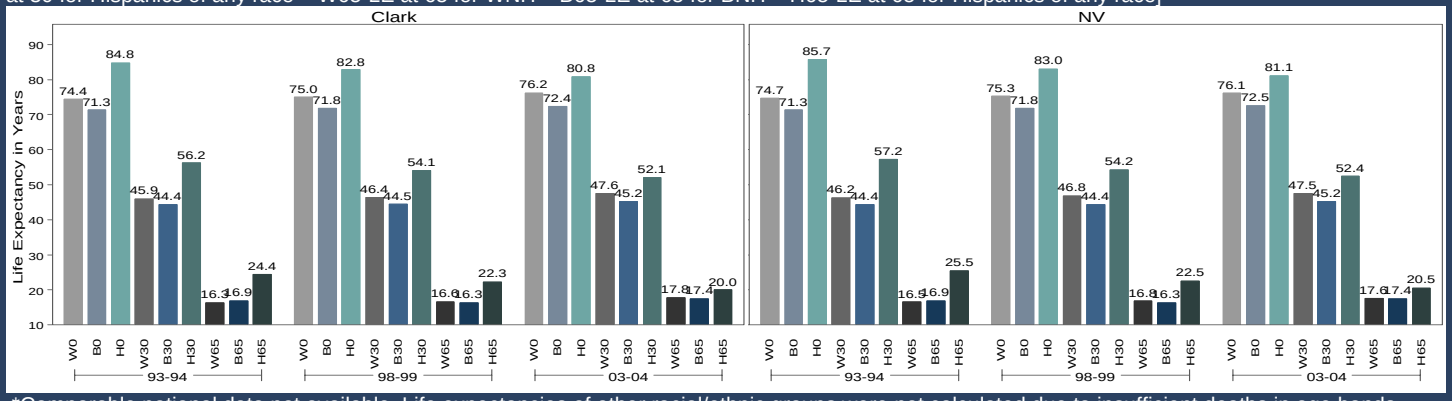


*Life expectancy estimates for 2004 at the national level were preliminary at the time this report was written.

Life expectancies at selected ages have been found to be higher for Hispanics than for non-Hispanic Whites (WNH) or Blacks (BNH) in selected years, although the ethnicity differences have decreased over time (Figure 9). The higher than average life expectancy seen in Hispanics may be attributable to the 'healthy worker effect', defined as a phenomenon of workers exhibiting death rates lower than those of the general population due to the fact that the severely ill and disabled are ordinarily excluded from employment. The 'healthy worker effect' should be taken into consideration especially when evaluating the health of the Hispanic population in the United States, the majority of whom originate from migrant workers who must have at least a minimum level of health to hold a job, whereas the general population includes everyone healthy and sick. Such selection bias due to screening out the less healthy population very likely contributes to lower death rates and higher life expectancy estimates among Hispanics. The life expectancy for BNH has been consistently lower than other racial/ethnic groups in both the county and state. In Clark County, life expectancy for BNH newborns was 3.1 years less than that for WNH newborns in 1993-94. In 2003-04, the difference was 3.8 years. Nationwide, life expectancy at birth for Blacks of both Hispanic and non-Hispanic origin was estimated at 73.3 years based on preliminary 2004 national data, whereas 78.3 years for Whites of both Hispanic and non-Hispanic origin (National Vital Statistics Reports, 2006).

Figure 9: Life Expectancy (LE) for Whites not of Hispanic Origin (WNH), Blacks not of Hispanic Origin (BNH) and Hispanics of any race, at Birth, Age 30 and Age 65, Clark County and Nevada*

[W0-LE at birth for WNH B0-LE at birth for BNH H0-LE at birth for Hispanics of any race W30-LE at 30 for WNH B30-LE at 30 for BNH H30-LE at 30 for Hispanics of any race W65-LE at 65 for WNH B65-LE at 65 for BNH H65-LE at 65 for Hispanics of any race]



*Comparable national data not available. Life expectancies of other racial/ethnic groups were not calculated due to insufficient deaths in age bands.

Mortality

In 2000-02, age-adjusted death rates (AADR) for cancer, chronic lower respiratory disease and chronic liver disease and cirrhosis were higher in the county and state than in the nation, while AADR for diabetes and Alzheimer's disease were lower in the county and state than in the nation (Table 7). AADR for the seven chronic diseases were not significantly different between the county and state based on available data.

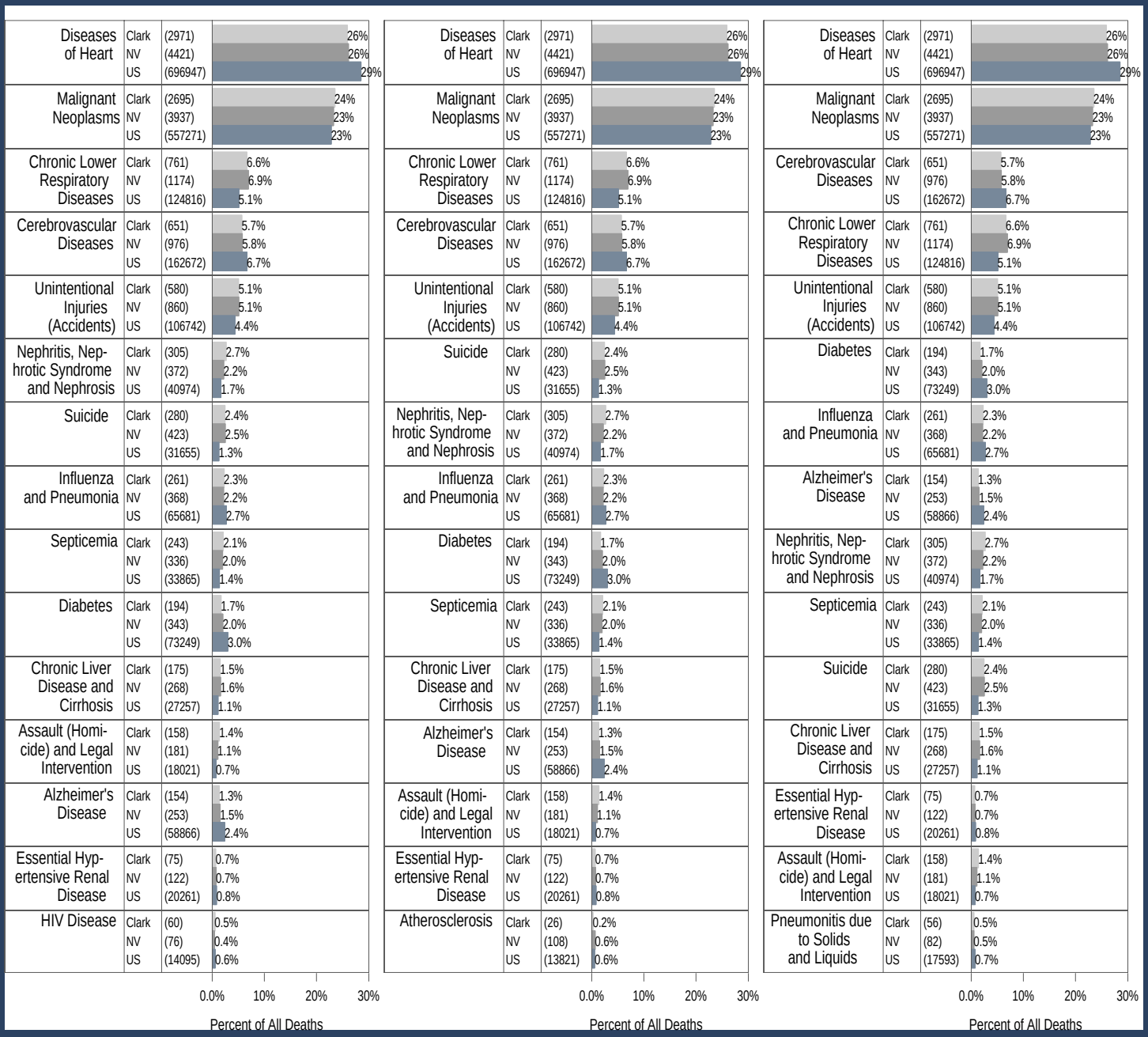
Table 7: Age-adjusted Death Rate (Deaths per 100,000 Population) by Selected Leading Cause of Death

		Diseases of Heart	Malignant Neoplasms (Cancer)	Chronic Lower Respiratory Diseases	Cerebrovascular Diseases (Stroke)	Diabetes	Chronic Liver Disease and Cirrhosis	Alzheimer's Disease
2000[1]	CC	256.1	216.3	60.4	58.2	14.3	15.0	11.8
	NV	255.3	213.6	61.3	56.5	15.4	14.8	14.5
	US	257.6	199.6	44.2	60.8	25.0	9.5	18.0
2001[1]	CC	258.8	208.9	60.3	57.2	15.3	14.2	13.2
	NV	256.6	205.9	65.5	55.0	17.6	14.5	14.6
	US	247.8	196.0	43.7	57.9	25.3	9.5	19.1
2002[1]	CC	245.9	205.2	64.1	56.6	14.4	12.0	16.1
	NV	246.0	202.6	65.6	56.9	17.6	12.5	16.8
	US	240.8	193.5	43.5	56.2	25.4	9.4	20.2
2003[2]	CC	233.2 (225.8~240.6)	194.3 (187.5~201.0)	58.2 (54.5~61.9)	55.6 (52.0~59.2)	13.6 (11.8~15.4)	9.9 (8.4~11.4)	18.3 (16.2~20.4)
	NV	240.1 (233.7~246.4)	195.7 (190.0~201.4)	61.8 (58.6~65.0)	56.4 (53.3~59.5)	14.8 (13.2~16.4)	11.4 (10.0~12.8)	19.4 (17.6~21.2)
2004[2]	CC	232.0 (224.8~239.2)	182.9 (176.5~189.3)	49.5 (46.1~52.8)	51.8 (48.4~55.2)	11.2 (9.7~12.8)	9.6 (8.2~11.1)	17.9 (15.9~19.9)
	NV	233.8 (227.7~239.9)	186.3 (180.8~191.7)	55.5 (52.6~58.5)	52.6 (49.7~55.5)	13.7 (12.2~15.2)	11.5 (10.2~12.9)	17.4 (15.7~19.0)

[1]Age-adjusted death rates (AADR) by disease as underlying cause of death from CDC WONDER online database (available up to 2002 as final data at the time this report was written). [2]AADR by disease as underlying cause of death with 95% confidence intervals in parentheses from Nevada State Health Division (NSHD). NSHD has a much earlier closing date for death records than the national database and uses different population estimates and age grouping from the national database in age-specific death rates calculations. As a result statistics from the two data sources are not entirely comparable.

Based on number of deaths, seven out of the fifteen leading causes of death in Clark County in 2002 were chronic diseases, including disease of heart, cancer or malignant neoplasms, chronic lower respiratory disease, cerebrovascular disease, diabetes, chronic liver disease and cirrhosis, and Alzheimer's disease (Figure 10). These chronic diseases accounted for 7,601 deaths, representing about 66 percent of all deaths among Clark County residents in 2002. A similar rank of causes of death was observed in the state in the same year. While chronic lower respiratory disease accounted for a higher number of deaths than cerebrovascular disease in both the county and state in 2002, the reverse was true nationwide.

Figure 10: Fifteen Leading Causes of Death as Percent of All Deaths in Clark County, Nevada and U.S., 2002*



*Percentages annotated on graphs with number of deaths by cause of death in parentheses.

Source: Number of deaths extracted from CDC WONDER online database available up to 2002 as final data at the time this report was written.
Note: Rank based on number of deaths.

Communicable Disease Report

Background

In Clark County, more than fifty communicable diseases and conditions are reportable pursuant to the Nevada Administrative Code (NAC) Chapter 441A, including unusual occurrences of illness and outbreaks of disease. Data collected during the investigation of these reports were compiled and analyzed to provide a picture of the health status of Clark County as it relates to infectious disease. This report provides Clark County data for the time period 2000-2004. It includes data summaries of selected reportable diseases in Clark County. We hope local data and knowledge can be used to identify emerging health issues, raise awareness of health status, and help guide health policy formation and community action.

Key Findings

- For most reportable diseases that are sexually transmitted, higher incidence rates are seen in Non-Hispanic Blacks than other racial/ethnic groups. Hepatitis A and pertussis rates are higher in Hispanics than non-Hispanics. Higher incidence rates are also observed among Hispanics than Non-Hispanics for amebiasis, campylobacteriosis, giardiasis, and shigellosis.
- Recent years saw a downward trend in the reported incidences of many vaccine preventable diseases such as *Haemophilus influenzae*, hepatitis A, measles, mumps, pertussis, rubella and meningococcal disease. In 2004, the incidence rates were significantly lower in the county than in the nation for hepatitis A, pertussis and meningococcal disease.
- Sexually transmitted diseases such as chlamydia, gonorrhea and primary and secondary syphilis showed significant increases between 2000 and 2004.
- The reported incidences of such enteric diseases as campylobacteriosis, giardiasis and salmonellosis decreased in recent years, with significantly lower rates in the county than in the nation. Slight increases were seen however, for shigellosis and *E. coli* O157:H7 infections.

Vaccine Preventable Diseases

Many diseases that were previously burdensome in Clark County and the United States are decreasing in incidence due to the availability of vaccines. For example, before 1963 when the first measles vaccines were licensed, approximately 500,000 cases of measles were reported annually in the United States[1]. In 2004, a total of 37 cases of measles were reported to the Centers for Disease Control and Prevention (CDC) by local and state health departments, accounting for an incidence of less than one case per million population[2]. Similar trends have been seen in Clark County for several vaccine-preventable diseases, including measles, mumps, rubella, polio, diphtheria and tetanus, each of which had a 5-year average of fewer than five cases per year during 2000-2004.

Although this trend of vaccine-preventable illnesses is encouraging, current immunization coverage in Nevada for pre-school-aged children falls below the corresponding Healthy People 2010 objective target. Healthy People 2010 Objective 14-24 is to "Increase the proportion of young children and adolescents who receive all vaccines that have been recommended for universal administration for at least 5 years". The target is that 80% of children aged 19-35 months will have received the recommended vaccines (4 DTaP, 3 polio, 1 MMR, 3 Hib and 3 Hepatitis B) by year 2010. In 2004, the estimated coverage in Nevada was only 68.4%, compared to 80.9% for the United States as a whole[3]. Children in Clark County are required to show evidence of vaccinations prior to entering school in accordance with Nevada Revised Statues; however it is the pre-school population that is falling behind in Nevada.

Rates of *Haemophilus influenzae* infection and meningococcal disease (infection with *Neisseria meningitidis*) decreased slightly in Clark County between 2002 and 2004, with 5-year averaged rates of 0.45 and 0.46 cases per 100,000 population respectively. Rates of meningococcal disease stayed below that of the Healthy People 2010 target of one case per 100,000 population.

Rates of hepatitis A decreased significantly from 2000-2004, reaching an historical low of 0.41 cases per 100,000 population in Clark County in 2004. The addition of hepatitis A vaccination to the Health Card program in 1999, as well as mandatory vaccination for students entering the school district after June 30, 2002 may have contributed to this decrease in hepatitis A levels, although nationwide rates of hepatitis A are also at historical lows. In both Clark County and the United States the incidence rate of hepatitis A was substantially higher in individuals of Hispanic origin versus those of non-Hispanic origin.

There was no significant difference in the rate of acute hepatitis B in Clark County through the report period. Males in both Clark County and the United States had a significantly higher incidence of hepatitis B infection than females, with white non-Hispanic males accounting for over 40% of cases in Clark County between 2000 and 2004. Individuals aged 25-39 years old had a substantially higher incidence than those in any other age group, according to both Clark County and US data.

There was a significant increase in influenza incidence between 2002 and 2003, which was matched by a significant decrease between 2003 and 2004. The 2003 influenza season started earlier and ended with a greater number of cases than other years within the report period, without explanation. The majority of cases were reported in winter and spring. The highest incidence rate occurred in infants younger than one year of age, followed by those aged 1-4 years old.

The local rate of pertussis increased between 2001 and 2002, with a slight decrease between 2002 and 2004. The national incidence rate of pertussis increased from 2001-2003, and was significantly higher than that reported in Nevada. Vaccine-induced immunity for pertussis wanes over time, and as such, adolescents and adults often lack immunity to the disease and can serve as a source of illness to un-immunized or under-immunized infants. The recent licensure of pertussis-containing vaccines for adolescents and adults may impact rates of the disease in the future. In 2000-2004, infants less than one year of age had a significantly higher incidence than any other age group in Clark County, which is consistent with United States data for 2003. These infants have usually not completed the pertussis vaccination series when they become infected. Individuals of Hispanic origin had a significantly higher incidence rate in Clark County than those of non-Hispanic origin.

Sexually Transmitted Diseases

The rate of chlamydia in Clark County increased significantly from 2000-2004. The incident rates were highest among those aged 15 to 24 years, and non-Hispanic blacks had the highest incidence rate among all racial/ethnic groups. The rate for females was significantly higher than that for males in both the county and the US.

The rate of gonorrhea in Clark County increased from 2002-2004, with similar age and race/ethnicity patterns to chlamydia in Clark County and the US.

An increase was also seen in the reported incidence of primary and secondary syphilis in Clark County between 2002 and 2004. Males had a significantly higher rate than females in Clark County and non-Hispanic blacks had a higher incidence than any other racial/ethnic groups. There was no statistically significant change in the incidence rate of early latent syphilis cases from 2000-2004.

From 2000 to 2004, 1289 HIV infections (16.67 cases per 100,000) and 1142 AIDS cases (14.7 cases per 100,000) were reported in Clark County. Men accounted for more than 80% of the reported HIV/AIDS cases. The incidence rate was highest among Non-Hispanic Blacks, and among those aged 25-39 years. Based on aggregated county data, the major routes of transmission were men having sex with men, heterosexual contacts and injecting drug use.

Enteric Diseases

The Southern Nevada Health District invests a great deal of time and resources into the investigation of enteric diseases, which are often associated with food and/or water sources, although person-to-person spread may also occur for some infections.

Rotavirus infection is the most common cause of severe gastroenteritis in infants and young children in the United States[4]. The 5-year averaged rate in Clark County 2000-2004 was 33.93 cases per 100,000 population. The number of cases reported is generally higher in the winter months in Clark County, with a gradual decrease from February through September. Although rotavirus is a notifiable illness in Nevada, only case counts are recorded, and each individual report is not investigated to the same extent as many other reportable illnesses are.

After rotavirus, the four most commonly reported and investigated enteric diseases in Clark County during 2000-2004 were salmonellosis, giardiasis, campylobacteriosis, and shigellosis, with 5-year averaged rates of these diseases being 9.40, 7.58, 7.25 and 4.04 cases per 100,000, respectively.

Although there was a downward trend in the reported incidence of campylobacteriosis in Clark County between 2001 and 2004, there was no statistically significant difference, and the local rate remained below the Healthy People 2010 target throughout the report period. Children in the age groups less than one year-old and 1-4 years-old had incidence rates that were significantly higher than all other age groups, and individuals of Hispanic origin had a higher incidence than those of non-Hispanic origin. No significant difference was seen in the incidence rates of males and females.

Clark County experienced a decrease in the rate of giardiasis from 2000-2004. Children aged 1-4 years-old had a significantly higher incidence rate than other age groups, and males had a higher incidence rate than females. This is consistent with what was seen nationwide in 2003. Individuals of Hispanic origin had a higher incidence than those of non-Hispanic origin in Clark County.

In 2003 and 2004, the rates of reported salmonellosis cases in Clark County were lower than in 2000-2002. Clark County also had significantly lower rates than the United States. Children under the age of one year had the highest incidence rate of all age groups in Clark County, followed by those aged 1-4 years. This was also true at the national level. No statistically significant differences were seen among the gender or racial/ethnic groups.

Between 2000 and 2001, there was a significant decrease in the rate of shigellosis in Clark County, with no significant changes subsequent to 2001. Local rates were significantly lower than those nationwide. Hispanics of any race had a significantly higher rate than those of non-Hispanic origin in both Clark County and nationwide. No significant difference was seen in incidence rates between males and females.

The 5-year averaged incidence rate was less than one case per 100,000 population in Clark County for both amebiasis and infection with *E. coli* O157:H7 (0.76 and 0.88 cases per 100,000 population, respectively). The reported incidence of amebiasis decreased from 2002 through 2004, although this difference was not

statistically significant. As with giardiasis, individuals of Hispanic origin had rates that were higher than those of Non-Hispanic origin during this period. There was an increase in the rate of *E. coli* O157:H7 infections from 2001-2004 in Clark County, however the difference was not statistically significant. Individuals of non-Hispanic origin had higher incidence rates of *E. coli* O157:H7 infection than those of Hispanic origin, in both Clark County and the United States. No significant difference in rates was seen between genders.

Other Reportable Diseases/Conditions

There was no statistically significant change in the incidence rate of coccidioidomycosis, also known as Valley Fever, from 2000-2004 in Clark County. Both local and national data show that individuals 65 years-old and older had the highest incidence rates of all age groups. There was no significant difference in incidence relative to race/ethnicity in Clark County. In both Clark County and US, males had higher reported rates than females.

Respiratory syncytial virus (RSV) is the most common cause of lower respiratory tract infection in infants and young children[5]. The 5-year averaged rate of RSV infection in Clark County from 2000-2004 was 97.61 cases per 100,000 population. The rate increased from 2000-2002, and then decreased from 2002 through 2004. Most cases of RSV were reported between November and April. Although RSV is a notifiable illness in Nevada, only case counts are recorded, just as with rotavirus, and further demographic analysis is not routinely done.

There was an increase in the rate of aseptic meningitis from 2000-2003, followed by a decrease from 2003 to 2004, however the 2004 incidence was not significantly different from that of 2000. Individuals of Hispanic origin had a higher rate than those of non-Hispanic origin, and infants one year-old and younger had the highest incidence rate of all age groups. Reported cases of aseptic meningitis increased in the fall months, decreased through January, and then remained relatively steady through July.

The rate of bacterial meningitis in Clark County decreased between 2000 and 2004. As with aseptic meningitis, infants one year-old and younger had the highest incidence rate of all age groups, and there was no significant difference in rates among the racial/ethnic groups or between males and females. From 2000-2004, *Streptococcus* species and *Staphylococcus* species were isolated in approximately 80% of all cases of bacterial meningitis in Clark County.

A total of 359 cases of TB disease were reported from 2000 to 2004 in Clark County, with an averaged rate of 4.66 cases per 100,000 population. Based on aggregated county data, Asian/Pacific Islanders had significantly higher rates than other racial/ethnic groups, and men experienced a higher incidence rate than women. Similar patterns were also seen in the nation.

In 2004, 12 cases of West Nile Encephalitis were reported in Clark County, with an annual incidence rate of 0.7 cases per 100,000 population. Nationwide, the incidence rate in 2004 was 0.4 cases per 100,000, with a reported total of 1142 cases. The median age of the 12 cases reported in the county was 65 years.

References:

[1]Centers for Disease Control and Prevention. Epidemiology and Prevention of Vaccine-Preventable Diseases. Atkinson W, Hamborsky J, Wolfe S, eds. 8th ed. Washington DC: Public Health Foundation, 2004.

[2]Centers for Disease Control and Prevention. Measles – United States, 2004. MMWR 2005; 54:48; 1229-1231. Accessed online at http://www.cdc.gov/mmwr/preview/mmwrhtml/mm5448a1.htm

[3]National Immunization Survey, United States 2004. Accessed online at http://www.cdc.gov/mmwr/preview/mmwrhtml/mm5429a1.htm

[4]Centers for Disease Control and Prevention, National Center for Infectious Diseases, Respiratory and Enteric Viruses Branch. *Rotavirus*. Accessed online at http://www.cdc.gov/ncidod/dvrd/revb/gastro/rotavirus.htm Last reviewed January 20, 2005.

[5]Centers for Disease Control and Prevention, National Center for Infectious Diseases, Respiratory and Enteric Viruses Branch. *Respiratory Syncytial Virus*. Accessed online at http://www.cdc.gov/ncidod/dvrd/revb/respiratory/rsvfeat.htm Last reviewed January 21, 2005.

HAEMOPHILUS INFLUENZA (INVASIVE)

Introduction

Naturally-acquired disease caused by *Haemophilus Influenza* (H. flu) seems to occur in humans only. Most strains of H. flu are opportunistic pathogens living in their host without causing disease. Serious infection is usually caused by strains carrying a polysaccharide capsule. Of the six capsular types, type b (Hib) causes invasive infections such as bacteremia and acute bacterial meningitis. Occasionally, it causes obstructive laryngitis, cellulitis, osteomyelitis and joint infections. Unencapsulated H. flu strains are less invasive and may cause ear infections and sinusitis in children and are associated with pneumonia.

Before the introduction of Hib conjugate vaccines in 1988, Hib was one of the most important causes of meningitis and pneumonia in young children. Hib disease may be transmitted through contact with mucus or droplets from the nose and throat of an infected person. Symptoms may include fever, lethargy, vomiting and a stiff neck. Other symptoms depend upon the part of the body affected. The incubation period for Hib disease is unknown, but is probably less than one week. Hib conjugate vaccines are effective in preventing infection and are available as one of the routine childhood immunizations, typically given at 2, 4 and 12 months. A detailed recommendation of Hib vaccination is provided at http://www.cdc.gov/mmwr/preview/mmwrhtml/00023705.htm.

Summary of data

Disease Abstract, 2004*

	Clark	Nevada	US
Number of cases reported	7	20**	2,416**
Rate (cases per 100,000)	0.4	0.8**	0.8**
Median age at time of event	6	N/A	N/A

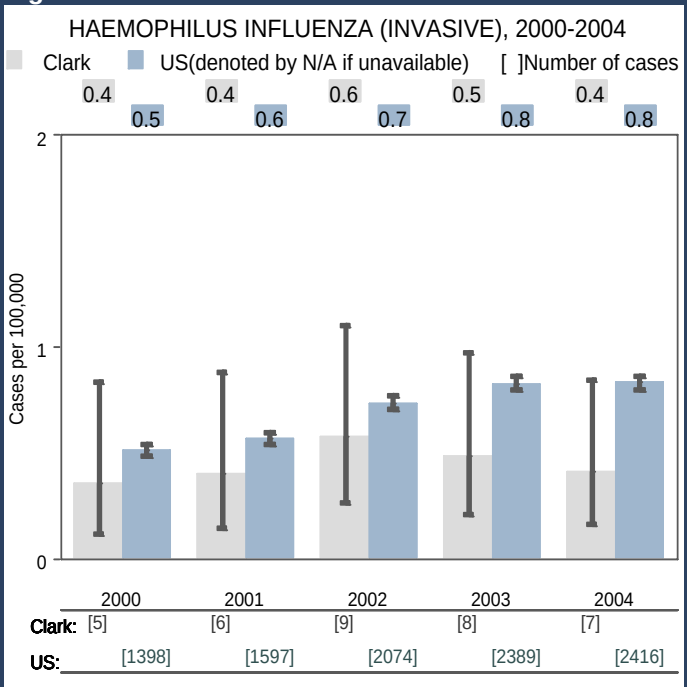
*Numbers for both the state and nation were from the 2004 MMWR Summary Report. Time of event is not uniformly definable and can be that of onset, diagnosis, lab collection or reporting.

**Corrected for errors in the MMWR Summary Report.

Trends

In Clark County the reported incidence of H. flu invasive disease decreased between 2002 and 2004. However the incidence rate in 2004 was not significantly different from those in previous years (Figure 1).

Figure 1: Annual Crude Incidence Rates*



*National rates as provided in the MMWR Summary Reports (2002-2004) used incorrect denominators. Corrected national rates were provided on graph.

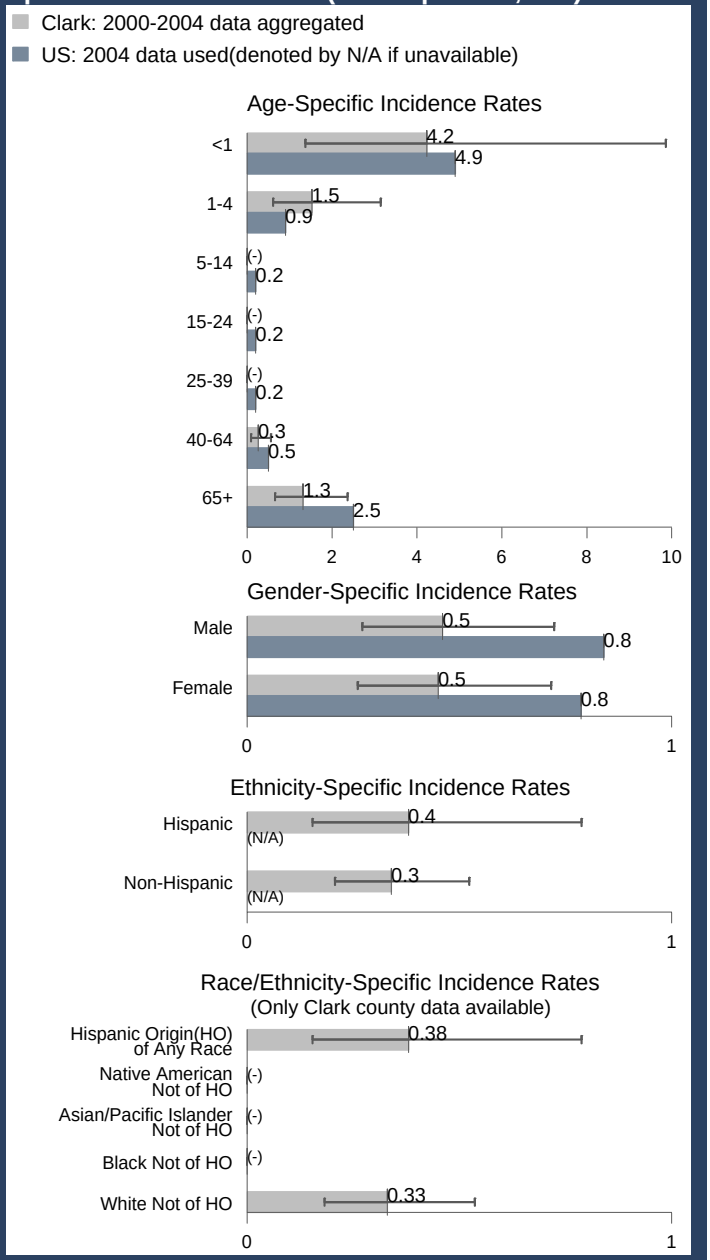
Seasonality

An average of one case was reported monthly from 2000 to 2004 in Clark County. No seasonal pattern was apparent in the number of cases reported monthly.

Demographics

Based on aggregated Clark County data of 2000-2004, children four years of age and younger had higher incidence rates than other age groups. Similar age patterns have also been observed in 2004 national data. No significant gender or ethnicity differences were indicated in the aggregated county data (Figure 2).

Figure 2: Age, Gender, Ethnicity and Race/Ethnicity Specific Incidence Rates (Cases per 100, 000)*

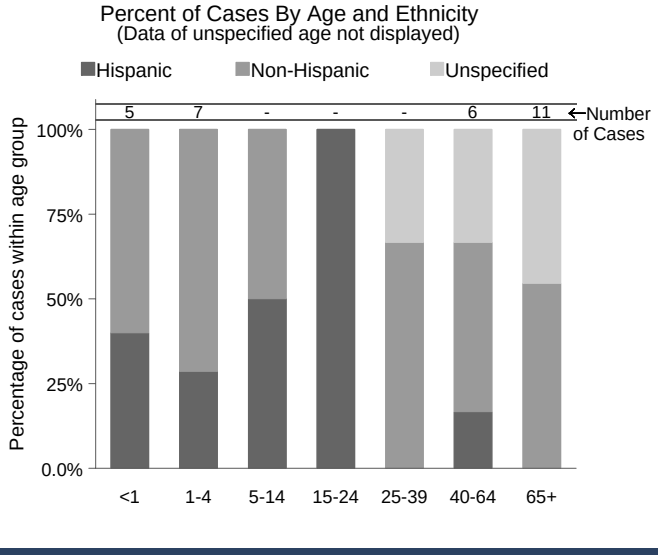


*National rates as provided in the MMWR Summary Reports used incorrect denominators. Corrected age and gender specific rates were provided on graph. However, data were not available to correct for ethnicity specific rates at the national level.

Note: Suppressed data denoted by '(-)' .

From 2000 to 2004 in Clark County, the majority of reported cases have tended to be Non-Hispanic for age groups of four years or younger and 65 years or older (Figure 3).

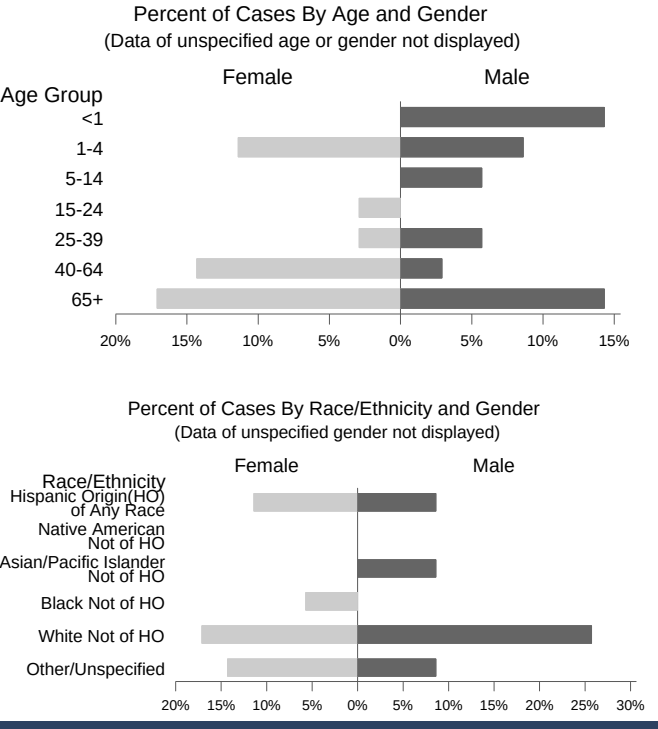
Figure 3: Percent of Cases (of 5-year case totals within age groups)



Note: Suppressed data denoted by '-' .

The age-gender and racial/ethnic-gender distributions of cases are provided in Figure 4. Mean and median ages of reported cases are provided in the appendix.

Figure 4: Percent of Cases (of 5-year case total)



HEPATITIS A

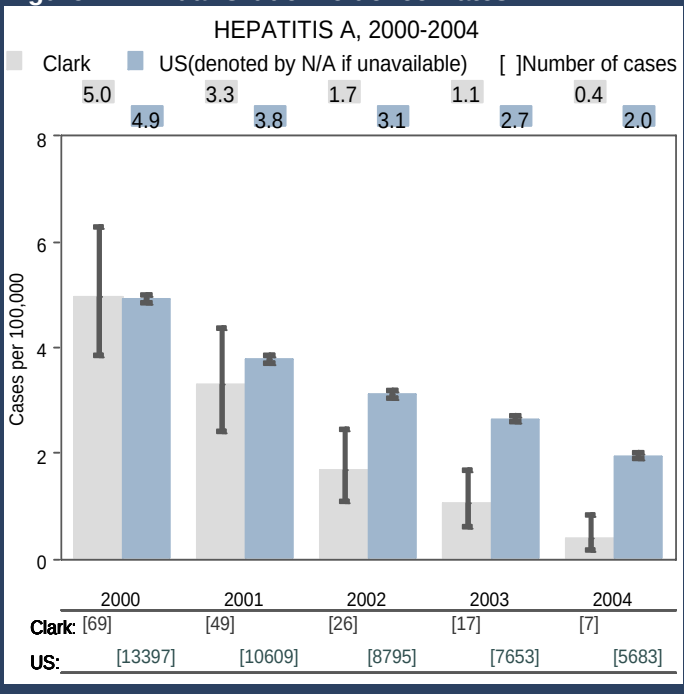
Introduction

Hepatitis A is a viral infection affecting the liver. Symptoms, which can occur 15-50 days after infection, may include nausea, loss of appetite, abdominal pain, malaise, dark urine and jaundice (yellowing of the skin and whites of eyes). Generally, the severity of illness increases with age. Infection is acquired through the fecal-oral route, either directly from person-to-person, or through contaminated food products. There is no carrier state of hepatitis A, and most individuals are no longer infectious one week after jaundice occurs. Infants and children may shed the virus for a longer period of time (sometimes up to six months).

There is no specific treatment of hepatitis A and most cases completely recover. Contacts of hepatitis A cases may acquire short-term protection against infection through passive immunization with immune globulin, if received within 14 days of exposure to the infected person. For long-term protection, the hepatitis A vaccination is quite effective in the prevention of clinical illness. In 1999, hepatitis A vaccination became a requirement for food handlers applying for Health Cards in Clark County. In addition, all students entering the Clark County School District after June 30, 2002 are required to be vaccinated for hepatitis A. A detailed recommendation of hepatitis A vaccination is provided at http://www2.ncid.cdc.gov/travel/yb/utils/ybGet.asp?section=dis&obj=hav.htm.

Although a similar trend has been observed nationally, the incidence rate in Clark County was significantly lower than that of the nation between 2002 and 2004 (Figure 1).

Figure 1: Annual Crude Incidence Rates



Summary of data

Disease Abstract, 2004*

	Clark	Nevada	US
Number of cases reported	7	17	5,683
Rate (cases per 100,000)	0.4	0.7	2.0
Median age at time of event	33	N/A	N/A

*Numbers for both the state and nation were from the 2004 MMWR Summary Report. Time of event is not uniformly definable and can be that of onset, diagnosis, lab collection or reporting.

Trends

A downward trend was indicated in the reported incidence of hepatitis A in Clark County between 2000 and 2004. The incidence rate in 2004 was significantly lower than that in 2000 (Figure 1).

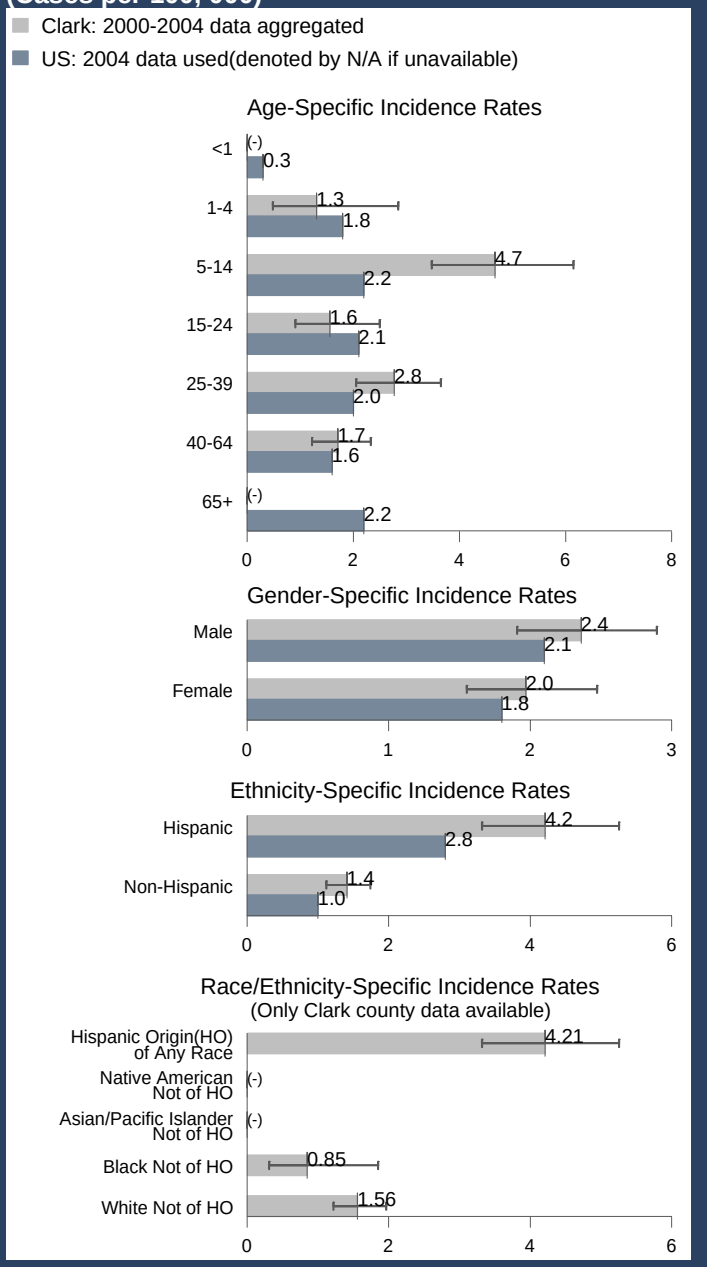
Seasonality

An average of three cases was reported monthly from 2000 to 2004 in Clark County. No seasonal pattern was apparent in the number of cases reported monthly.

Demographics

Based on aggregated Clark County data of 2000-2004, children aged 5-14 years and adults aged 25-39 years had higher incidence rates than other age groups. A higher rate was seen in males, yet the gender difference was not significant. Hispanics of any race had a significantly higher incidence rate than non-Hispanic groups. Similar gender and ethnicity patterns have been observed in 2004 national data (Figure 2).

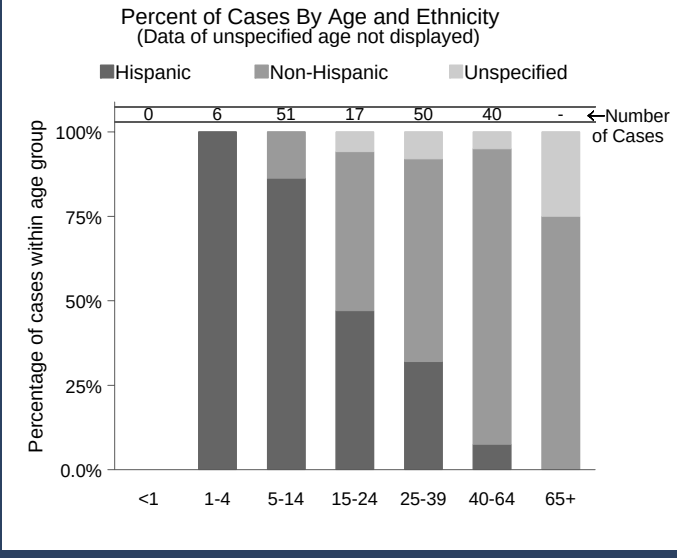
Figure 2: Age, Gender, Ethnicity and Race/Ethnicity Specific Incidence Rates (Cases per 100, 000)



Note: Suppressed data denoted by '(-)' .

From 2000 to 2004 in Clark County, the majority of reported cases have tended to be Hispanic for those aged 14 years and younger, and non-Hispanic for those aged 25 years and older (Figure 3).

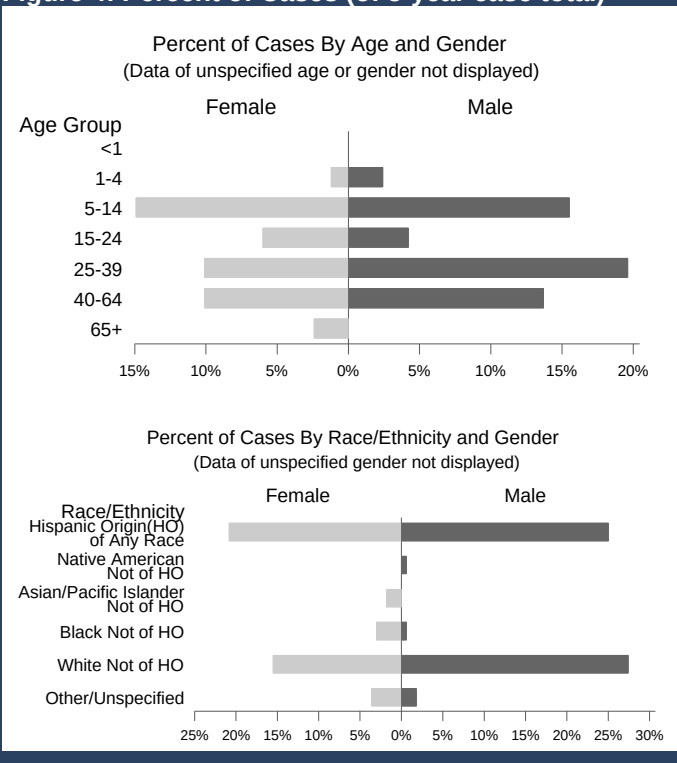
Figure 3: Percent of Cases (of 5-year case totals within age groups)



Note: Suppressed data denoted by '-' .

The age-gender and racial/ethnic-gender distributions of cases are provided in Figure 4. Mean and median ages of reported cases are provided in the appendix.

Figure 4: Percent of Cases (of 5-year case total)



HEPATITIS B (ACUTE)

Introduction

Hepatitis B is a viral infection causing both acute and chronic liver disease. In Clark County, acute infections of hepatitis B are reportable, while chronic carriers of hepatitis B are not. Most adults infected with acute hepatitis B will recover completely and thus become immune to a future infection. In contrast, most infants and children with acute infection will become chronically infected with the virus. Symptoms, which usually occur 60-180 days after infection, include nausea, loss of appetite, abdominal pain, vomiting, dark urine and jaundice (yellowing of the skin and whites of eyes). Most individuals with chronic hepatitis B remain asymptomatic for many years, yet a carrier state may progress to cirrhosis or cancer of the liver. Hepatitis B virus is found in several body fluids including, but not limited to blood, semen and vaginal secretions. The primary modes of transmission include sexual or close household contact with an infected individual, mother-to-infant transmission at birth and sharing of intravenous drug needles.

While acute hepatitis B usually resolves on its own, antiviral drugs are available for the treatment of chronic infection. Hepatitis B vaccine is available to the general public, and is specifically recommended for contacts of infected individuals that may have been exposed to the virus. Hepatitis B immune globulin administered at birth to infants of infected mothers may prevent infection. Individuals who donate blood products and organs in the United States are screened for hepatitis B to ensure that the risk of transmission through these products is minimized. Personal preventive measures include avoiding direct contact with blood, using barrier protection such as condoms during sexual intercourse, and using sterile, unused needles for medications or drugs taken intravenously. A detailed recommendation of hepatitis B vaccination is provided at http://www.cdc.gov/ncidod/diseases/hepatitis/b/factvax.htm.

Summary of data

Disease Abstract, 2004*

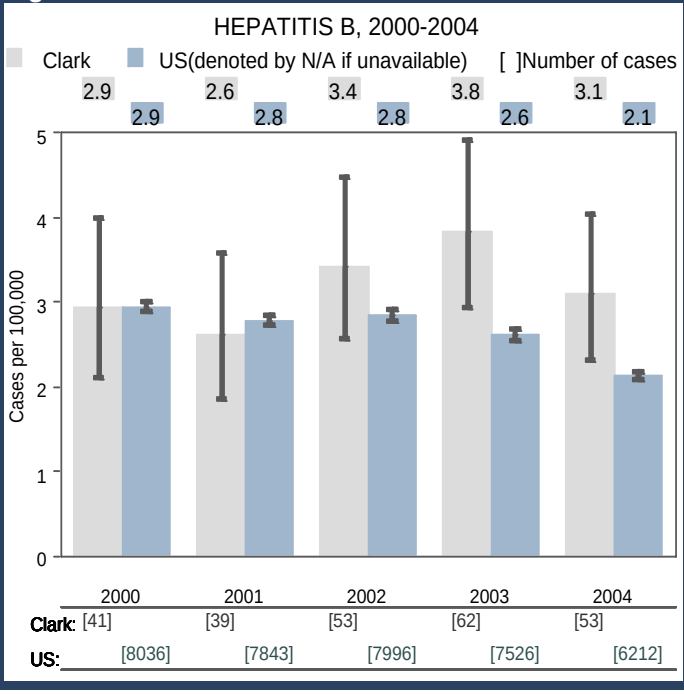
	Clark	Nevada	US
Number of cases reported	53	77	6,212
Rate (cases per 100,000)	3.1	3.2	2.1
Median age at time of event	37	N/A	N/A

*Numbers for both the state and nation were from the 2004 MMWR Summary Report. Time of event is not uniformly definable and can be that of onset, diagnosis, lab collection or reporting.

Trends

The reported incidence of acute hepatitis B in Clark County slightly increased between 2001 and 2003, although the incidence rates in 2000 to 2004 were not significantly different (Figure 1).

Figure 1: Annual Crude Incidence Rates



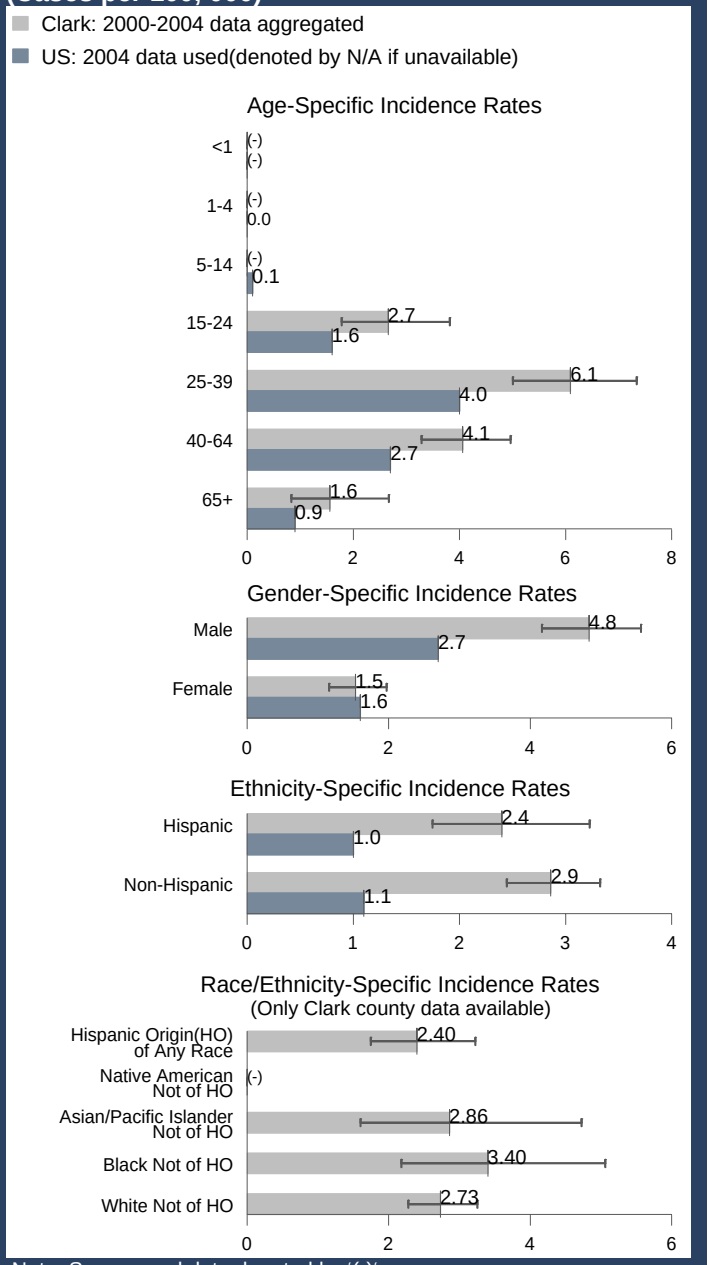
Seasonality

An average of four cases was reported monthly from 2000 to 2004 in Clark County. No seasonal pattern was apparent in the number of cases reported monthly.

Demographics

Based on aggregated Clark County data of 2000-2004, adults aged 25-39 years had a higher incidence rate than other age groups. Males had a significantly higher incidence rate than females. Similar age and gender patterns have also been observed in 2004 national data. A higher rate was seen in the non-Hispanic group in Clark County, yet the ethnicity difference was not significant (Figure 2).

Figure 2: Age, Gender, Ethnicity and Race/Ethnicity Specific Incidence Rates (Cases per 100, 000)

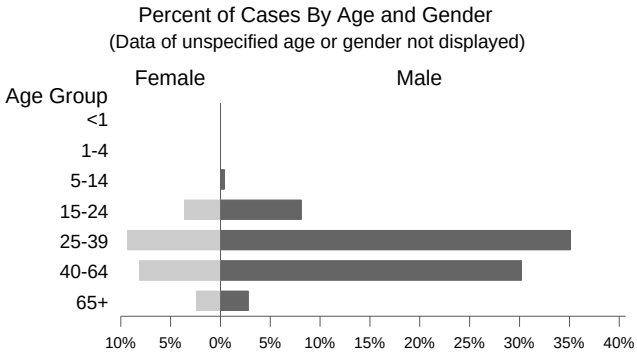


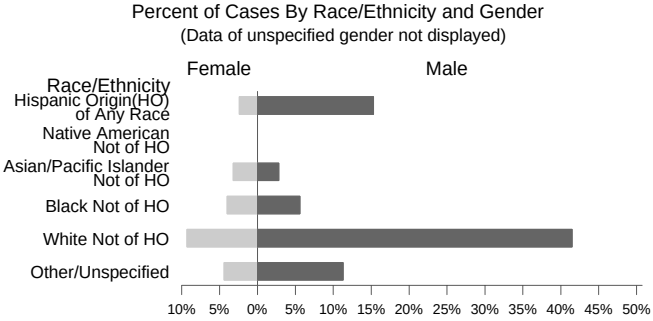
Note: Suppressed data denoted by '(-)' .

From 2000 to 2004 in Clark County, the majority of reported cases have tended to be non-Hispanic for almost all age groups (data not shown here).

The age-gender and racial/ethnic-gender distributions of cases are provided in Figure 3. Annual age, gender, ethnicity specific incidence rates, percent of cases and mean/median age of reported cases are provided in the appendix.

Figure 3: Percent of Cases (of 5-year case total)





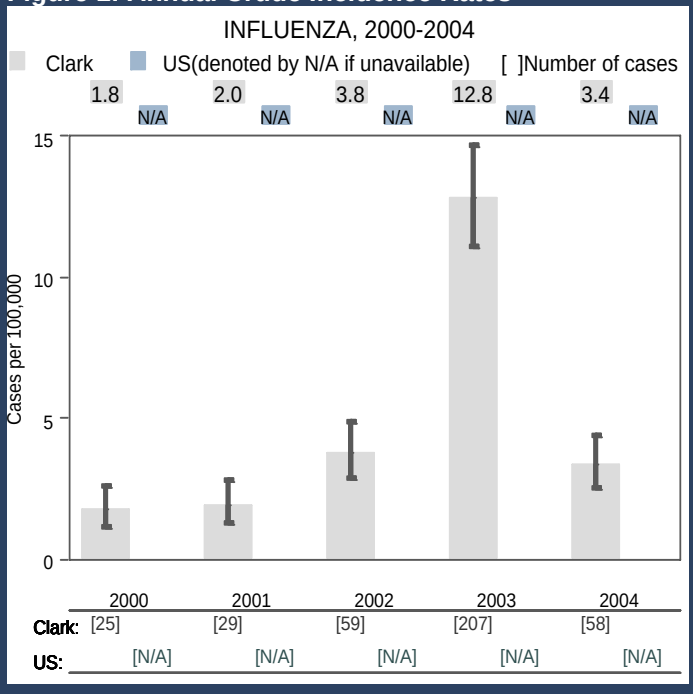
INFLUENZA

Introduction

Influenza is a viral infection of the respiratory tract. Symptoms, which usually appear 1-3 days after exposure to the virus, include fever, headache, cough, sore throat, muscle aches, runny or stuffy nose and fatigue. The most common complication of infection is secondary bacterial pneumonia. Transmission of influenza occurs when an individual inhales virus that is released from the respiratory tract of an infected individual during a cough or sneeze. An individual can also become infected through touching an object contaminated with the influenza virus and then touching his or her mouth or nose.

There are anti-viral medications available which may shorten the severity of influenza illness and the length of time that an individual is infectious. The best way to prevent infection with influenza is to receive vaccination each fall. The vaccine is updated annually to contain strains of the virus estimated to circulate in the coming year. The flu vaccine may prevent illness from occurring, or may be effective in reducing the severity of disease and preventing complications from infection. Individuals can also take personal protective measures against infection with influenza, such as avoiding contact with ill individuals, washing hands frequently and practicing other healthy habits such as getting sufficient rest, exercising and eating healthful foods. A detailed recommendation of the flu vaccination is provided at http://www.cdc.gov/flu/protect/preventing.htm.

Figure 1: Annual Crude Incidence Rates



Summary of data

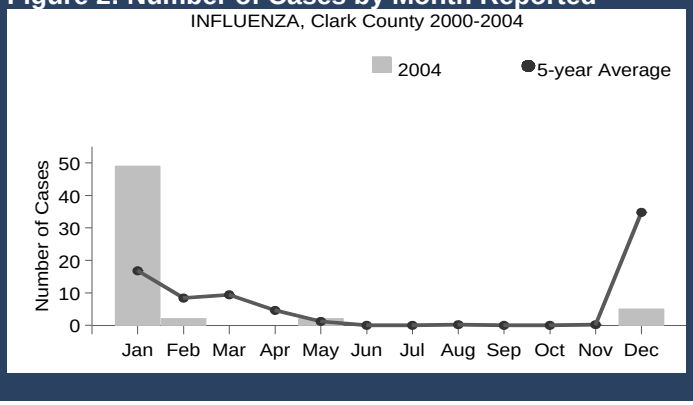
Trends

A significant increase was observed in the reported incidence of influenza in Clark County in 2003. The incidence rate dropped in 2004 and was not significantly different from that in 2000 (Figure 1).

Seasonality

An average of six cases was reported monthly from 2000 to 2004 in Clark County. The majority of cases were reported in winter and spring months (Figure 2).

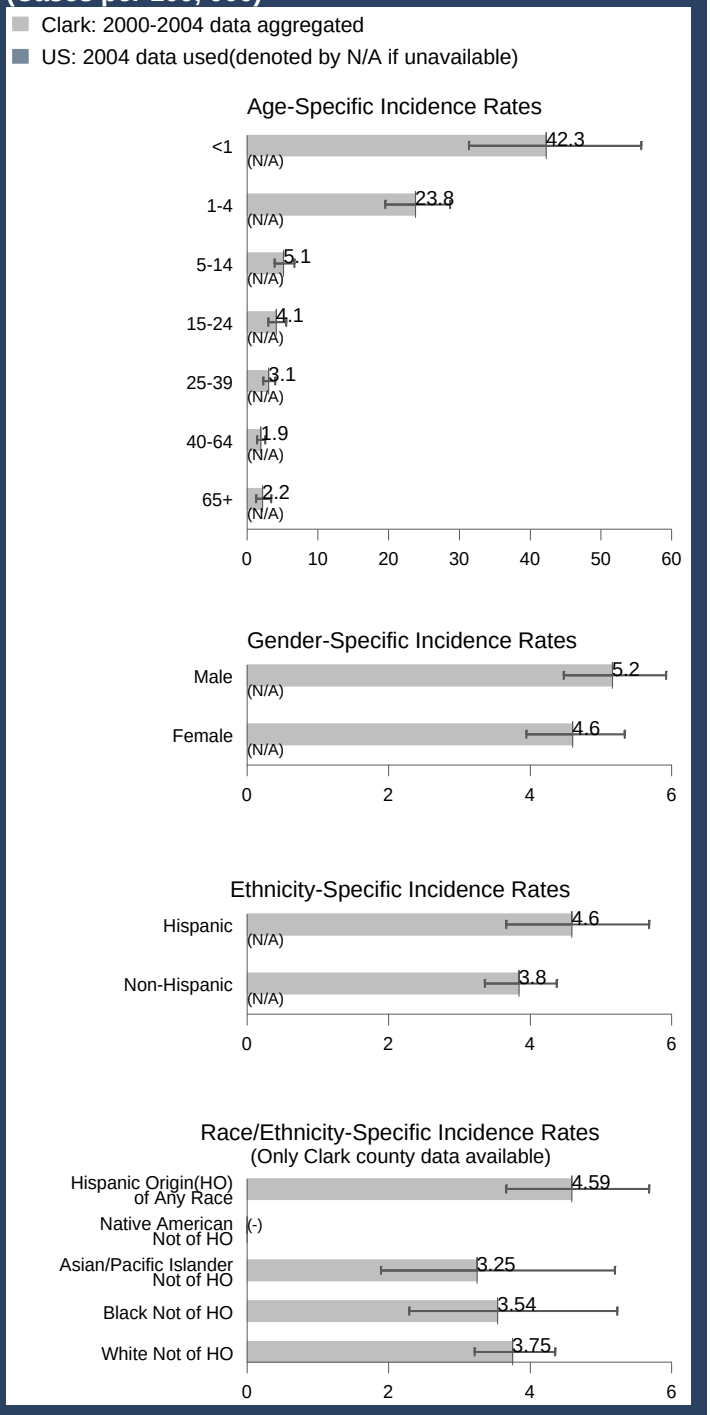
Figure 2: Number of Cases by Month Reported



Demographics

Based on aggregated Clark County data of 2000-2004, children of four years old or younger had significantly higher incidence rates than other age groups. No significant gender or racial/ethnic differences were indicated in the aggregated county data (Figure 3).

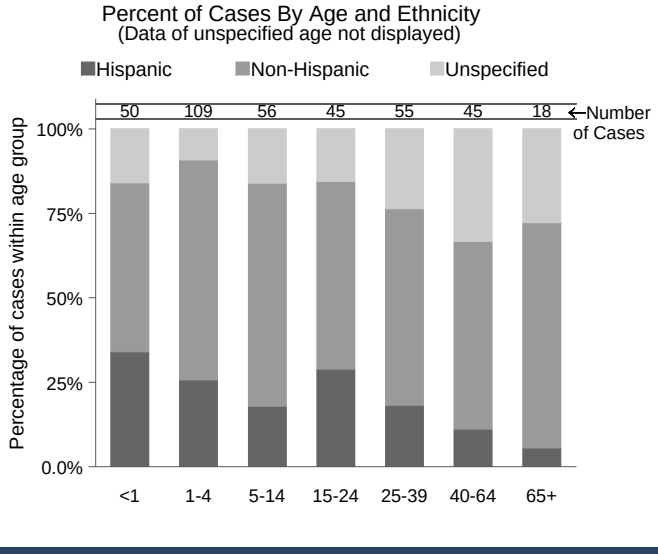
Figure 3: Age, Gender, Ethnicity and Race/Ethnicity Specific Incidence Rates (Cases per 100, 000)



Note: Suppressed data denoted by '(-)' .

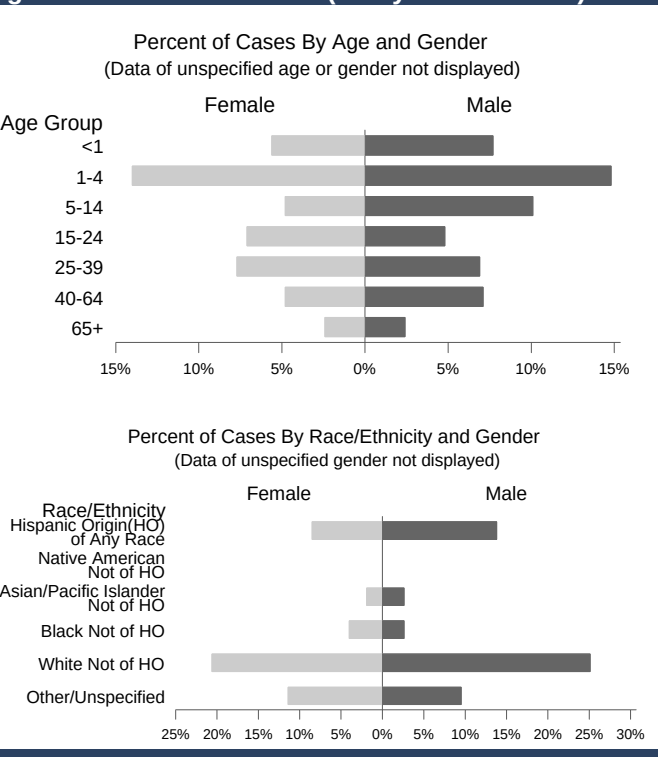
From 2000 to 2004 in Clark County, the majority of reported cases have tended to be non-Hispanic for all age groups (Figure 4).

Figure 4: Percent of Cases (of 5-year case totals within age groups)



The age-gender and racial/ethnic-gender distributions of cases are provided in Figure 5. Annual age, gender, ethnicity specific incidence rates, percent of cases and mean/median age of reported cases are provided in the appendix.

Figure 5: Percent of Cases (of 5-year case total)



PERTUSSIS

Introduction

Pertussis, also referred to as whooping cough, is a bacterial infection caused by *Bordetella pertussis*. The illness begins with a stage consisting of cold-like symptoms, and progresses to a second stage, which is characterized by bursts of rapid, severe coughs. At the end of these bursts when the infected individual attempts to breathe in, particularly in young children, a high-pitched whoop may occur. Vomiting often follows these episodes. These spells can continue for several weeks, and recovery is gradual. Older individuals and those with remaining protection from the vaccine often have milder disease, and may serve as sources of severe illness for younger, unvaccinated or under-vaccinated children. Transmission occurs through contact with respiratory droplets or by contact with airborne droplets of respiratory secretions.

The cough associated with pertussis is caused by a toxin released by the bacteria. As such, while antibiotics are used to clear the bacteria, and may be effective in modifying the course of illness if administered early on, residual toxin may continue to cause the individual to cough. Severe cases of pertussis, especially in young infants, often require hospitalization for respiratory support. Household and other close contacts of pertussis cases should receive a course of antibiotics in order to prevent secondary cases from occurring. A multi-dose vaccine is available for pertussis and is approved for individuals younger than seven years old. Immunity from this vaccine wanes with age, and thus most adolescents and adults are unprotected against the illness. In May 2005, a booster vaccine was licensed by the Food and Drug Administration for individuals aged 10-18 years, and in June 2005, a vaccine was licensed for those aged 11 through 64 years. A detailed recommendation of pertussis vaccination is provided at http://www.cdc.gov/nip/publications/VIS/vis-dtp.pdf.

Summary of data

Disease Abstract, 2004*

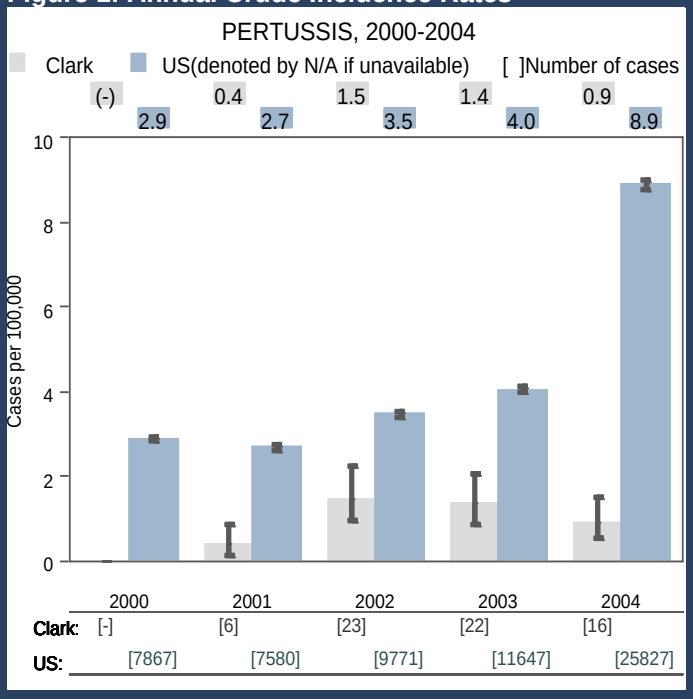
	Clark	Nevada	US
Number of cases reported	16	53	25,827
Rate (cases per 100,000)	0.9	2.2	8.9
Median age at time of event	0	N/A	N/A

*Numbers for both the state and nation were from the 2004 MMWR Summary Report. Time of event is not uniformly definable and can be that of onset, diagnosis, lab collection or reporting.

Trends

The reported incidence of pertussis in Clark County slightly decreased between 2002 and 2004. The incidence rates in Clark County have been significantly lower than those of the nation (Figure 1).

Figure 1: Annual Crude Incidence Rates



Note: Suppressed data denoted by '(-) ' or '[-]'.

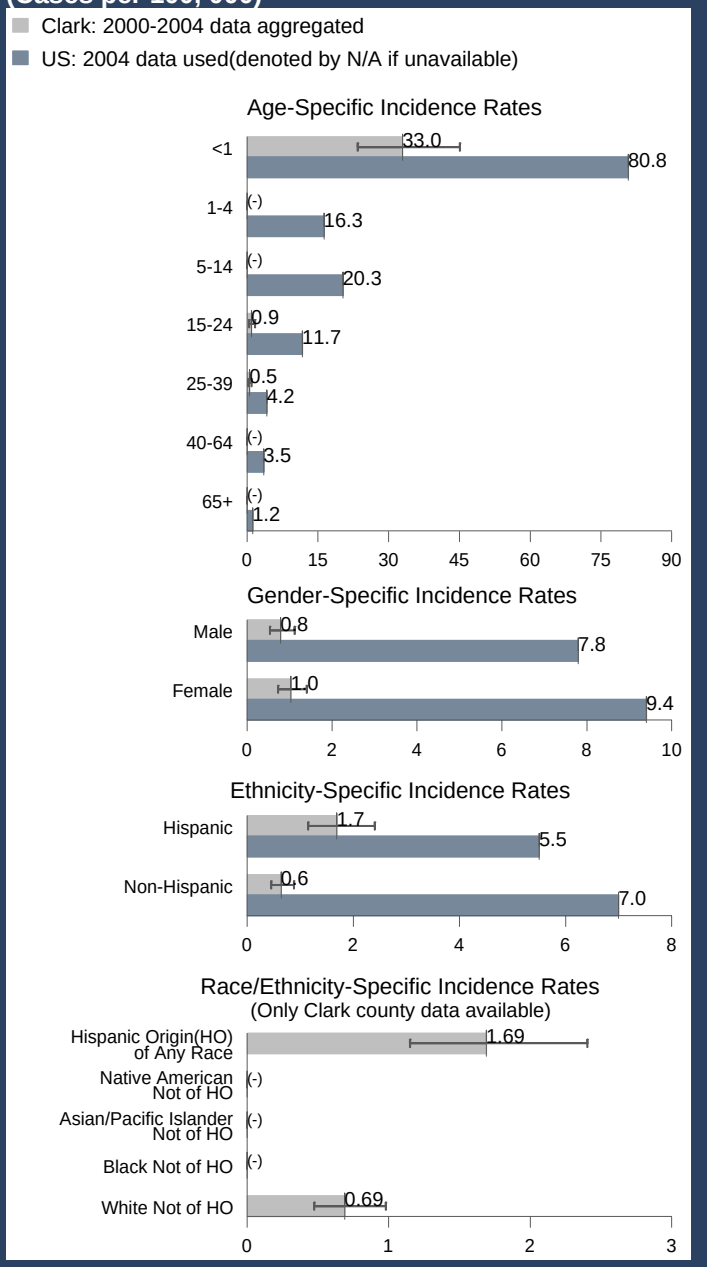
Seasonality

An average of one case was reported monthly from 2000 to 2004 in Clark County. More cases were reported in winter months, although no seasonal pattern was apparent.

Demographics

Based on aggregated Clark County data of 2000-2004, children less than one year of age had a significantly higher incidence rate than other age groups. Hispanics of any race had a significantly higher incidence rate than non-Hispanic groups. A higher rate was seen in females, yet the gender difference was not significant. Similar age and gender patterns have also been observed in 2004 national data (Figure 2).

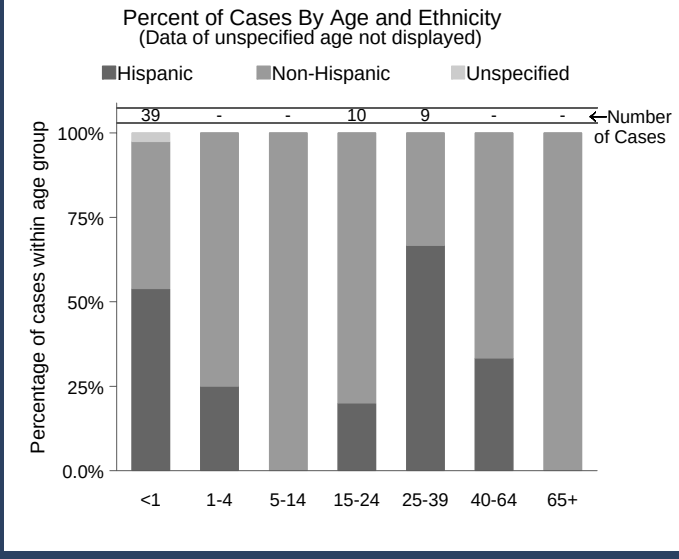
Figure 2: Age, Gender, Ethnicity and Race/Ethnicity Specific Incidence Rates (Cases per 100, 000)



Note: Suppressed data denoted by '(-)' .

From 2000 to 2004 in Clark County, the majority of reported cases have tended to be Hispanic for those less than one year old and those between 25 to 39 years of age (Figure 3).

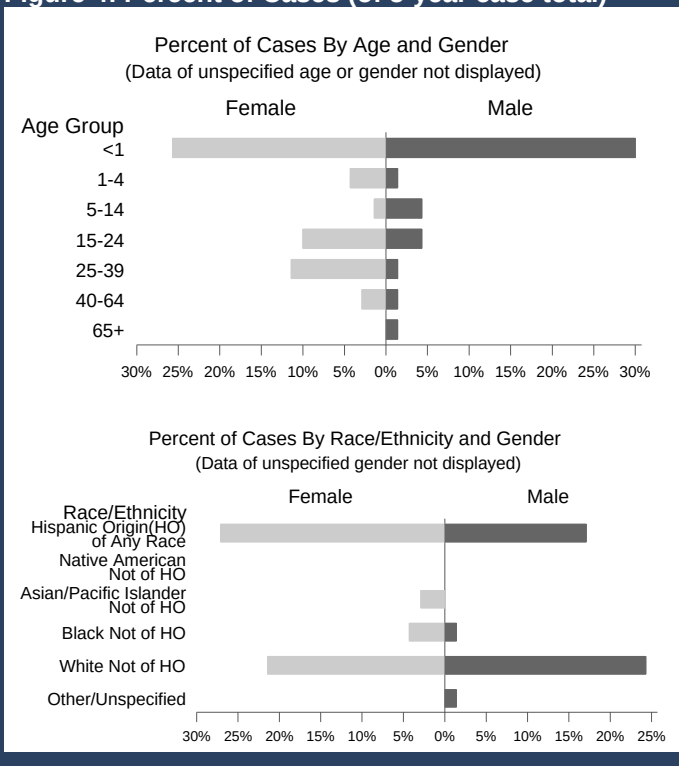
Figure 3: Percent of Cases (of 5-year case totals within age groups)



Note: Suppressed data denoted by '-' .

The age-gender and racial/ethnic-gender distributions of cases are provided in Figure 4. Mean and median ages of reported cases are provided in the appendix.

Figure 4: Percent of Cases (of 5-year case total)



CHLAMYDIA

Introduction

Chlamydia is the most frequently reported bacterial STD in the United States, and is associated with a spectrum of diseases. There are three known species of chlamydia bacteria that cause human diseases. Infections by these organisms can affect organs including eyes, lungs, and urinary-genital area, depending on the species involved, the age of the person infected, and how the infection is transmitted. The most well-known chlamydia infection is the sexually transmitted disease caused by *Chlamydia trachomatis* (*C. trachomatis*), commonly referred to as "chlamydia". Many infections are asymptomatic. When symptoms do occur, they may begin in as little as 5 to 10 days after infection. Women who have symptoms may experience vaginal irritation with discharge. Men may have discharge from the urethra and burning upon urination. The infection may move inside the body if left untreated and cause pelvic inflammatory disease (PID) in women, or epididymitis in men. Long-term consequences of PID may include infertility, chronic pelvic pain and a higher risk of ectopic pregnancy in women, while epididymitis can result in testicular swelling, pain, and ultimately infertility in men. Besides being transmitted sexually, *C. trachomatis* can also be passed from an infected woman to her baby during childbirth. In the newborn, this can cause conjunctivitis as well as pneumonia.

Chlamydia can be easily cured with antibiotics if treated in time. It is very important that a person who has a chlamydial infection abstain from having sex until both patient and partner have been treated. Chlamydial infections in newborns can be prevented by screening pregnant women, and treating all infected mothers with antibiotics before delivery. Recommendations about prevention can be found at http://www.cdc.gov/std/Chlamydia/.

Summary of data

Disease Abstract, 2004*

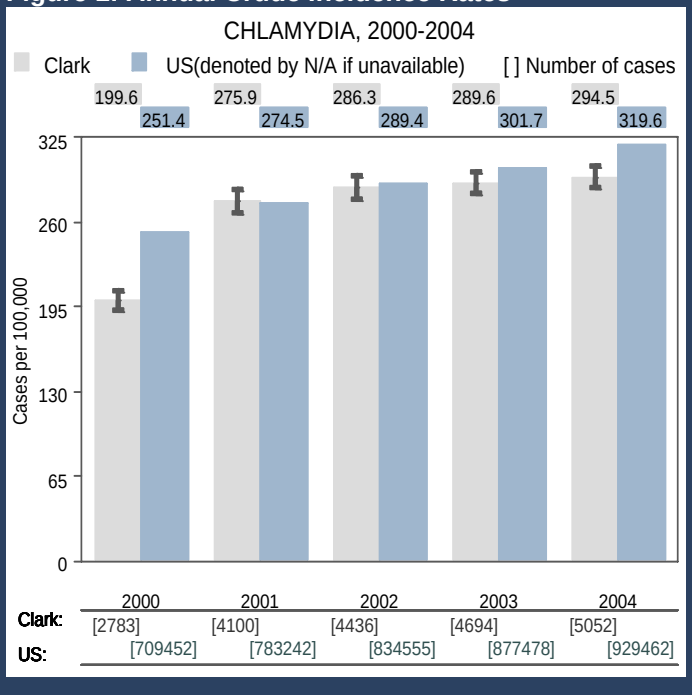
	Clark	Nevada	US
Number of cases reported	5,052	6,690	929,462
Rate (cases per 100,000)	294.5	298.5	319.6
Median age at time of event	22	N/A	N/A

*Numbers and rates for both the state and nation were from the 2004 National STD Surveillance Report. Time of event is not uniformly definable and can be that of onset, diagnosis, lab collection or reporting.

Trends

An upward trend was observed in the reported incidence of chlamydia in both Clark County and the nation between 2000 and 2004. The incidence rate in 2004 was significantly higher than that in 2000 in Clark County (Figure 1).

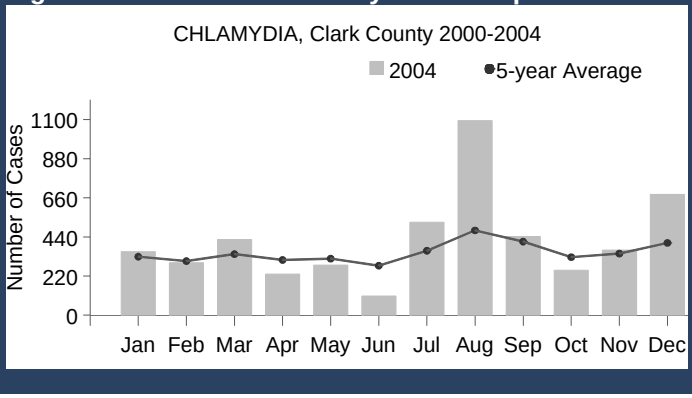
Figure 1: Annual Crude Incidence Rates



Seasonality

An average of 351 cases was reported monthly from 2000 to 2004 in Clark County. No seasonal pattern was apparent in the number of cases reported monthly (Figure 2).

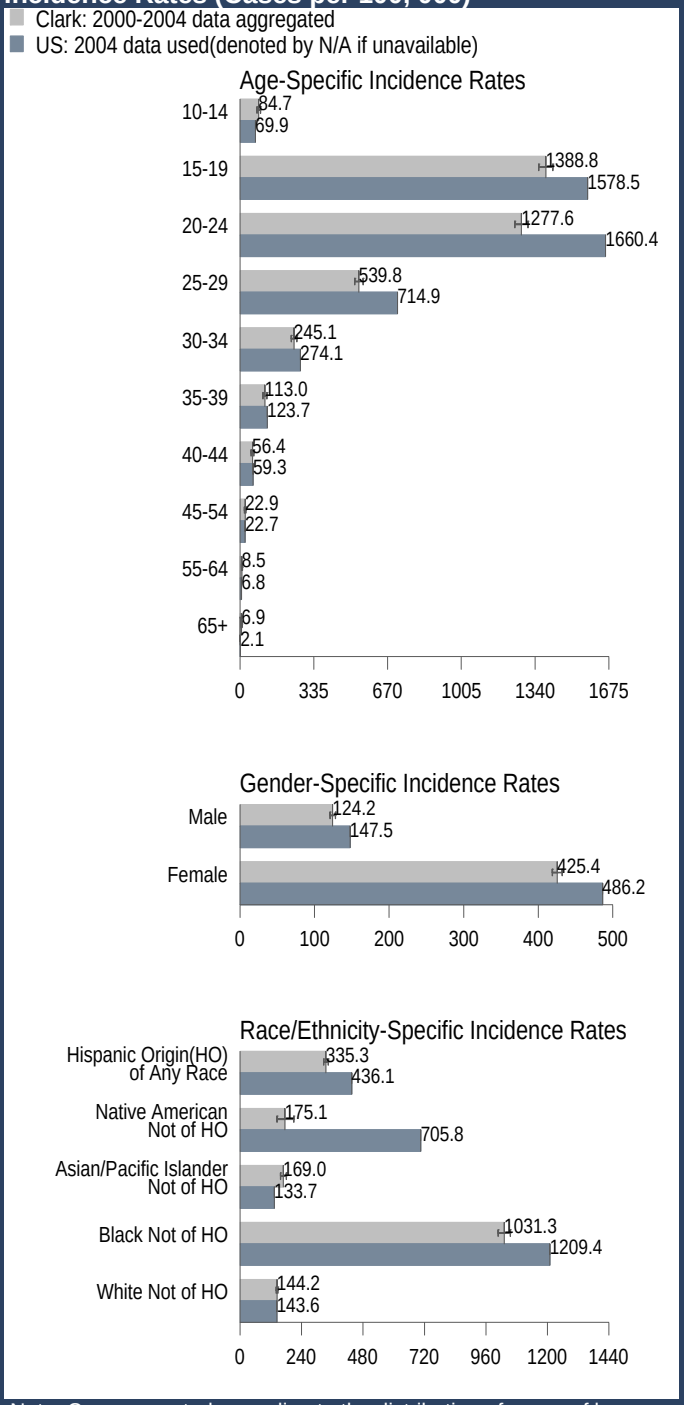
Figure 2: Number of Cases by Month Reported



Demographics

Based on aggregated county data of 2000 to 2004, the 15 to 19 age group had a significantly higher incidence rate than other age groups; the female rate was significantly higher than that of males; non-Hispanic Blacks had a significantly higher rate than other racial/ethnic groups. Similar demographic patterns have been observed in 2004 national data (Figure 3).

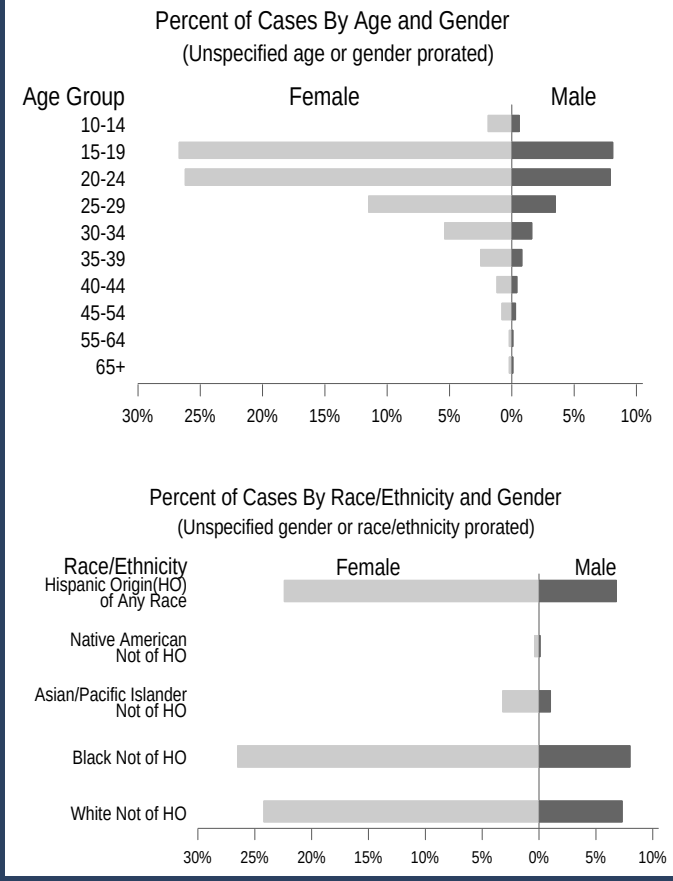
Figure 3: Age, Gender, and Race/Ethnicity Specific Incidence Rates (Cases per 100, 000)



Note: Cases prorated according to the distribution of cases of known demographics where age, gender, or race/ethnicity were unspecified. The 0-9 year age groups were not shown in age-related figures due to possible non-sexual transmission.

The age-gender and racial/ethnic-gender distributions of cases are provided in Figure 4. Annual age, gender, ethnicity specific incidence rates, percent of cases and mean/median age of reported cases are provided in the appendix.

Figure 4: Percent of Cases (of 5-year case total)



Associated Risk Factors

Based on available county data (not shown here), unprotected intercourse (without condoms) and multiple sex partners, in addition to being sexually active, tend to place people at particular risk of chlamydial infections.

GONORRHEA

Introduction

Gonorrhea is a sexually transmitted disease caused by the bacterium *Neisseria gonorrhoeae*. It can lead to infection of the urethra, cervix, rectum, eyes, throat and joints. Most commonly, the term gonorrhea refers to urethritis (inflammation of the urethra) and/or cervicitis (inflammation of the cervix of the uterus) in a sexually active person. For men, the incubation period usually is 2 to 7 days after exposure to an infected partner, but it can take as long as 30 days for symptoms to begin. For women, the early symptoms of gonorrhea often are mild. However, many people experience no symptoms, especially with infection of the rectum or throat. When symptoms do occur, they can include thick discharge from the penis or vagina, pain or burning with urination, increased frequency of urination, swollen or painful testicles in men, and intermenstrual or postcoital bleeding in women. In men, untreated gonorrhea can lead to epididymitis, prostatitis and other complications including infertility. In women, pelvic inflammatory disease can result from untreated gonorrhea, leading to infertility, chronic pelvic pain, and an increased risk of ectopic pregnancy. Gonorrhea is spread through semen or vaginal fluids during unprotected sexual contact with an infected partner. It can also be spread from mother to child during birth. In the newborn, gonorrhea infection may cause blindness, joint infection, or a life threatening blood infection.

Treatment for gonorrhea involves a course of antibiotic medications to eliminate the infection. Practicing safe sex, such as using condoms correctly and consistently, is important in preventing gonorrhea. Pregnant women are recommended to get tested for gonorrhea during prenatal care. Treatment of gonorrhea as soon as it is detected in pregnant women will reduce the risk of complications in the newborn. Recommendations about prevention can be found at http://www.cdc.gov/std/Gonorrhea/.

Summary of data

Disease Abstract, 2004*

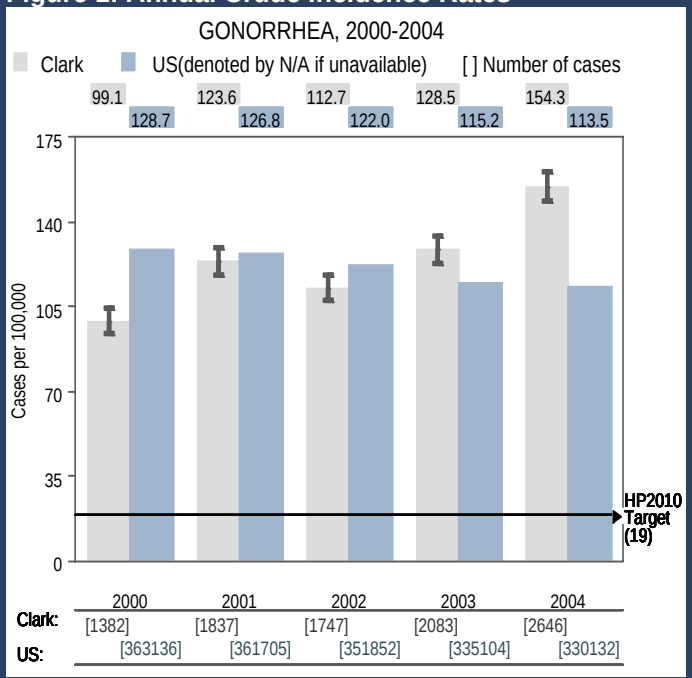
	Clark	Nevada	US
Number of cases reported	2,646	3,078	330,132
Rate (cases per 100,000)	154.3	137.3	113.5
Median age at time of event	25	N/A	N/A

*Numbers and rates for both the state and nation were from the 2004 National STD Surveillance Report. Time of event is not uniformly definable and can be that of onset, diagnosis, lab collection or reporting.

Trends

An upward trend was observed in the reported incidence of gonorrhea in Clark County between 2002 and 2004. The incidence rate in 2004 was significantly higher than that in 2000 (Figure 1).

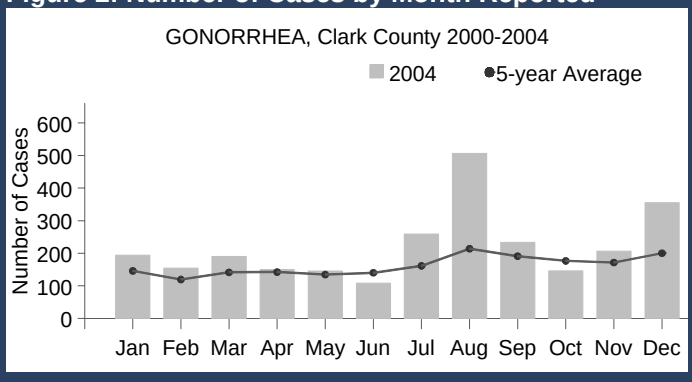
Figure 1: Annual Crude Incidence Rates



Seasonality

An average of 162 cases was reported monthly from 2000 to 2004 in Clark County. No seasonal pattern was apparent in the number of cases reported monthly (Figure 2).

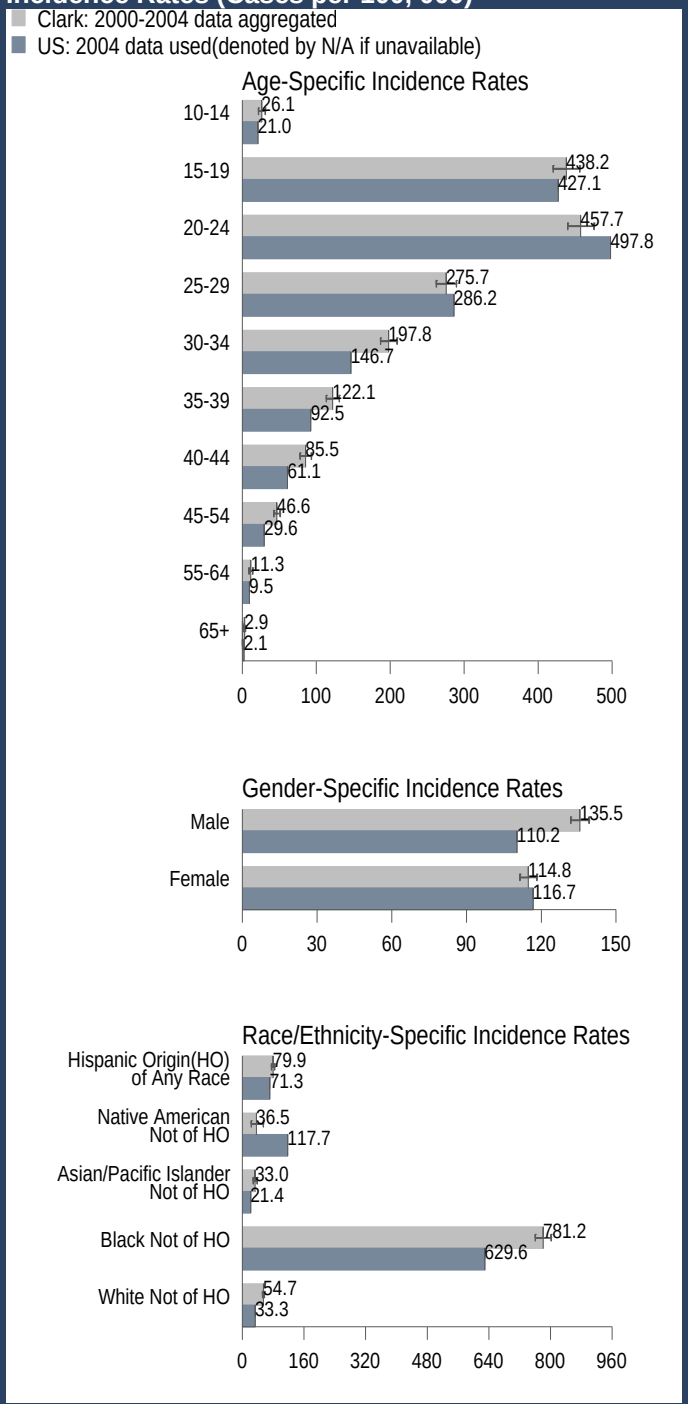
Figure 2: Number of Cases by Month Reported



Demographics

Based on aggregated county data of 2000 to 2004, the 15 to 24 age group had a significantly higher incidence rate than other age groups; the male rate was significantly higher than that of females; non-Hispanic Blacks had a significantly higher rate than other racial/ethnic groups. Similar age and ethnicity patterns have been observed in 2004 national data (Figure 3).

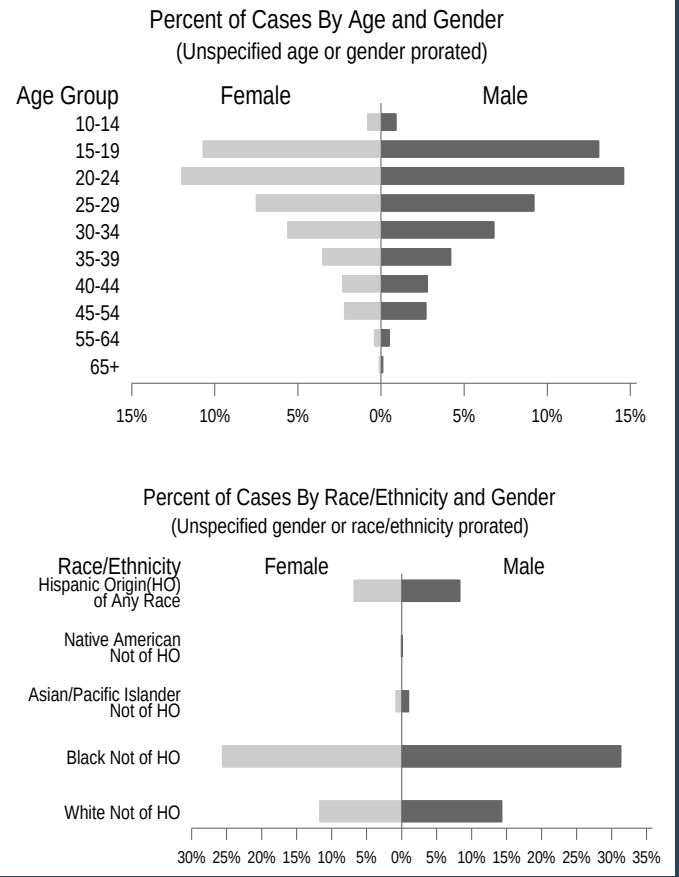
Figure 3: Age, Gender, and Race/Ethnicity Specific Incidence Rates (Cases per 100, 000)



Note: Cases prorated according to the distribution of cases of known demographics where age, gender, or race/ethnicity were unspecified. The 0-9 year age groups were not shown in age-related figures due to possible non-sexual transmission.

The age-gender and racial/ethnic-gender distributions of cases are provided in Figure 4. Annual age, gender, ethnicity specific incidence rates, percent of cases and mean/median age of reported cases are provided in the appendix.

Figure 4: Percent of Cases (of 5-year case total)



Associated Risk Factors

Based on available county data (not shown here), unprotected intercourse and multiple sex partners, in addition to being sexually active, tend to place people at particular risk of gonorrhea infections.

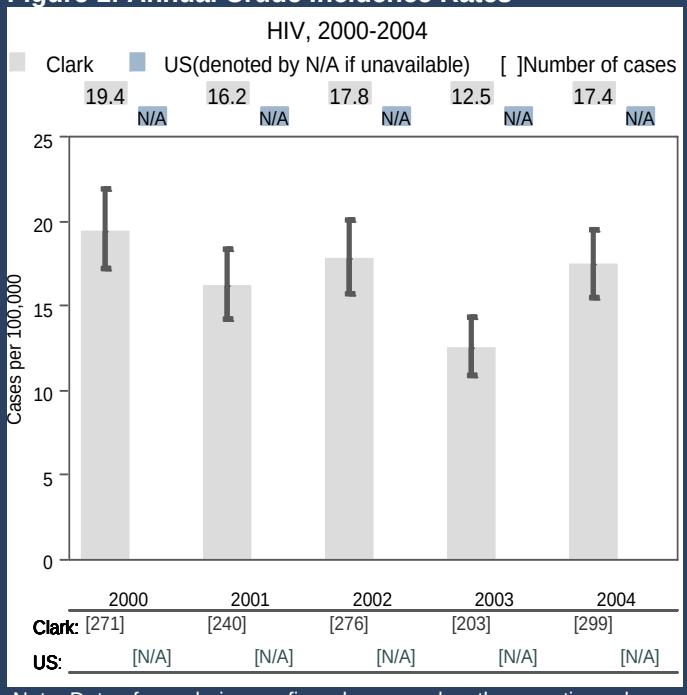
HIV/AIDS

Introduction

Human Immunodeficiency Virus (HIV) is a virus that attacks the body's immune system by damaging or destroying the cells of the immune system. HIV interferes with the body's ability to effectively fight off viruses, bacteria and fungi that cause disease. This makes an infected person more susceptible to certain types of cancers and to opportunistic infections a healthy person would normally resist. Acquired Immune Deficiency Syndrome (AIDS) is the later stage of HIV infection. Worldwide, an estimated 3.1 million adults and children died from AIDS during 2005. An estimated 4.9 million adults and children were newly infected with HIV in 2005, and an estimated 40.3 million people are living with HIV at the end of 2005, the majority of whom live in Sub-Sahara Africa (World Health Organization, 2005 AIDS Epidemic Update). In the United States, the estimated number of persons living with HIV/AIDS was 627,765 at the end of 2004 (CDC, 2004 HIV/AIDS Surveillance Report).

People infected with HIV may have no symptoms for 10 or more years. HIV most commonly spreads by sexual contact with an infected partner. It can also spread through infected blood and shared needles or syringes contaminated with the virus. Untreated women with HIV also can pass the infection to their babies during pregnancy and delivery, and through their breast milk. HIV is not spread by casual contact like sneezing, coughing, eating or drinking from common utensils, shaking hands, hugging, or use of restrooms and drinking fountains. Proper and consistent use of condoms during sexual intercourse provides a high degree of protection against many STDs including HIV infection. Antiretroviral treatment is the mainstay in HIV treatment, but there is no cure. Recommendations about prevention can be found at http://www.cdc.gov/std/hiv/.

Figure 1: Annual Crude Incidence Rates



Note: Date of case being confirmed was used as the reporting scheme for county level data.

Seasonality: HIV Infection

An average of 21 cases of HIV infection was reported monthly from 2000 to 2004 in Clark County. No seasonal pattern was apparent in the number of cases reported monthly.

Summary of data: HIV Infection

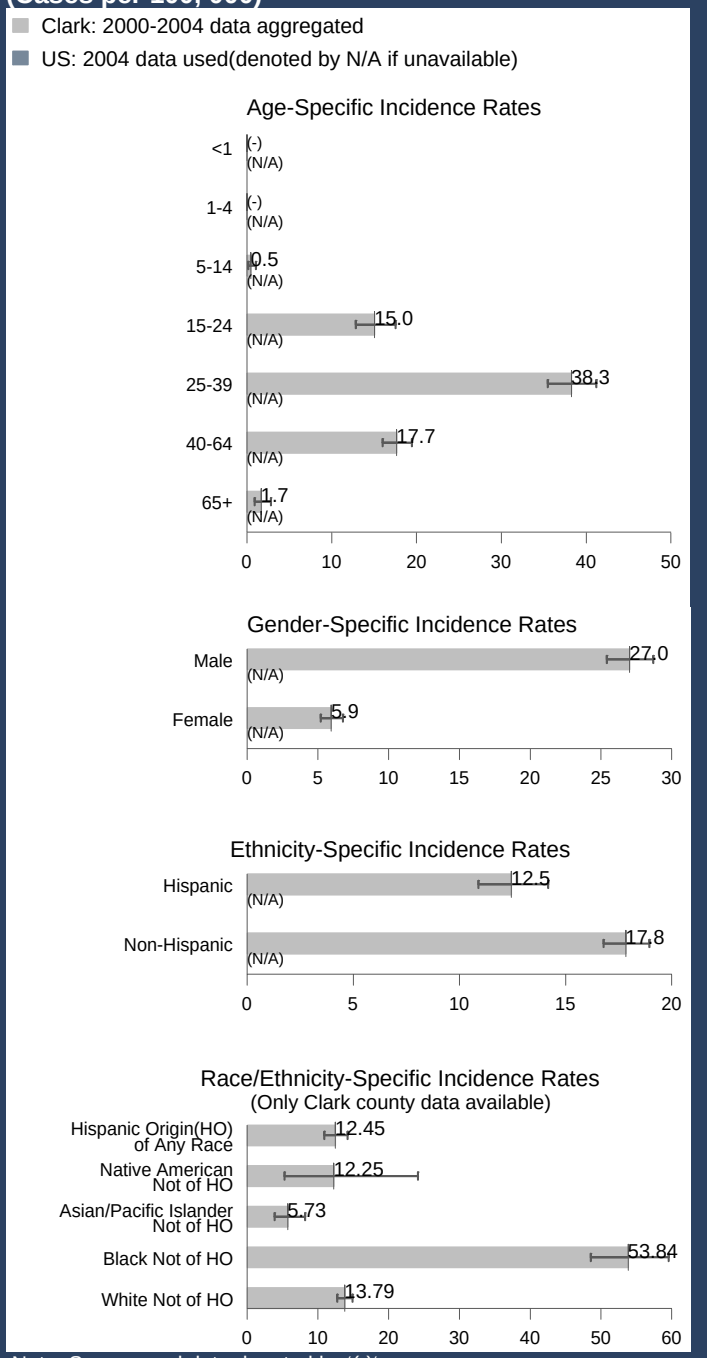
Trends: HIV Infection

Two hundred ninety nine cases of HIV infection were reported in Clark County in 2004. The incidence rate in 2004 was not significantly different from those in previous years (Figure 1).

Demographics: HIV Infection

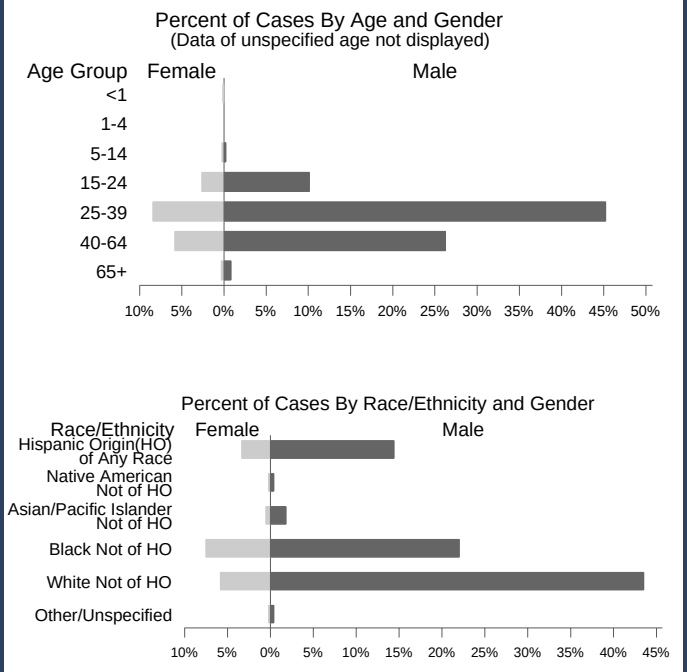
Based on aggregated county data of 2000 to 2004, the 25 to 39 age group had a significantly higher incidence rate than other age groups; the male rate was significantly higher than that of females; non-Hispanic Blacks had a significantly higher rate than other racial/ethnic groups (Figure 2).

Figure 2: Age, Gender, Ethnicity and Race/Ethnicity Specific Incidence Rates of Reported HIV Infections (Cases per 100, 000)



Note: Suppressed data denoted by '(-)' .

Figure 3: Percent of Cases of Reported HIV Infections (of 5-year case total)



Associated Risk Factors: HIV Infection

A breakdown of reported HIV infections in Clark County from 2000 to 2004 by exposure category can be seen in Table 1. Of the 299 newly reported HIV cases in Clark County in 2004, 209 (69.9%) were acquired among men having sex with men (MSM). This compares to 146 (71.9%) in 2003 and 181 (65.6%) in 2002. There were 20 cases (6.7%) reported among injecting drug users (IDUs) in Clark County in 2004, compared with 12 (5.9%) in 2003 and 18 (6.5%) in 2002. The trends in reported HIV cases in Clark County among the three major risk groups (MSM, heterosexuals and IDUs) are shown in Figure 4.

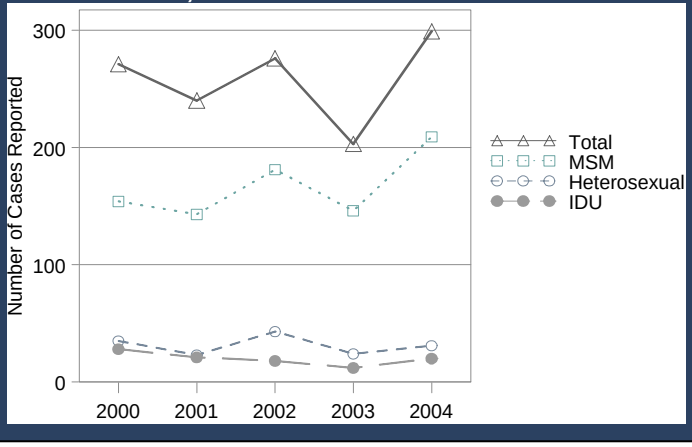
Table 1: Reported HIV Infections by Year and Exposure Category in Clark County, 2000-2004 (unspecified exposure category not displayed)

Year	Exposure Category							
	MSM	IDU	MSM &IDU	Hemophilia*	Hetero-sexual contact	Blood-transfusion **	MTC#	Total
2000	154	28	8	.	35	0	.	271
2001	143	21	12	.	23	0	.	240
2002	181	18	14	.	43	0	.	276
2003	146	12	9	.	24	0	.	203
2004	209	20	12	.	31	0	.	299
Total	833	99	55	.	156	0	5	1289

Note: Suppressed data denoted by '.'.
*Hemophilia/Coagulation Disorder. **Receipt of blood, component or tissue. #Mother to child transmission. The five prenatal transmission cases are still under investigation to locate and determine the continued positive status of child.

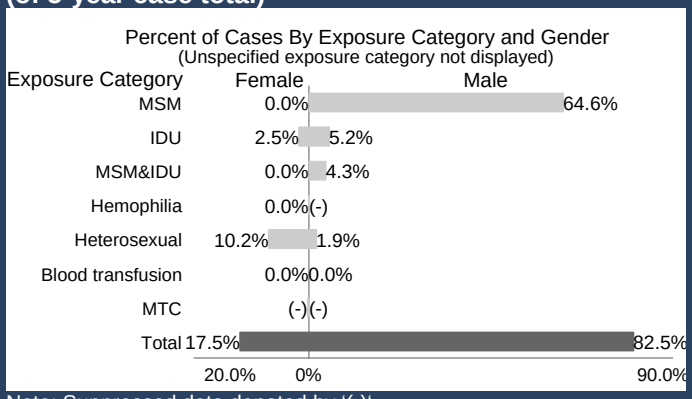
The age-gender and racial/ethnic-gender distributions of reported HIV cases in Clark County are provided in Figure 3. Annual age, gender, ethnicity specific incidence rates and percent of cases are provided in the appendix.

Figure 4: Reported HIV Infections among MSM, heterosexuals, and IDUs



A breakdown of HIV cases in Clark County by exposure category and gender is shown in Figure 5. Of the 1289 HIV cases reported from 2000 to 2004, 1063 (82.5%) were male and 226 (17.5%) were female; 833 (64.6%) were acquired among MSM, and 131 (10.2%) were heterosexually acquired among females. Among those whose route of transmission was IDU, the majority were male, accounting for 5.2% (67 cases) of the 5-year case total.

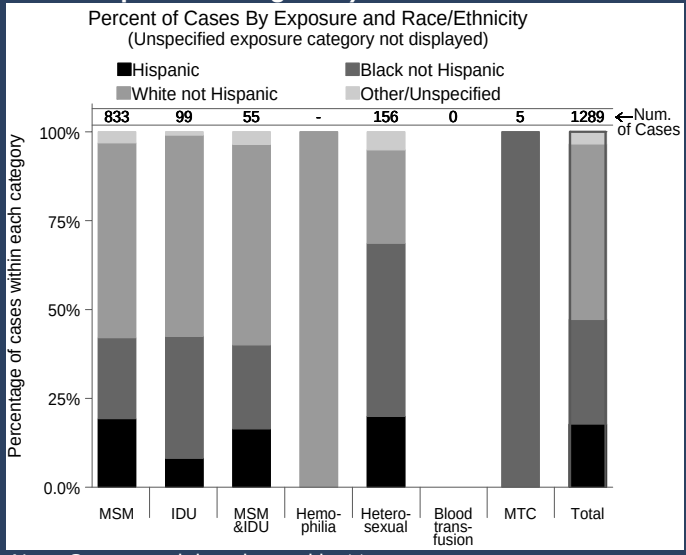
Figure 5: Percent of Cases of Reported HIV Infections (of 5-year case total)



Note: Suppressed data denoted by '(-)' .

A breakdown of HIV cases by exposure category and race/ethnicity is presented in Figure 6. Of the 1289 HIV cases reported from 2000 to 2004, 636 (49.3%) were non-Hispanic Whites, 380 (29.5%) were non-Hispanic Blacks, and 228 (17.7%) were Hispanics. Non-Hispanic Whites accounted for more than the majority of cases reported in each exposure category with the exceptions of such possible routes of transmission as heterosexual contacts, receipt of blood, component or tissue and mother to child transmission.

Figure 6: Percent of Cases (of 5-year HIV case totals within exposure categories)



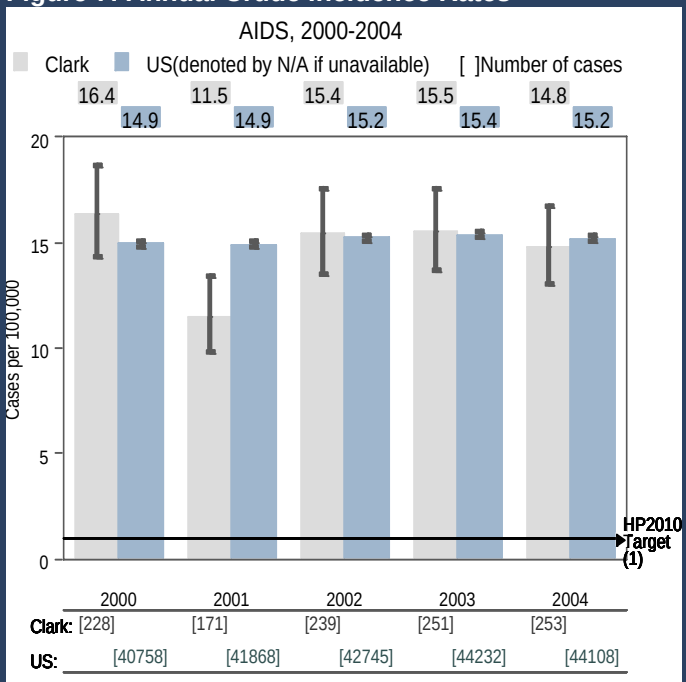
Note: Suppressed data denoted by '-' .

Summary of data: AIDS

Trends: AIDS

Two hundred fifty three cases of AIDS were reported in Clark County in 2004. The incidence rate in 2004 was not significantly different from those in previous years (Figure 7).

Figure 7: Annual Crude Incidence Rates



Note: Date of case being confirmed was used as the reporting scheme for county level data.

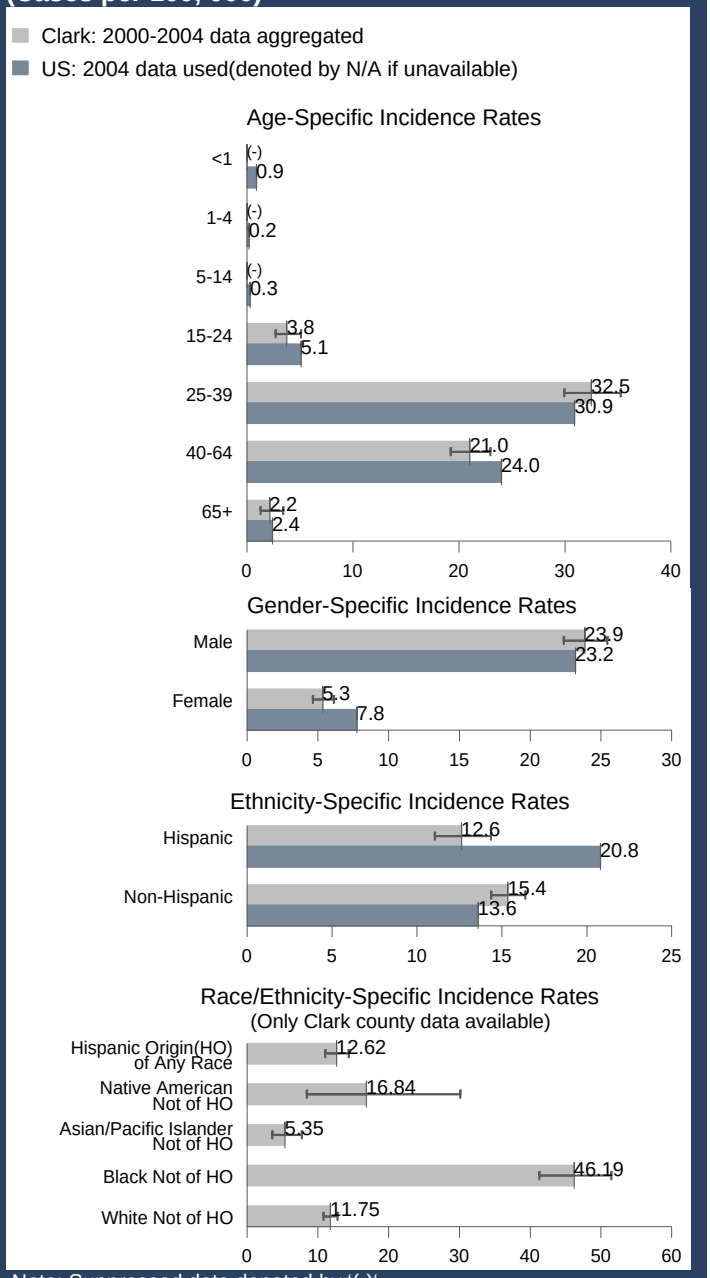
Seasonality: AIDS

An average of 19 cases of AIDS was reported monthly from 2000 to 2004 in Clark County. No seasonal pattern was apparent in the number of cases reported monthly.

Demographics: AIDS

Based on aggregated county data of 2000 to 2004, the 25 to 39 age group had a significantly higher incidence rate than other age groups; the male rate was significantly higher than that of females; non-Hispanic Blacks had a significantly higher rate than other racial/ethnic groups. Similar age and gender patterns were also seen in 2004 national data (Figure 8).

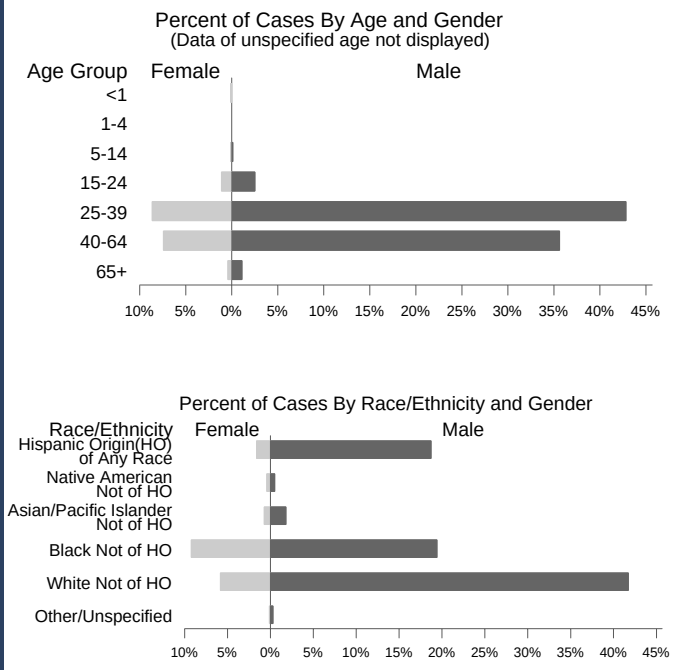
Figure 8: Age, Gender, Ethnicity and Race/Ethnicity Specific Incidence Rates of Reported AIDS Cases (Cases per 100, 000)



Note: Suppressed data denoted by '(-)' .

The age-gender and racial/ethnic-gender distributions of reported AIDS cases in Clark County are provided in Figure 9. Annual age, gender, ethnicity specific incidence rates and percent of cases are provided in the appendix.

Figure 9: Percent of Cases of Reported AIDS Cases (of 5-year case total)



Associated Risk Factors: AIDS

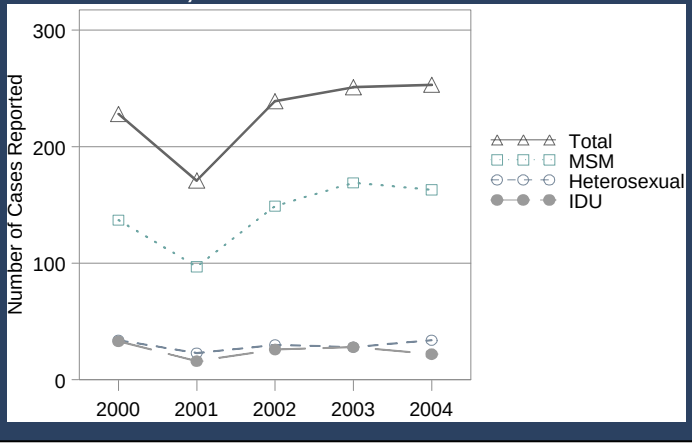
A breakdown of reported AIDS cases in Clark County from 2000 to 2004 by exposure category can be seen in Table 2. Of the 253 newly reported AIDS cases in Clark County in 2004, 163 (64.4%) were acquired among MSM. This compares to 169 (67.3%) in 2003 and 149 (62.3%) in 2002. There were 22 cases (8.7%) reported among injecting drug users (IDUs) in Clark County in 2004, compared with 28 (11.2%) in 2003 and 26 (10.9%) in 2002. The trends in reported AIDS cases in Clark County among the three major risk groups (MSM, heterosexuals and IDUs) are shown in Figure 10.

Table 2: Reported AIDS Cases by Year and Exposure Category in Clark County, 2000-2004 (unspecified exposure category not displayed)

Year	Exposure Category							
	MSM	IDU	MSM &IDU	Hemophilia	Hetero-sexual contact	Blood-transfusion	MTC	Total
2000	137	33	7	0	34	.	.	228
2001	97	16	9	0	23	.	.	171
2002	149	26	16	0	30	.	.	239
2003	169	28	13	0	28	.	.	251
2004	163	22	12	0	34	.	.	253
Total	**715**	**125**	**57**	**0**	**149**	.	.	**1142**

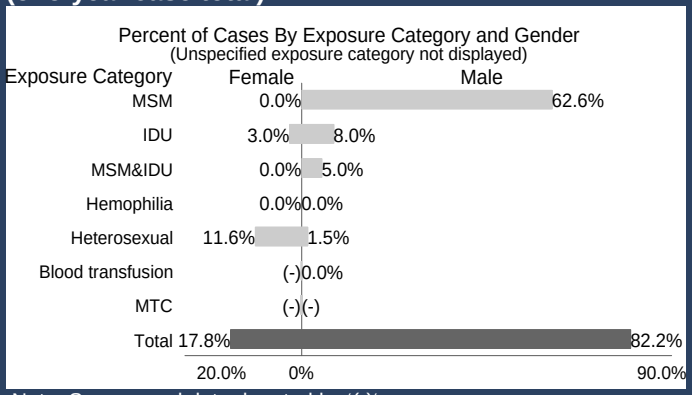
Note: Suppressed data denoted by '.'.

Figure 10: Reported AIDS Cases among MSM, heterosexuals, and IDUs



A breakdown of AIDS cases in Clark County by exposure category and gender is shown in Figure 11. Of the 1142 AIDS cases reported from 2000 to 2004, 939 (82.2%) were male and 203 (17.8%) were female; 715 (62.6%) were acquired among MSM, and 132 (11.6%) were heterosexually acquired among females. Among those whose route of transmission was IDU, the majority were male, accounting for 8% (91 cases) of the 5-year case total.

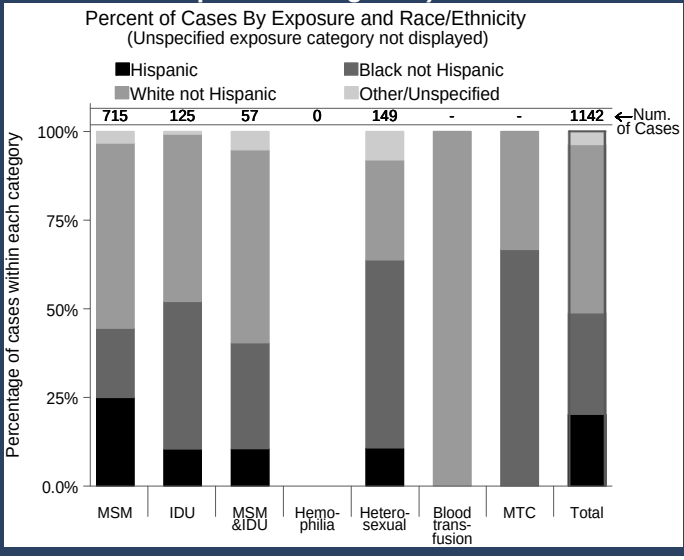
Figure 11: Percent of Cases of Reported AIDS Cases (of 5-year case total)



Note: Suppressed data denoted by '(-)' .

A breakdown of AIDS cases by exposure category and race/ethnicity is presented in Figure 12. Of the 1142 AIDS cases reported from 2000 to 2004, 542 (47.5%) were non-Hispanic Whites, 326 (28.5%) were non-Hispanic Blacks, and 231 (20.2%) were Hispanics.

Figure 12: Percent of Cases (of 5-year AIDS case totals within exposure categories)



HIV/AIDS-related deaths

A total of 64 deaths among HIV/AIDS cases in Clark County were reported to the Nevada State Health Division during 2004. Table 3 shows the number of HIV/AIDS-related deaths, percent of all deaths and age-adjusted death rates (AADR) in the county, state and nation from 2000 to 2004. In terms of AADR, both the county and the nation lagged far behind the healthy people 2010 (HP2010) target of 0.7 deaths per 100,000 population.

Table 3: Deaths with HIV/AIDS as Underlying Cause: Clark County, Nevada and U.S., 2000-2004

	Clark			NV			US		
	Num	% all deaths	AADR*	Num	% all deaths	AADR*	Num	% all deaths	AADR*
2000[1]	77	0.75%	5.5	89	0.58%	4.4	14,478	0.60%	5.2
2001[1]	67	0.61%	4.7	76	0.47%	3.6	14,175	0.59%	5.0
2002[1]	60	0.52%	3.9	76	0.45%	3.5	14,095	0.58%	4.9
2003[2]	65	0.55%	4.1 (3.1~5.1)	76	0.43%	3.3 (2.6~4.1)	13,658	0.56%	4.7
2004[2]	64	0.53%	3.8 (2.9~4.7)	78	0.44%	3.3 (2.6~4.0)	12,995	0.54%	4.4

*Age-adjusted deaths rates (per 100,000 population).
[1]From CDC WONDER online database (available up to 2002 as final data at the time this report was written). [2]County and state level statistics from Nevada State Health Division. 95% confidence intervals for AADR provided in parentheses. Statistics at the national level from National Vital Statistics reports (final for 2003 and preliminary for 2004).

SYPHILIS

Introduction

Syphilis is a sexually transmitted disease caused by the bacterium *Treponema pallidum.* It is usually transmitted by direct contact with infectious lesions or sores, but it can also be passed from mother to infant during pregnancy causing congenital syphilis. Rarely, it is transmitted via blood transfusion. Without treatment, it can damage many parts of the body and cause death. Syphilis in adults progresses in stages, sometimes overlapping, including primary, secondary, latent or late. The first stage, primary syphilis, is marked by a firm, painless sore(s), usually appearing at the place of initial exposure to the bacteria after an incubation period of 10 to 90 days. Local lymph node swelling can occur. The sore may last from 1 to 6 weeks and heal by itself without treatment. However, if adequate treatment is not received, the infection progresses to the secondary stage, characterized by non-itchy skin rash and mucous membrane lesions. Rashes can appear as the primary sore is healing or several weeks after the sore has healed. Other symptoms of secondary syphilis may include fever, headache, loss of appetite, weight loss, sore throat, muscle aches, joint pain, enlarged lymph nodes and fatigue. In this stage, syphilis may affect the liver, kidneys, and eyes or cause meningitis. The symptoms of secondary syphilis will eventually go away, but without treatment, the infection will progress to the latent or late stages of disease. The latent stage of syphilis begins when symptoms of secondary syphilis disappear. It can start from two years to over 30 years after initial infection. Latent syphilis is further described as either early or late. In early latent syphilis, the infected person will continue to have syphilis and be contagious without symptoms of disease. Some people with latent syphilis do not go on to develop late stage syphilis even without treatment. But others will go on to develop late stage syphilis that can appear even years later and result in mental illness, blindness, deafness, memory loss or other neurological problems, heart disease, and death. Late latent syphilis is not considered contagious since the risk of infecting a sexual partner is low or absent at this stage.

Syphilis is easy to cure in its early stages. The dose of antibiotics and length of treatment depends on the stage of syphilis and symptoms of the disease. In late syphilis however, damage already done to body organs cannot be reversed. The surest way to prevent the transmission of syphilis is to avoid contact with infected tissues and body fluids. Using condoms properly and consistently during sexual intercourse reduces the risk of getting syphilis. A pregnant woman can avoid passing syphilis on to her unborn child by getting tested and treated for the disease during pregnancy. Recommendations about prevention can be found at *http://www.cdc.gov/std/syphilis/*.

Summary of data: Syphilis (Primary & Secondary)

Disease Abstract, 2004*

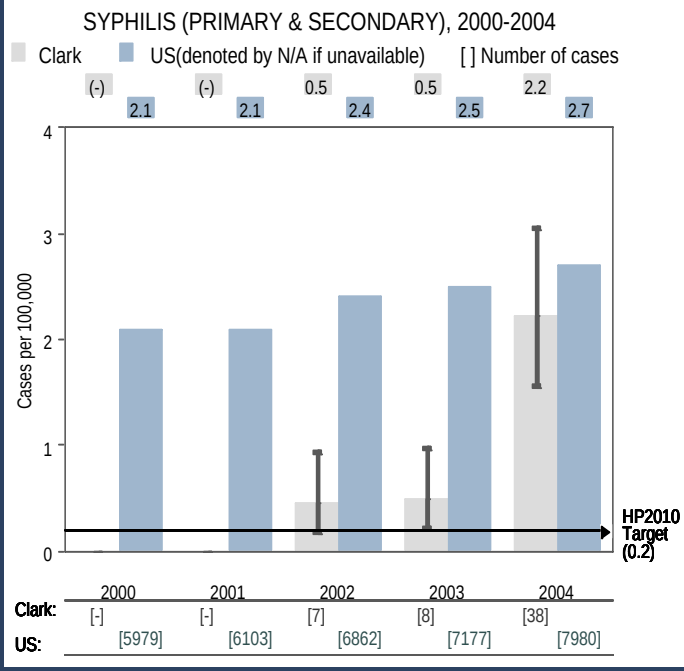
	Clark	Nevada	US
Number of cases reported	38	40	7,980
Rate (cases per 100,000)	2.2	1.8	2.7
Median age at time of event	29	N/A	N/A

*Numbers and rates for both the state and nation were from the 2004 National STD Surveillance Report. Time of event is not uniformly definable and can be that of onset, diagnosis, lab collection or reporting.

Trends: Syphilis (Primary & Secondary)

An upward trend was observed in the reported incidence of primary and secondary (p&s) syphilis in Clark County between 2002 and 2004 (Figure 1).

Figure 1: Annual Crude Incidence Rates



Note: Suppressed data denoted by '(-)' or '[-]' .

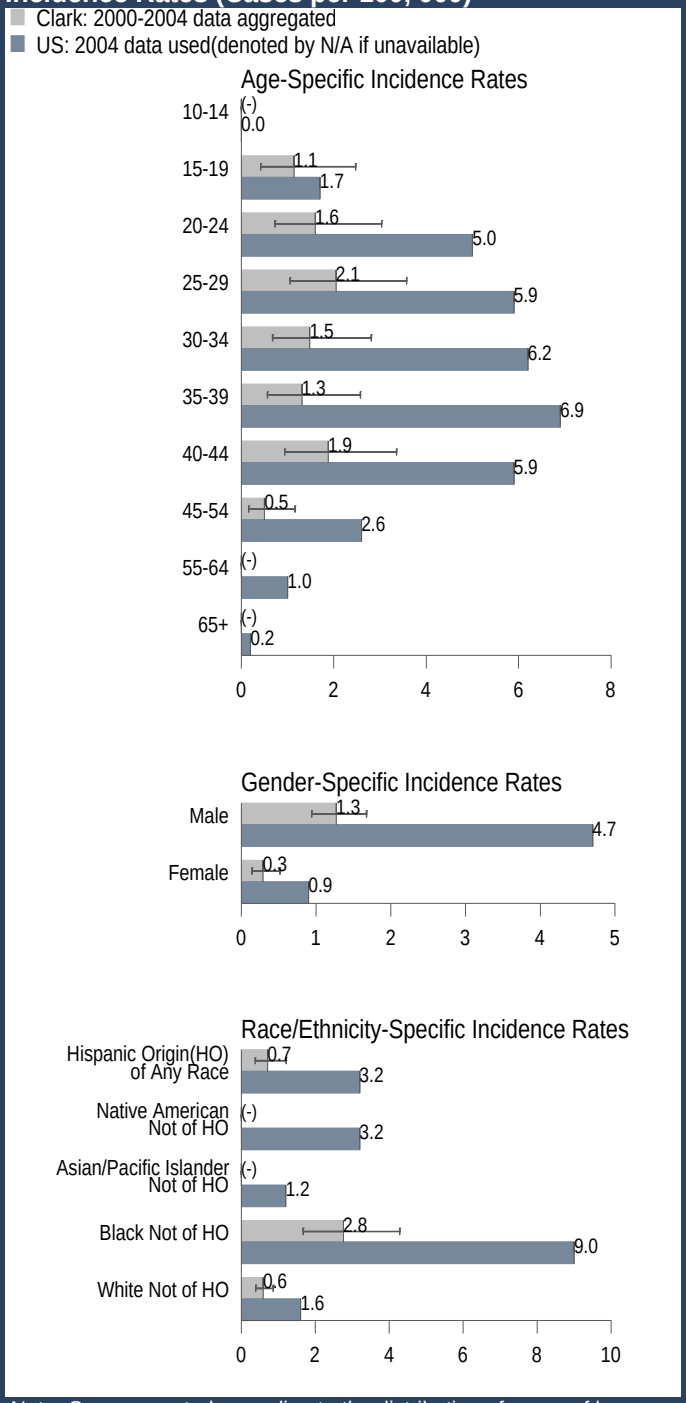
Seasonality: Syphilis (Primary & Secondary)

An average of one p&s syphilis case was reported monthly from 2000 to 2004 in Clark County with no apparent seasonal patterns.

Demographics: Syphilis (Primary & Secondary)

Based on aggregated county data of 2000 to 2004, the 15 to 39 age groups had higher incidence rates than other age groups; the male rate was significantly higher than that of females; non-Hispanic Blacks had a significantly higher rate than other racial/ethnic groups. Similar age and gender patterns have been observed in 2004 national data (Figure 2).

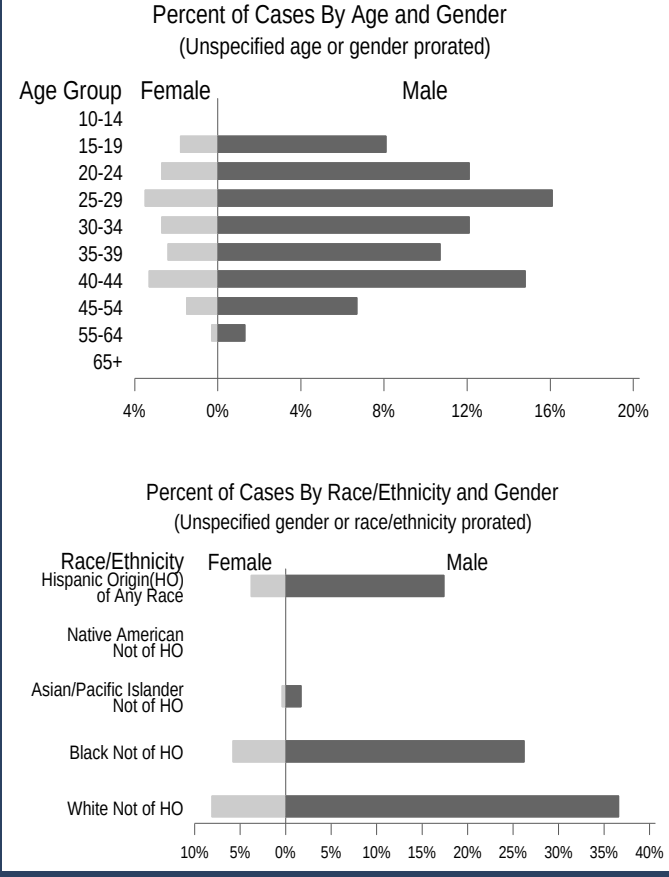
Figure 2: Age, Gender, and Race/Ethnicity Specific Incidence Rates (Cases per 100, 000)



Note: Cases prorated according to the distribution of cases of known demographics where age, gender, or race/ethnicity were unspecified. Suppressed data denoted by '(-)' . The 0-9 year age groups were not shown in age-related figures due to possible non-sexual transmission.

The age-gender and racial/ethnic-gender distributions of cases are provided in Figure 3. Mean and median ages of reported cases are provided in the appendix (Table 1).

Figure 3: Percent of Cases (of 5-year case total)

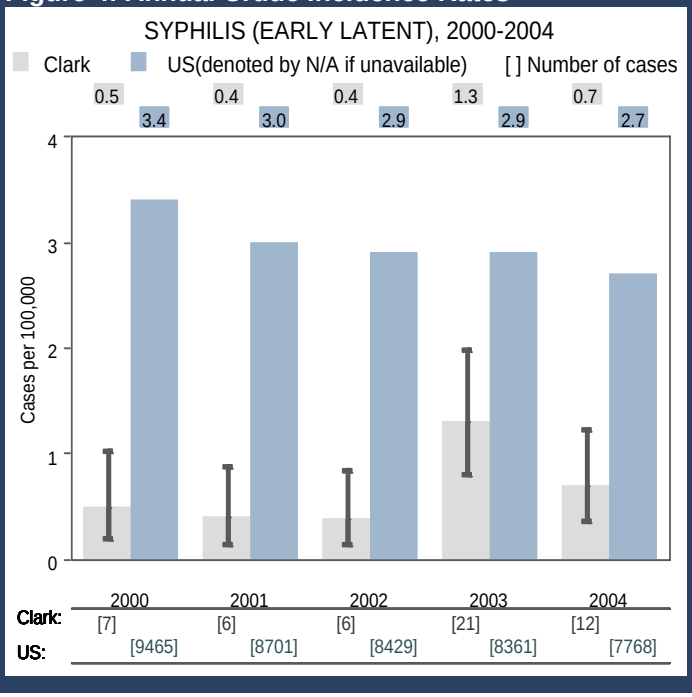


Summary of data: Syphilis (Early Latent)

Trends: Syphilis (Early Latent)

The reported incidence of early latent syphilis in Clark County increased between 2000 and 2004. However, the incidence rate in 2004 was not significantly different from those in previous years (Figure 4).

Figure 4: Annual Crude Incidence Rates



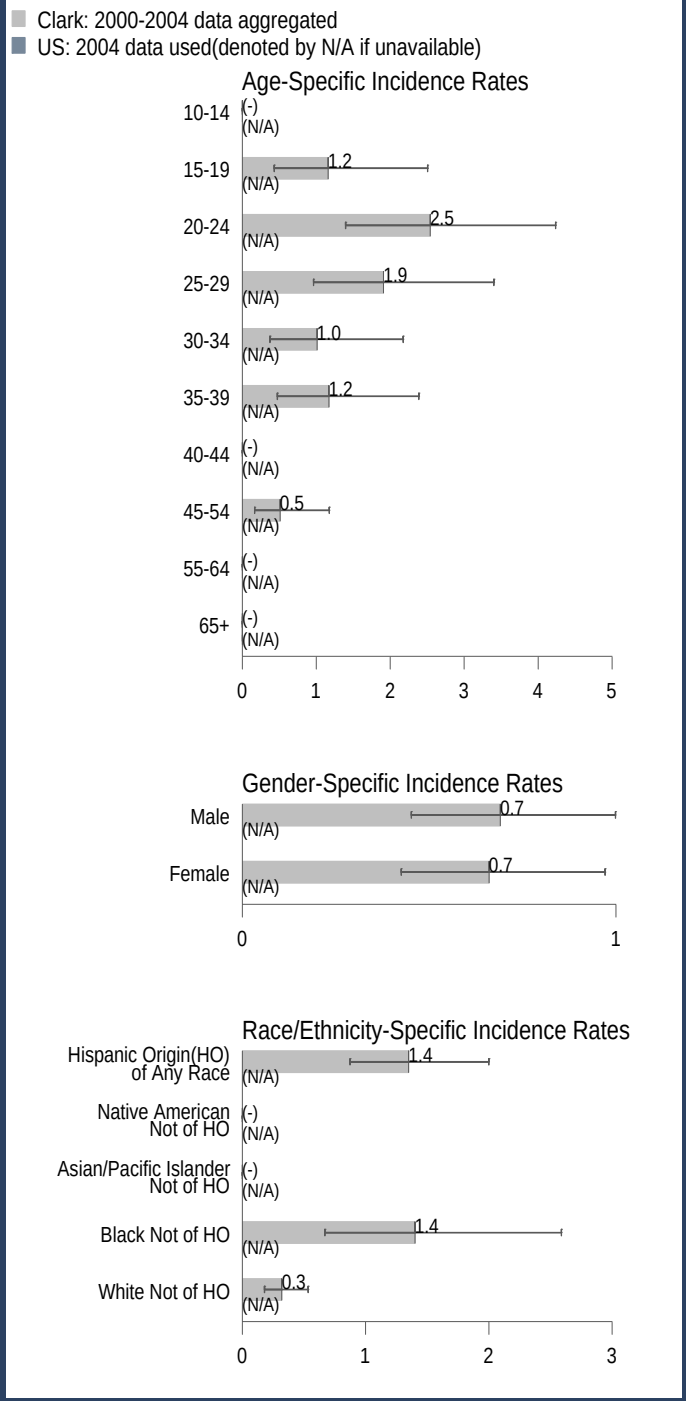
Seasonality: Syphilis (Early Latent)

An average of one early latent syphilis case was reported monthly from 2000 to 2004 in Clark County with no apparent seasonal patterns.

Demographics: Syphilis (Early Latent)

Based on aggregated county data of 2000 to 2004, the 15 to 39 age groups had higher incidence rates than other age groups. The male rate was slightly higher than that of female, although the gender difference was not significant (Figure 5).

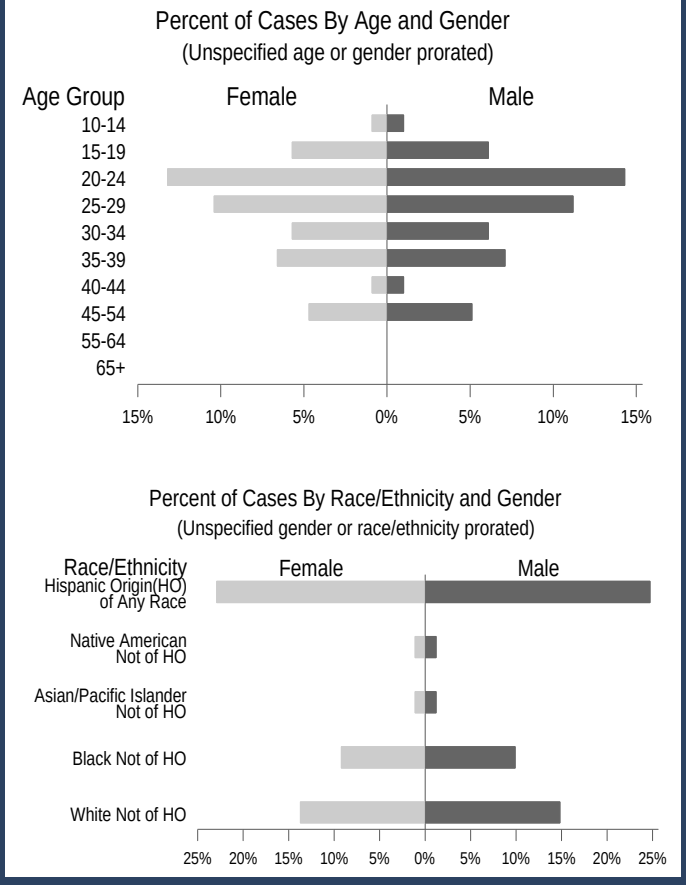
Figure 5: Age, Gender, and Race/Ethnicity Specific Incidence Rates (Cases per 100, 000)



Note: Cases prorated according to the distribution of cases of known demographics where age, gender, or race/ethnicity were unspecified. Suppressed data denoted by '(-)' . The 0-9 year age groups were not shown in age-related figures due to possible non-sexual transmission.

The age-gender and racial/ethnic-gender distributions of cases are provided in Figure 6. Mean and median ages of reported cases are provided in the appendix (Table 2).

Figure 6: Percent of Cases (of 5-year case total)



Associated Risk Factors

Based on available county data (not shown here), high-risk sexual activities tend to put people at particular risk of syphilis infection. Such risky behaviors include unprotected intercourse (without condoms), having multiple sex partners, men having unprotected sex with other men, rectal intercourse, etc.

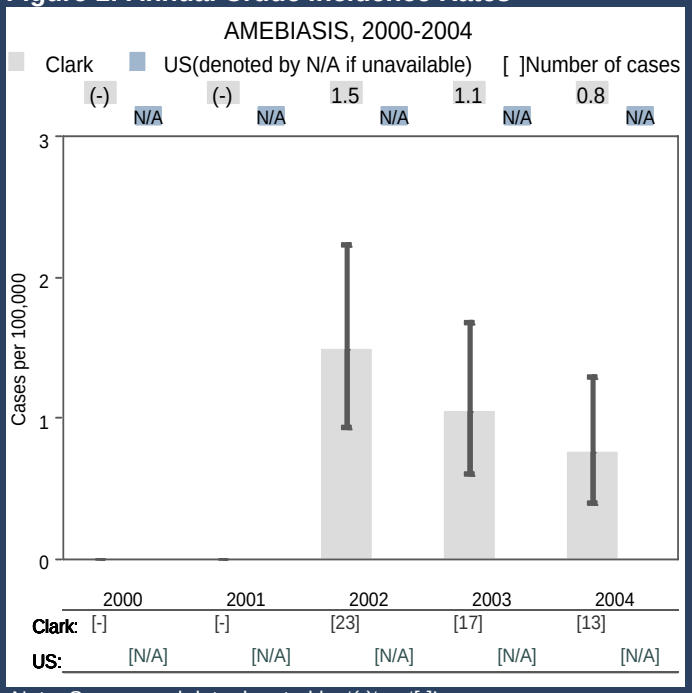
AMEBIASIS

Introduction

Amebiasis refers to infection with a parasite called *Entamoeba histolytica*. Symptoms are variable and may include diarrhea (with or without blood or mucus), fever, abdominal pain and constipation. Many people infected with the parasite do not have any symptoms; however if the parasite enters the blood, it can spread and cause abscesses in the liver, and less commonly, the brain and lungs. The major mode of transmission is person to person through fecal-oral transfer of cysts from infected feces. Although illness typically occurs 2-4 weeks after a person ingests the parasite, the incubation period can range from a few days to several years.

No vaccine is available. Some infections may be treated with a single antibiotic; however treatment of extraintestinal infection or those that do not respond to the single antibiotic often require a course of several medications. The best way to avoid amebiasis is to avoid drinking untreated water, and to practice appropriate hand hygiene. A detailed recommendation of preventive measures can be found at *http://www2.ncid.cdc.gov/travel/yb/utils/ybGet.asp?section=dis&obj=amebiasis.htm*.

Figure 1: Annual Crude Incidence Rates



Note: Suppressed data denoted by '(-)' or '[-]'.

Summary of data

Trends

In Clark County the reported incidence of amebiasis decreased between 2002 and 2004. However the incidence rate in 2004 was not significantly different from that in 2002 (Figure 1).

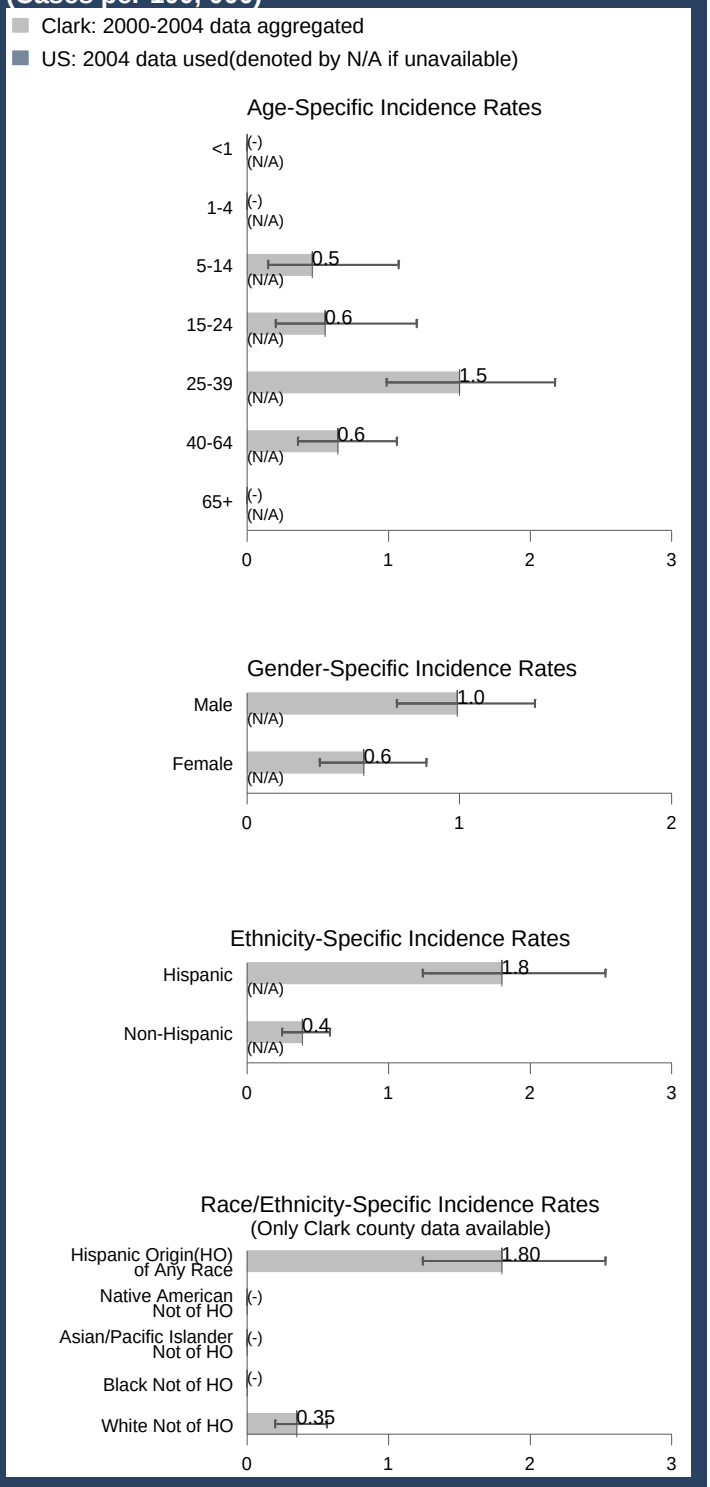
Seasonality

An average of one case was reported monthly from 2000 to 2004 in Clark County. No seasonal pattern was apparent in the number of cases reported monthly.

Demographics

Based on aggregated Clark County data of 2000-2004, adults aged 25-39 years had a higher incidence rate than other age groups, yet the differences were not significant across age groups. While a higher rate was seen in men, the gender difference also was not significant. Hispanics of any race had a significantly higher incidence rate than non-Hispanic groups (Figure 2).

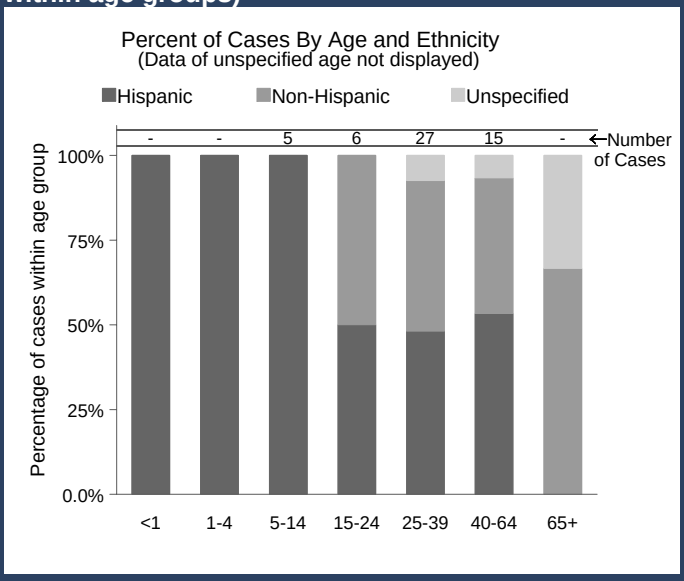
Figure 2: Age, Gender, Ethnicity and Race/Ethnicity Specific Incidence Rates (Cases per 100, 000)



Note: Suppressed data denoted by '(-)' .

From 2000 to 2004 in Clark County, all reported cases were Hispanic for age groups of 14 years or younger (Figure 3).

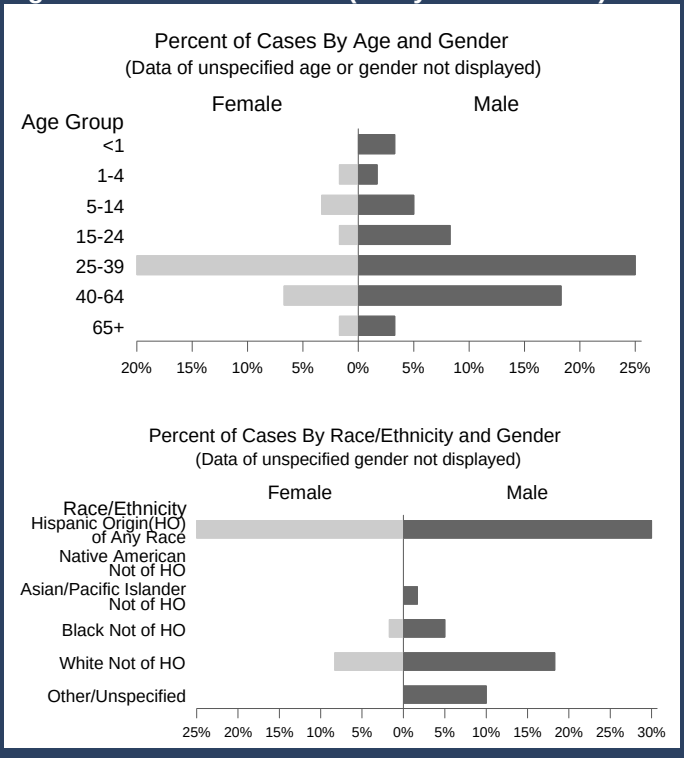
Figure 3: Percent of Cases (of 5-year case totals within age groups)



Note: Suppressed data denoted by '-' .

The age-gender and racial/ethnic-gender distributions of cases are provided in Figure 4. Mean and median ages of reported cases are provided in the appendix.

Figure 4: Percent of Cases (of 5-year case total)



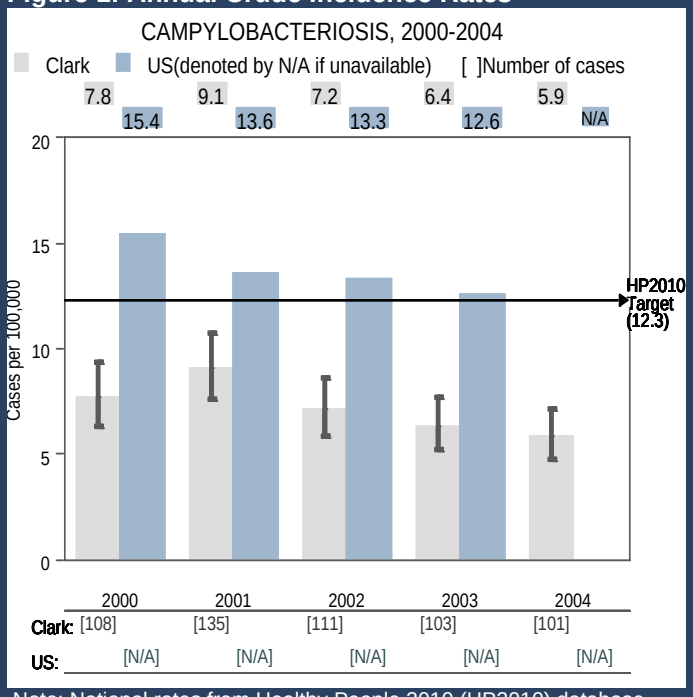
CAMPYLOBACTERIOSIS

Introduction

Campylobacteriosis refers to infection with a bacterium called *Campylobacter* (in the United States, typically *Campylobacter jejuni* or, less commonly, *Campylobacter coli*). Symptoms vary and may include diarrhea, fever, abdominal pain, nausea and vomiting. Some infections are asymptomatic. Illness typically occurs 1-10 days after a person ingests the bacteria. The bacterium is often transmitted through contaminated animal products, such as raw or undercooked poultry and unpasteurized milk products. Several animals such as puppies, kittens and birds can also be infected with *Campylobacter* spp., and serve as sources of infection to their owners through fecal exposure. Person-to-person transmission is not common.

No vaccine is available. Rehydration and electrolyte replacement may be necessary for some cases of campylobacteriosis. Antibiotics are typically only effective early in infection or in cases where the bacteria have entered the blood. The best way to avoid campylobacteriosis is to practice proper food preparation techniques and hand hygiene. A detailed recommendation of preventive measures is found at http://www.cdc.gov/ncidod/dbmd/diseaseinfo/campylobacter_g.htm.

Figure 1: Annual Crude Incidence Rates

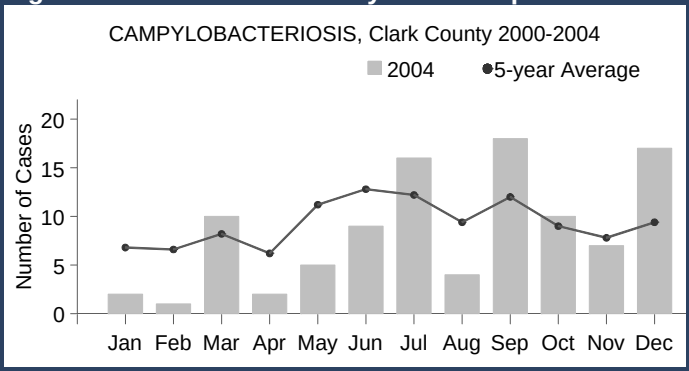


Note: National rates from Healthy People 2010 (HP2010) database.

Seasonality

An average of nine cases was reported monthly from 2000 to 2004 in Clark County. More cases were reported in fall and winter months, although no seasonal pattern was apparent (Figure 2).

Figure 2: Number of Cases by Month Reported



Summary of data

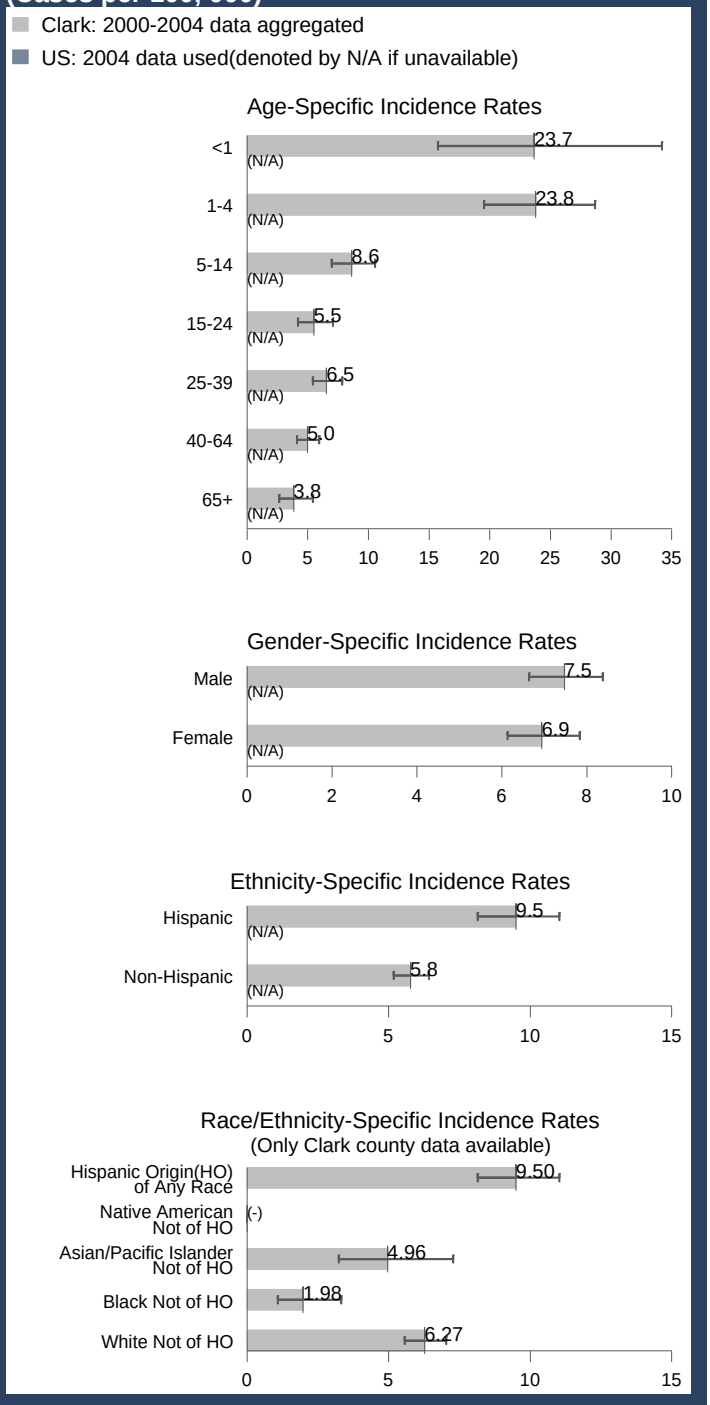
Trends

A downward trend was indicated in the reported incidence of campylobacteriosis in Clark County between 2001 and 2004, although the incidence rate in 2004 was not significantly different from that in 2000 (Figure 1).

Demographics

Based on aggregated Clark County data of 2000-2004, children four years old or younger had significantly higher incidence rates than other age groups. A higher rate was seen in males, yet the gender difference was not significant. Hispanics of any race had a significantly higher incidence rate than non-Hispanic groups (Figure 3).

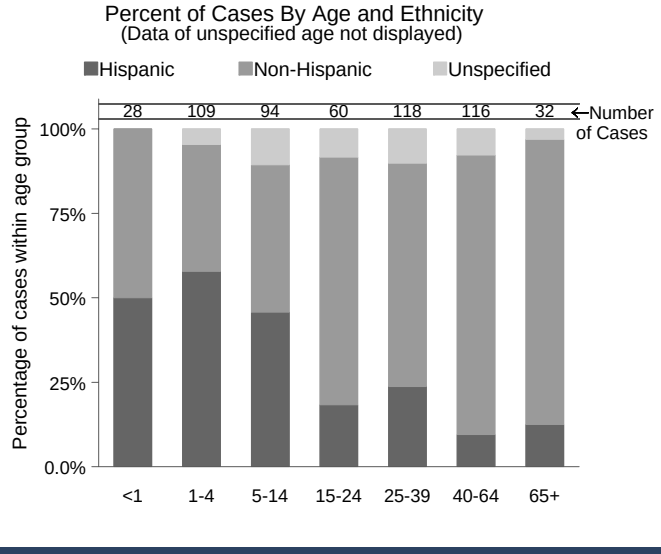
Figure 3: Age, Gender, Ethnicity and Race/Ethnicity Specific Incidence Rates (Cases per 100, 000)



Note: Suppressed data denoted by '(-)' .

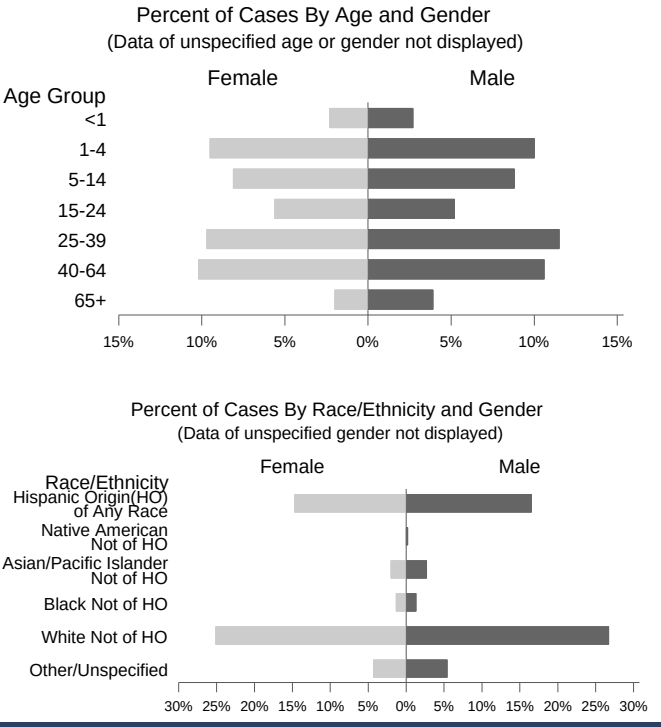
From 2000 to 2004 in Clark County, the majority of reported cases have tended to be non-Hispanic for age groups of 15 years and older (Figure 4).

Figure 4: Percent of Cases (of 5-year case totals within age groups)



The age-gender and racial/ethnic-gender distributions of cases are provided in Figure 5. Annual age, gender, ethnicity specific incidence rates, percent of cases and mean/median age of reported cases are provided in the appendix.

Figure 5: Percent of Cases (of 5-year case total)



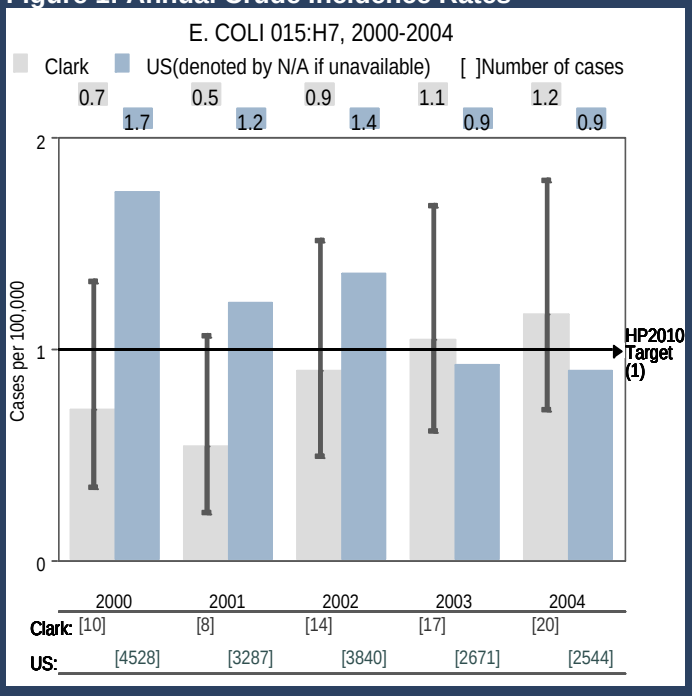
E. COLI O157:H7

Introduction

Escherichia coli (E. coli) *O157:H7* is a type of bacteria naturally present in the intestines of cattle. The most common route of infection with *E. coli O157:H7* is consumption of undercooked animal products, specifically ground beef, or from eating foods contaminated with juices from such products. Illness is characterized by diarrhea, which may range from mild and non-bloody to severe diarrhea containing blood. Symptoms typically begin 2-10 days after ingestion of the bacterium. Children under the age of five and the immunocompromised elderly infected with *E. coli O157:H7* are at increased risk of developing hemolytic uremic syndrome (HUS), which is characterized by red blood cell destruction and kidney failure.

Antibiotic therapy has not shown to be effective in treating infection from *E. coli O157:H7* and may increase the risk of developing complications such as HUS. As such, treatment usually concentrates on preventing dehydration or treating complications of the infection such as dehydration or HUS. The best way to prevent infection with *E. coli O157:H7* is to practice proper food preparation techniques and hand hygiene. A detailed recommendation of preventive measures can be found at *http://www.cdc.gov/ncidod/dbmd/diseaseinfo/escherichiacoli_g.htm*.

Figure 1: Annual Crude Incidence Rates



Summary of data

Disease Abstract, 2004*

	Clark	Nevada	US
Number of cases reported	20	27	2,544
Rate (cases per 100,000)	1.2	1.1	0.9
Median age at time of event	12	N/A	N/A

*Numbers for both the state and nation were from the 2004 MMWR Summary Report. Time of event is not uniformly definable and can be that of onset, diagnosis, lab collection or reporting.

Trends

An upward trend was indicated in the reported incidence of *E. coli O157:H7* in Clark County between 2001 and 2004. However the incidence rate in 2004 was not significantly different from that in 2000 (Figure 1).

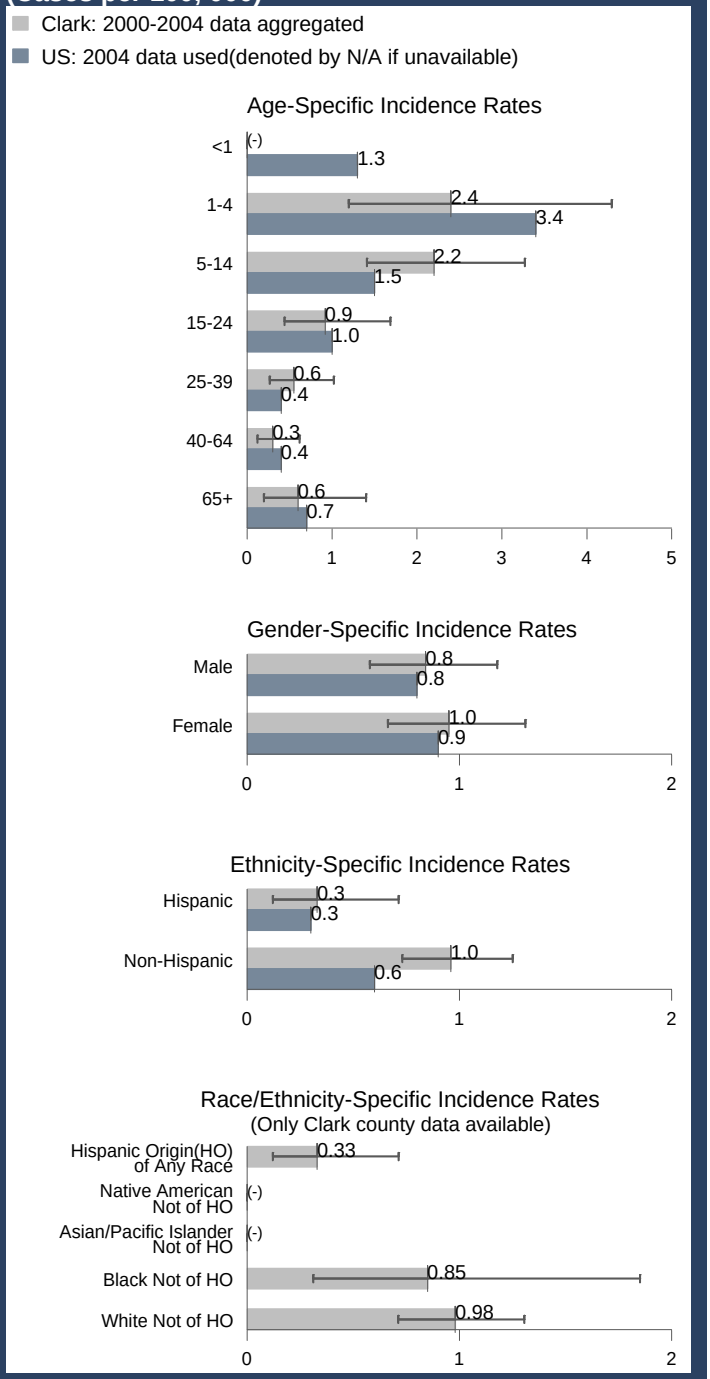
Seasonality

An average of one case was reported monthly from 2000 to 2004 in Clark County. More cases were reported in fall and winter months, although no seasonal pattern was apparent.

Demographics

Based on aggregated Clark County data of 2000-2004, children of 14 years and younger had higher incidence rates than other age groups. A downward trend was indicated in the incidence rate with increasing age until around age 65, at which time it began to increase. While a higher rate was seen in women, the gender difference was not significant. Whites of non-Hispanic origin had a higher incidence rate than other racial/ethnic groups, yet the racial/ethnic differences were not significant (Figure 2).

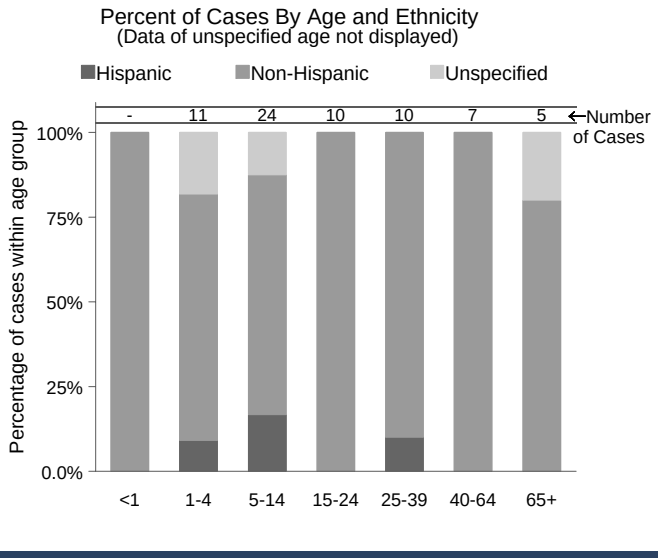
Figure 2: Age, Gender, Ethnicity and Race/Ethnicity Specific Incidence Rates (Cases per 100, 000)



Note: Suppressed data denoted by '(-)' .

From 2000 to 2004 in Clark County, the majority of reported cases have tended to be non-Hispanic for all age groups (Figure 3).

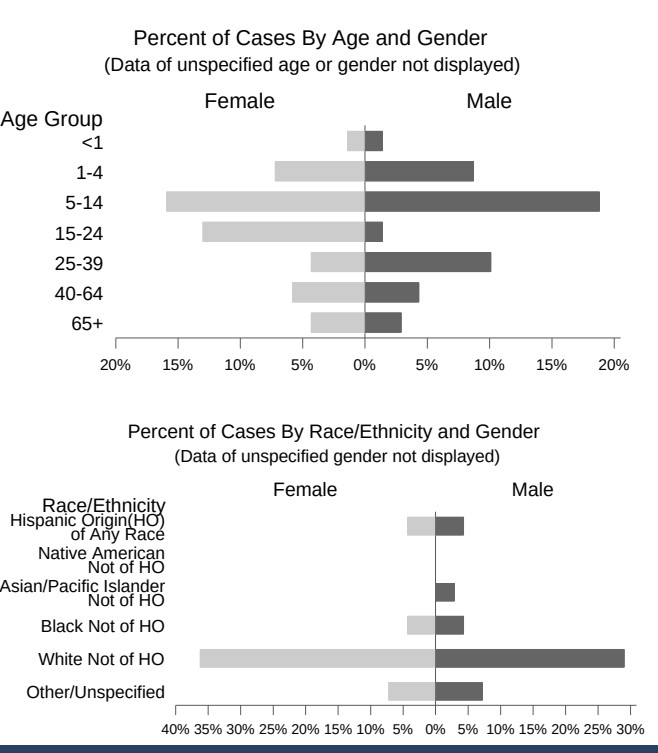
Figure 3: Percent of Cases (of 5-year case totals within age groups)



Note: Suppressed data denoted by '-' .

The age-gender and racial/ethnic-gender distributions of cases are provided in Figure 4. Mean and median ages of reported cases are provided in the appendix.

Figure 4: Percent of Cases (of 5-year case total)



GIARDIASIS

Introduction

Giardiasis refers to infection with a parasite called *Giardia lamblia*. Animals, including beavers and other wild and domestic animals, can be infected with the parasite, as well as humans. Symptoms are variable such as watery, foul-smelling diarrhea accompanied by stomach cramps or excess gas. However, many infections are asymptomatic. The major mode of transmission is person to person through fecal-oral transfer of cysts from infected feces. Cases of giardiasis are often linked to hikers and campers who have drunk stream water contaminated by animal feces or to child care centers with diapered children. Sporadic cases of giardiasis in individuals with no obvious risk factors are also common. Illness typically occurs 3-25 days after ingestion of the parasite; however the incubation period may be longer.

No vaccine is available. Treatment failure is not uncommon but is not indicative of resistance by the parasite, and a repeated course of medicine is often indicated. To prevent giardiasis, avoid drinking untreated surface water, especially from mountain streams, and practise good hand hygiene and sanitation when handling diapered children. A detailed recommendation of preventive measures is found at http://www.cdc.gov/ncidod/dpd/parasites/giardiasis/default.htm.

Summary of data

Disease Abstract, 2004*

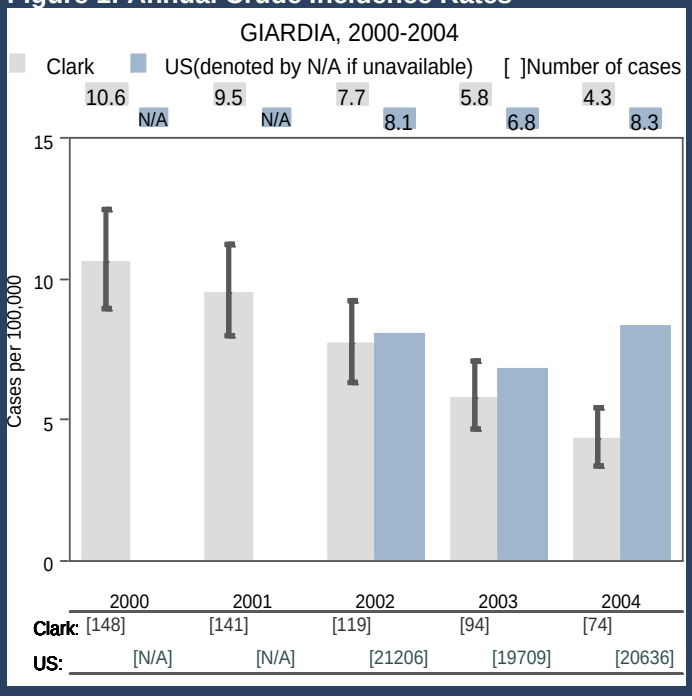
	Clark	Nevada	US
Number of cases reported	74	131	20,636
Rate (cases per 100,000)	4.3	5.4	8.3
Median age at time of event	31	N/A	N/A

*Numbers for both the state and nation were from the 2004 MMWR Summary Report. Time of event is not uniformly definable and can be that of onset, diagnosis, lab collection or reporting.

Trends

In Clark County the incidence of giardia decreased between 2000 and 2004. The incidence rate in 2004 was significantly lower than that in 2000 (Figure 1).

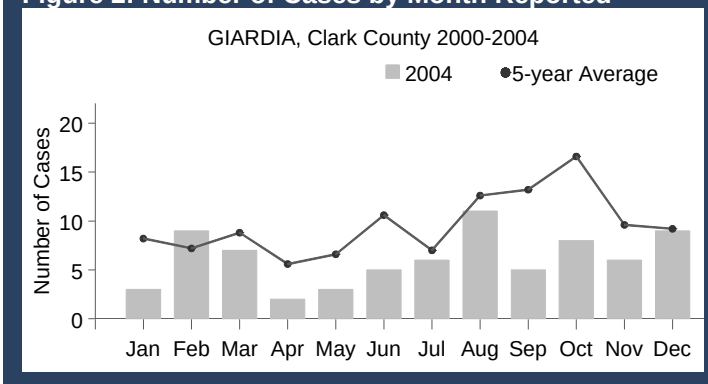
Figure 1: Annual Crude Incidence Rates



Seasonality

An average of 10 cases was reported monthly. More cases were seen in fall and winter months, although no seasonal pattern was apparent (Figure2).

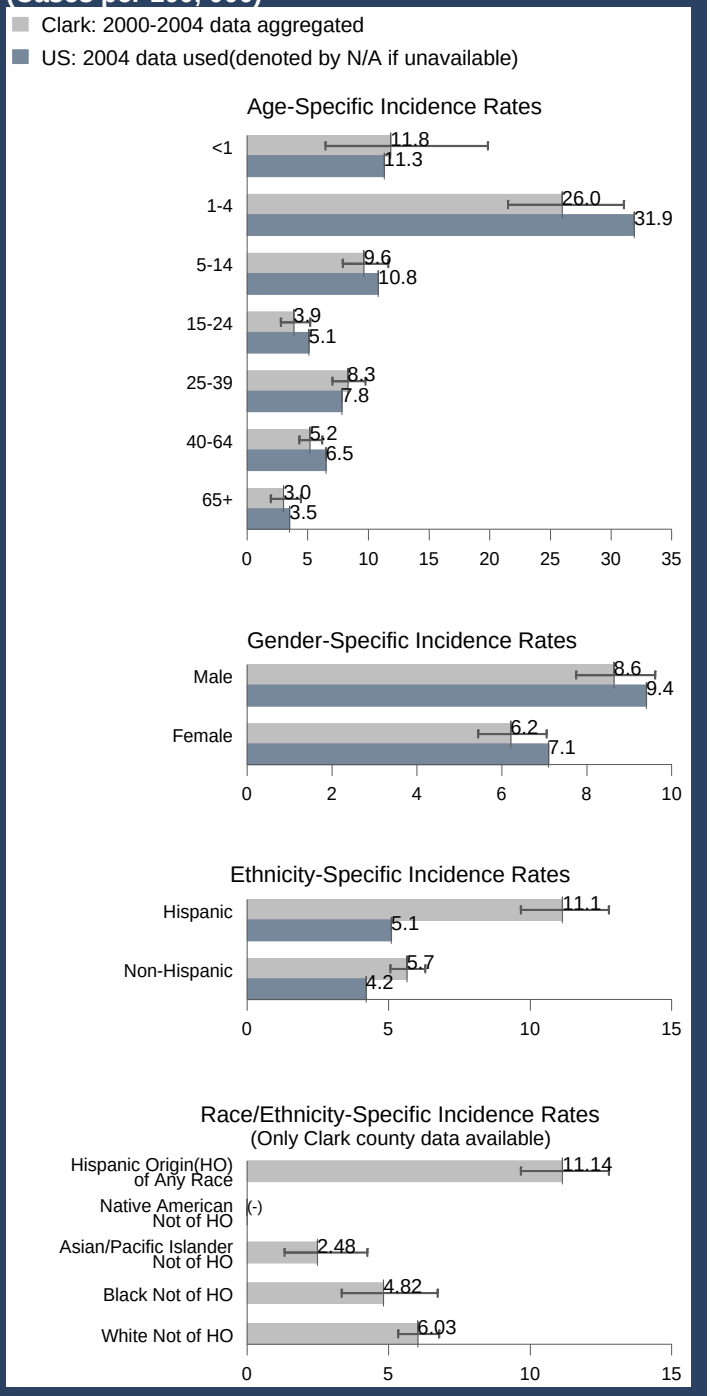
Figure 2: Number of Cases by Month Reported



Demographics

Based on aggregated Clark County data of 2000-2004, children aged 1-4 years had a significantly higher incidence rate than other age groups; the male rate was significantly higher than that of females, and Hispanics of any race had the highest incidence rate. Similar age, gender, and ethnic patterns have also been observed in 2004 national data (Figure 3).

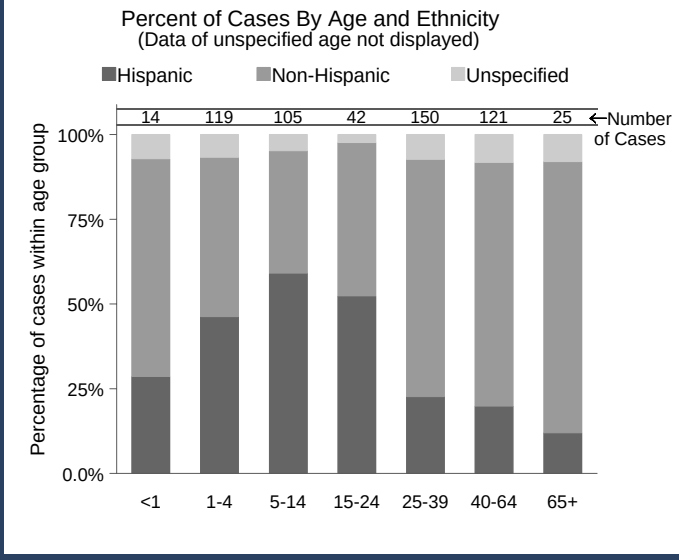
Figure 3: Age, Gender, Ethnicity and Race/Ethnicity Specific Incidence Rates (Cases per 100, 000)



Note: Suppressed data denoted by '(-)' .

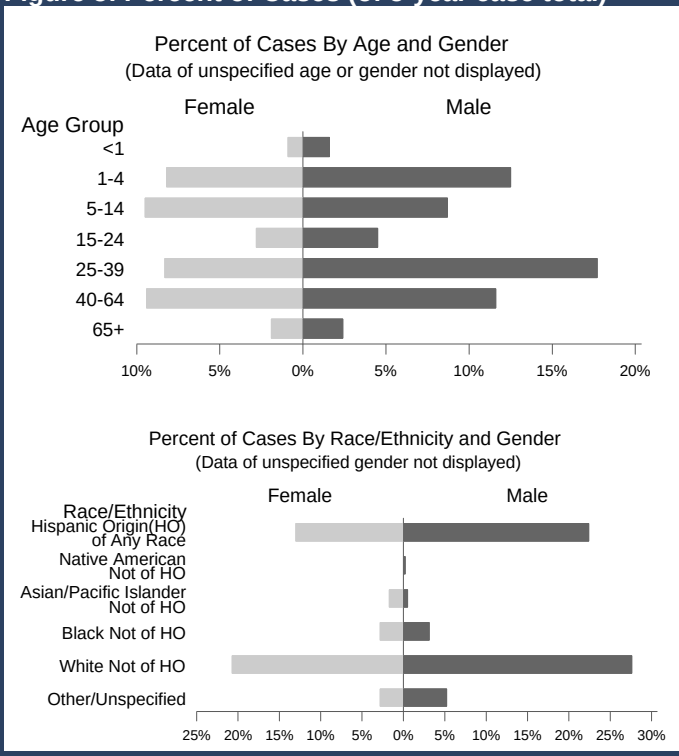
From 2000 to 2004 in Clark County, the majority of cases have tended to be Non-Hispanic in all age groups except for those aged 5-24 years (Figure 4).

Figure 4: Percent of Cases (of 5-year case totals within age groups)



The age-gender and racial/ethnic-gender distributions of cases are provided in Figure 5. Annual age, gender, ethnicity specific incidence rates, percent of cases and mean/median age of reported cases are provided in the appendix.

Figure 5: Percent of Cases (of 5-year case total)



ROTAVIRUS

Introduction

Rotavirus is a viral infection of the digestive tract. It is the most common cause of severe gastroenteritis (diarrhea) in infants and young children in the United States. Worldwide, rotavirus is a major cause of childhood deaths. Children with a rotavirus infection have fever, nausea, and vomiting, which are often followed by abdominal cramps and frequent, watery diarrhea. The watery diarrhea can be mild to severe and generally will last for 3 to 9 days. Sometimes the diarrhea that accompanies a rotavirus infection can cause children to lose body fluids very quickly and lead to dehydration, which can result in death if untreated. Signs of dehydration include thirst, irritability, restlessness, lethargy, sunken eyes, a dry mouth and tongue, dry skin, fewer trips to the bathroom to urinate, and a dry diaper for several hours (in infants).

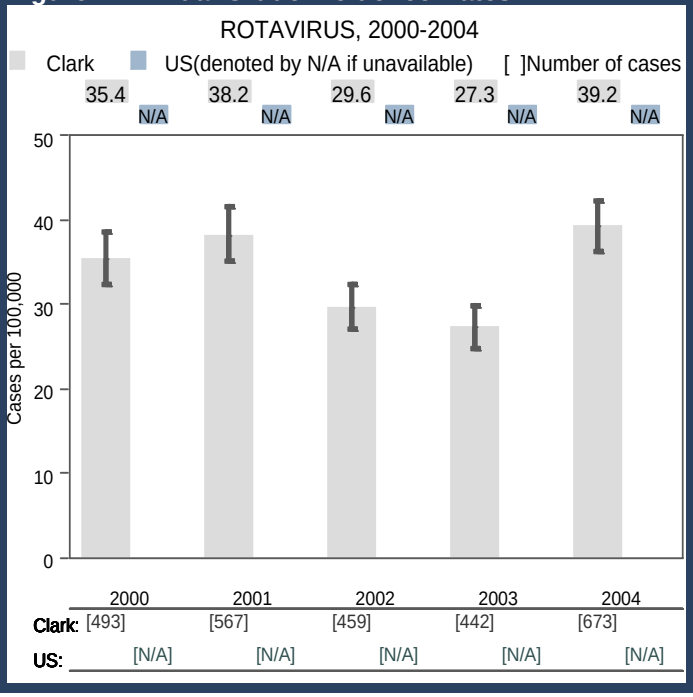
Rotavirus is transmitted by the fecal-oral route. Person-to-person spread through contaminated hands is probably the most important means of transmission. Rotavirus is quite stable in the environment, and is relatively resistant to most soaps and disinfectants. Total prevention of the spread of rotavirus is virtually impossible. The best way to limit the spread of the infection is to maintain hygienic practices at home and group settings such as healthcare and childcare facilities. Careful hand washing after using the toilet, diapering a child, and before preparing or serving food is helpful in preventing the spread of rotavirus. Giving special fluids by mouth is the most effective treatment in case of rotavirus gastroenteritis. Oral rehydration prevents most dehydration. Parents of children with severe diarrhea should start oral rehydration and take their child for medical evaluation. In February 2006, a newly approved rotavirus vaccine to prevent severe cases of rotavirus gastroenteritis became available. Detailed information about this new vaccine is found at http://www.fda.gov/bbs/topics/news/2006/NEW01307.html.

Summary of data

Trends

The incidence rate in 2004 was not significantly different from that in 2000 (Figure 1).

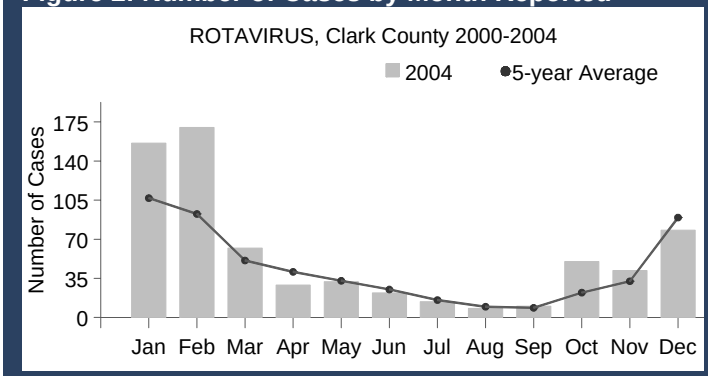
Figure 1: Annual Crude Incidence Rates



Seasonality

An average of 44 cases was reported monthly from 2000 to 2004 in Clark County. More cases were reported in spring and winter months (Figure 2).

Figure 2: Number of Cases by Month Reported



SALMONELLOSIS

Introduction

Salmonellosis refers to an infection with the bacterium *Salmonella*. Symptoms of infection include diarrhea, abdominal cramping, fever, headache, nausea and vomiting. The bacteria can also enter the blood, resulting in septicemia. Illness typically begins 6-72 hours after ingestion of the bacteria. There are many different subtypes of *Salmonella*, with some having a stronger association with specific risk factors than others. For example, *Salmonella arizonae* is commonly associated with exposure to infected reptiles, although some cases infected with this subtype deny exposure to such animals. Transmission occurs primarily through the fecal-oral route. This may occur through contact with the feces of infected animals (especially pet turtles, iguanas, snakes and chicks), directly from person-to-person, or through consumption of food contaminated by infected individuals or derived from infected animals.

No vaccine is available. Treatment for uncomplicated infections focuses on rehydration and electrolyte replacement. Antibiotics may be indicated for young infants, the elderly, immunocompromised individuals and those with invasive infection. The best way to avoid salmonellosis is to practice proper food preparation techniques and hand hygiene. A detailed recommendation of preventive measures is found at http://www.cdc.gov/ncidod/dbmd/diseaseinfo/salmonellosis_g.htm.

Summary of data

Disease Abstract, 2004*

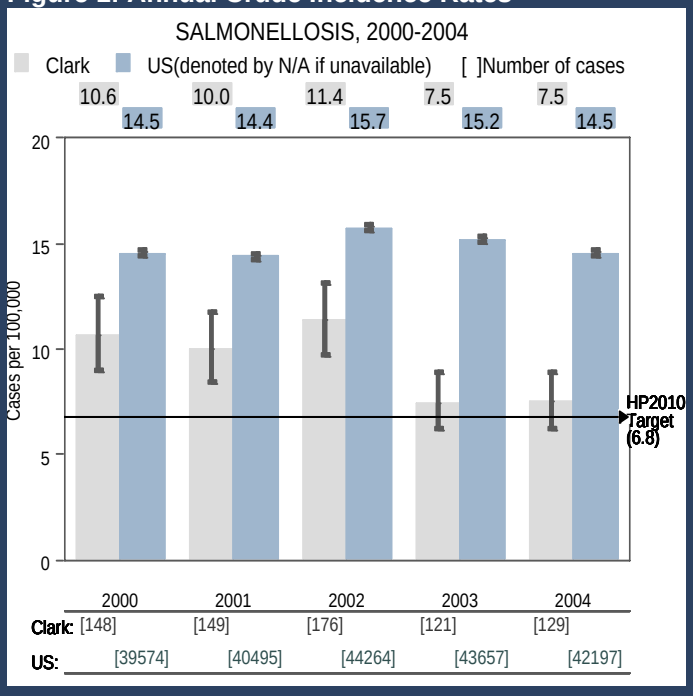
	Clark	Nevada	US
Number of cases reported	129	191	42,197
Rate (cases per 100,000)	7.5	7.9	14.5
Median age at time of event	19	N/A	N/A

*Numbers for both the state and nation were from the 2004 MMWR Summary Report. Time of event is not uniformly definable and can be that of onset, diagnosis, lab collection or reporting.

Trends

In Clark County, the reported salmonellosis incidences were lower in 2003 and 2004 than those in previous years. Clark County also had significantly lower incidence rates than the nation (Figure 1).

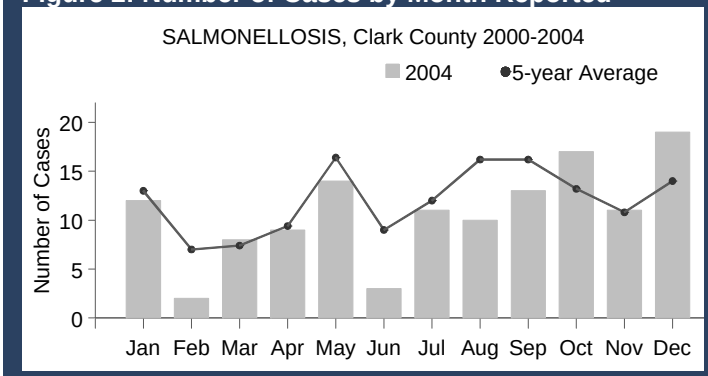
Figure 1: Annual Crude Incidence Rates



Seasonality

An average of 12 cases was reported monthly. More cases were seen in fall and winter months, although no seasonal pattern was apparent (Figure2).

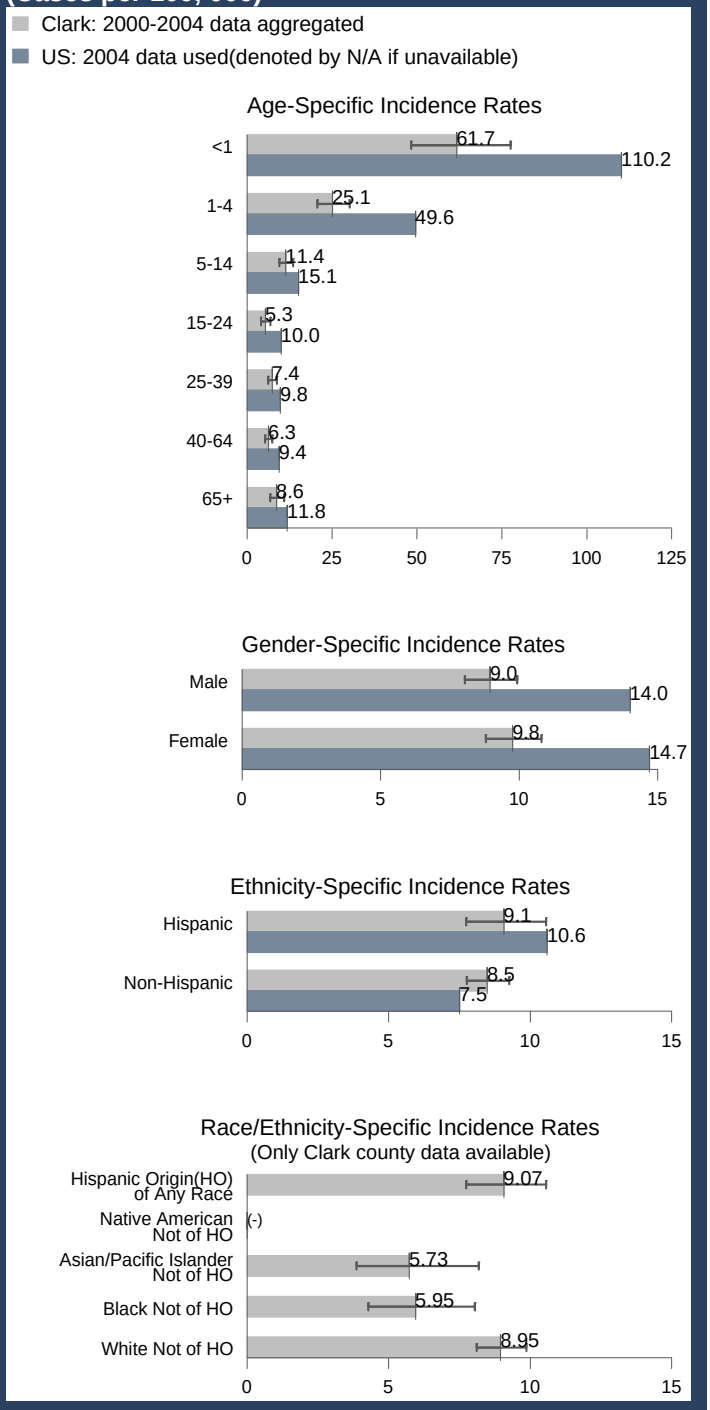
Figure 2: Number of Cases by Month Reported



Demographics

Based on aggregated Clark County data of 2000-2004, children under one year old had a significantly higher incidence rate than other age groups. A similar age pattern has also been observed in 2004 national data. No significant gender or racial/ethnic differences were indicated in the aggregated county data (Figure 3).

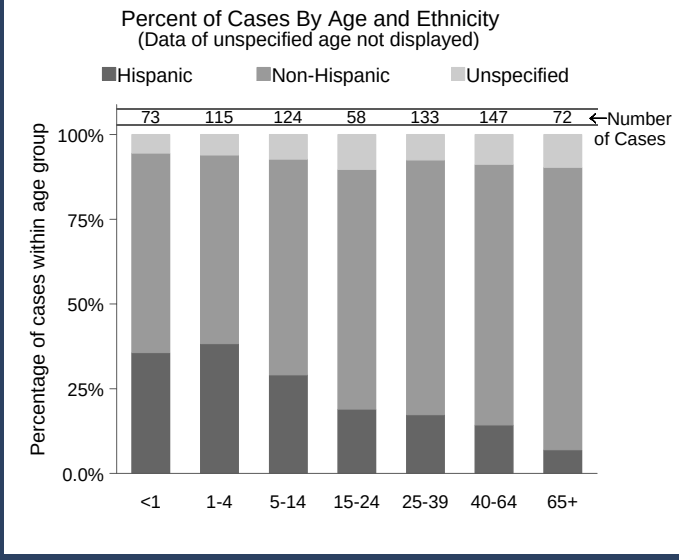
Figure 3: Age, Gender, Ethnicity and Race/Ethnicity Specific Incidence Rates (Cases per 100, 000)



Note: Suppressed data denoted by '(-)' .

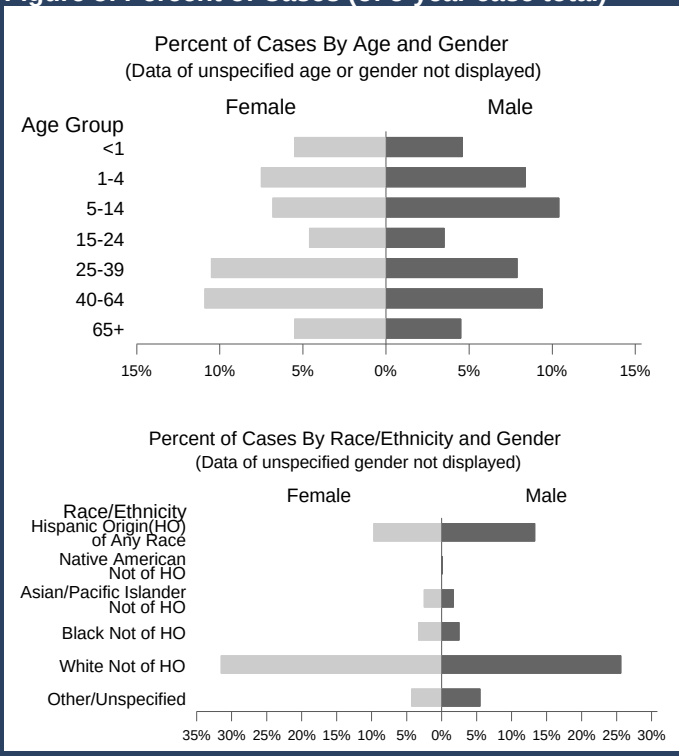
From 2000 to 2004 in Clark County, the majority of reported cases have tended to be Non-Hispanic in all age groups (Figure 4).

Figure 4: Percent of Cases (of 5-year case totals within age groups)



The age-gender and racial/ethnic-gender distributions of cases are provided in Figure 5. Annual age, gender, ethnicity specific incidence rates, percent of cases and mean/median age of reported cases are provided in the appendix.

Figure 5: Percent of Cases (of 5-year case total)



SHIGELLOSIS

Introduction

Shigellosis refers to infection with the bacterium *Shigella*. There are four serogroups in the genus *Shigella*: *S. dysenteriae*, *S. flexner*, *S. boydii* and *S. sonnei*. *S. sonnei* is the serogroup most commonly seen in the United States, whereas the other three serogroups are more common in developing nations. Symptoms of infection may include diarrhea (may contain blood), fever, abdominal cramping and vomiting. Some infected individuals experience no symptoms. Ingestion of only 10-100 organisms can cause illness, making spread from person-to-person through the fecal-oral route common. Food contaminated by an infected foodhandler may also serve as a source of infection. Symptoms typically begin within 12-96 hours after ingestion of the bacteria.

When there are signs of dehydration, rehydration and electrolyte replacement may be necessary. Appropriate antibiotics may be effective in shortening the duration and severity of disease, as well as shortening the length of time that an individual excretes the bacteria. However, some *Shigella* bacteria have become resistant to certain antibiotics, so it is important for medical practitioners to ensure that the antibiotic prescribed is effective against the bacteria. The best way to avoid shigellosis is to thoroughly wash raw fruits and vegetables, to avoid consumption of unpasteurized dairy products, and to practice diligent hand hygiene. A detailed recommendation of preventive measures is found at http://www.cdc.gov/ncidod/dbmd/diseaseinfo/shigellosis_g.htm.

Summary of data

Disease Abstract, 2004*

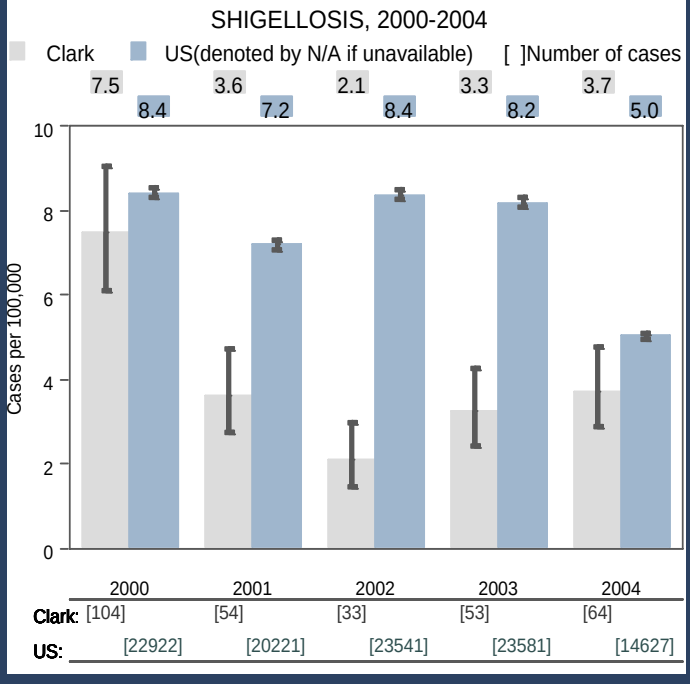
	Clark	Nevada	US
Number of cases reported	64	68	14,627
Rate (cases per 100,000)	3.7	2.8	5.0
Median age at time of event	7	N/A	N/A

*Numbers for both the state and nation were from the 2004 MMWR Summary Report. Time of event is not uniformly definable and can be that of onset, diagnosis, lab collection or reporting.

Trends

In Clark County the reported incidence of shigellosis increased between 2002 and 2004. However, the incidence rate in 2004 was significantly lower than that in 2000 (Figure 1)

Figure 1: Annual Crude Incidence Rates



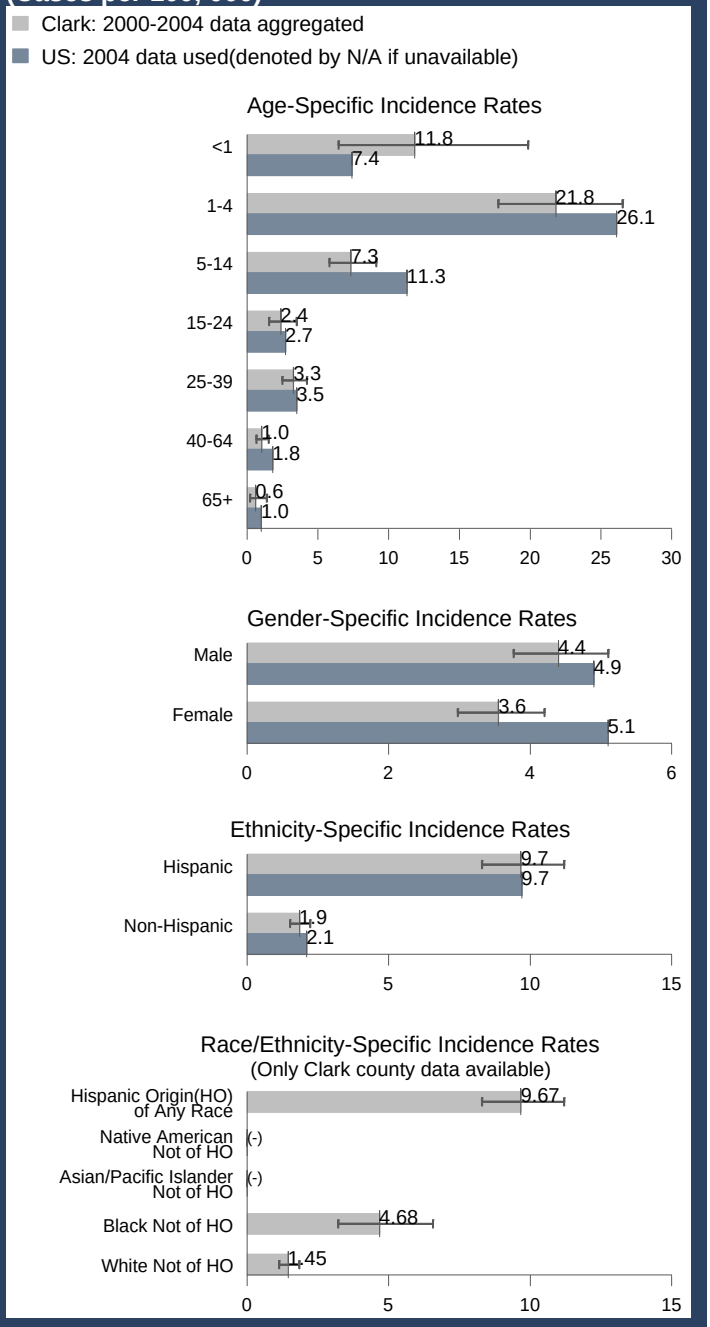
Seasonality

An average of five cases was reported monthly from 2000 to 2004 in Clark County. No seasonal pattern was apparent in the number of cases reported monthly.

Demographics

Based on aggregated Clark County data of 2000-2004, children four years of age and younger had higher incidence rates than other age groups. While a higher rate was seen in men than women, the gender difference was not significant. Hispanics of any race had a significantly higher incidence rate than non-Hispanic groups (Figure 2).

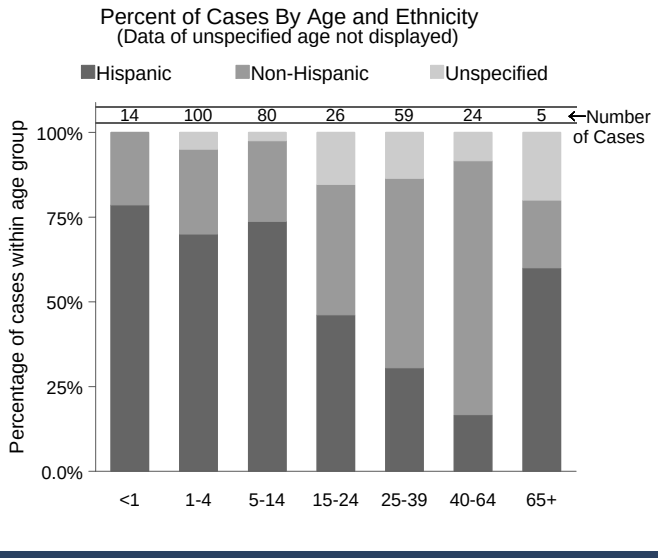
Figure 2: Age, Gender, Ethnicity and Race/Ethnicity Specific Incidence Rates (Cases per 100, 000)



Note: Suppressed data denoted by '(-)' .

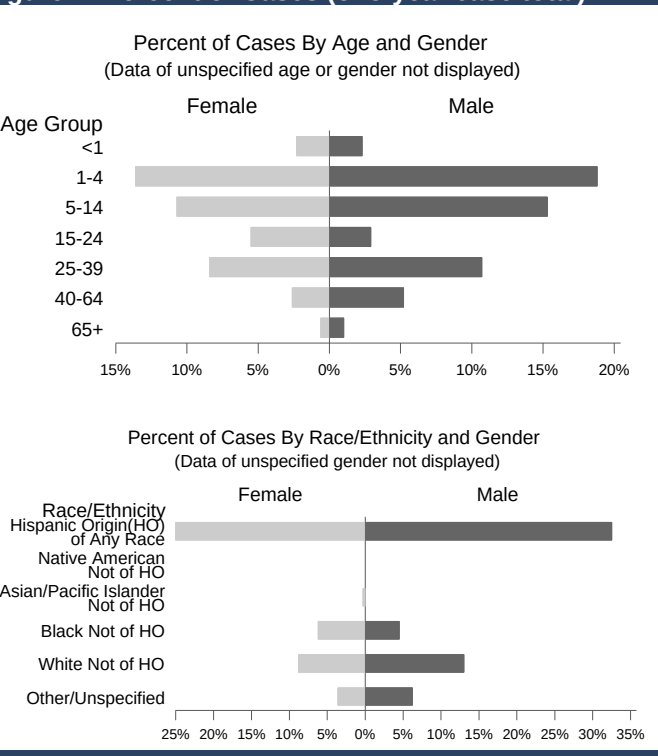
From 2000 to 2004 in Clark County, the majority of reported cases have tended to be Hispanic children and young adults (Figure 3).

Figure 3: Percent of Cases (of 5-year case totals within age groups)



The age-gender and racial/ethnic-gender distributions of cases are provided in Figure 4. Mean and median ages of reported cases are provided in the appendix.

Figure 4: Percent of Cases (of 5-year case total)



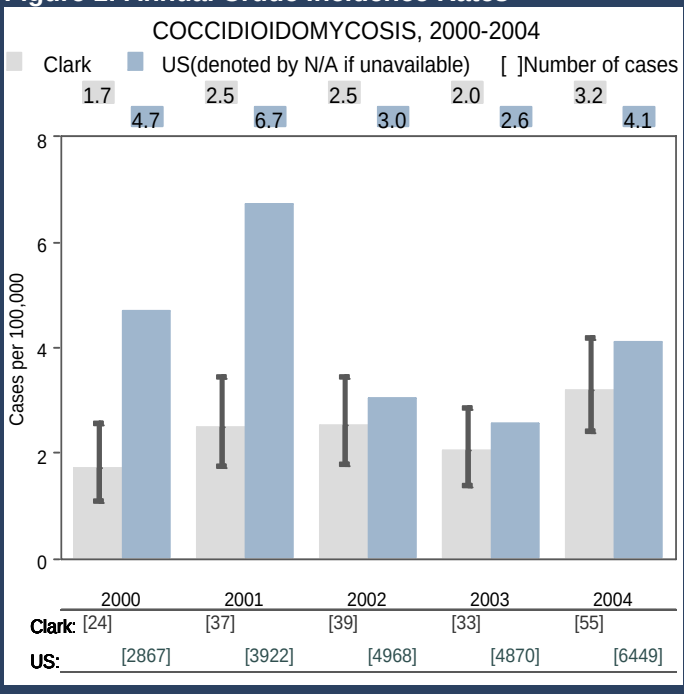
COCCIDIOIDOMYCOSIS

Introduction

Coccidioidomycosis, also known as Valley Fever, refers to an infection caused by the fungus *Coccidioides immitis*, which is found naturally in soil. An infected individual may initially have no symptoms, or may experience an acute influenza-like illness with fever, chills, cough, rash and muscle aches. This primary infection may resolve completely, or in some cases, may leave a nodule or thin-walled cavity in the lungs. In rare cases, the fungus may disseminate and cause abscesses in various parts of the body. Transmission occurs from inhalation of fungal spores dispersed when contaminated soil is disturbed. There is no person-to-person or animal-to-person spread.

Primary infection with *Coccidioides immitis* often resolves without any treatment. Several antifungal medications are available for use in severe cases. Measures to prevent infection focus on dust control methods, such as planting grass, wetting dusty soil and wearing facemasks in situations where there will be opportunity to inhale soil particles. A detailed recommendation of preventive measures is found at http://www.cdc.gov/ncidod/diseases/submenus/sub_cocci.htm.

Figure 1: Annual Crude Incidence Rates



Summary of data

Disease Abstract, 2004*

	Clark	Nevada	US
Number of cases reported	55	62	6,449
Rate (cases per 100,000)	3.2	2.6	4.1
Median age at time of event	61	N/A	N/A

*Numbers for both the state and nation were from the 2004 MMWR Summary Report. Time of event is not uniformly definable and can be that of onset, diagnosis, lab collection or reporting.

Trends

A slight increase was observed in the reported incidence of coccidioidomycosis in Clark County from 2000 to 2004. However, the incidence rate in 2004 was not significantly different from that in 2000 (Figure 1).

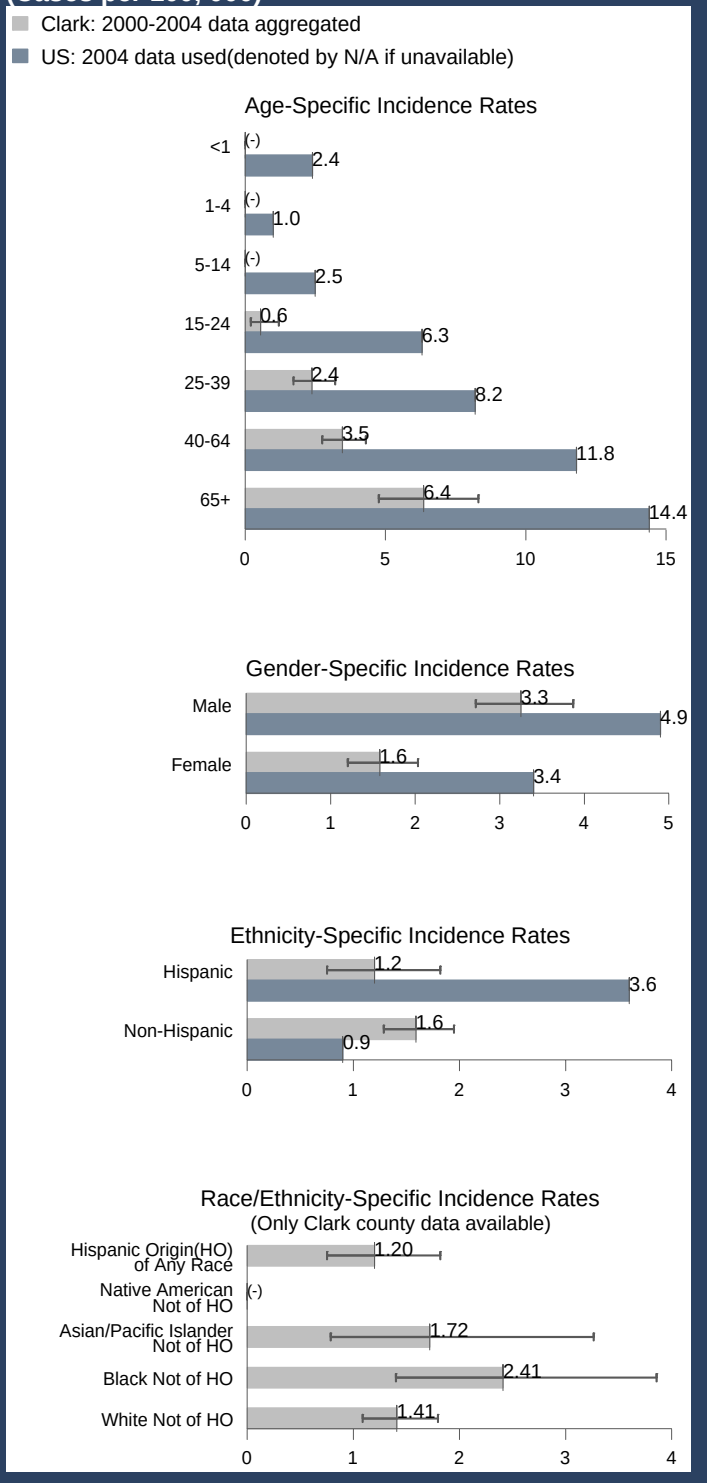
Seasonality

An average of three cases was reported monthly from 2000 to 2004 in Clark County. No seasonal pattern was apparent in the number of cases reported monthly.

Demographics

Based on aggregated Clark County data of 2000-2004, people 65 years of age and older had a significantly higher incidence rate than other age groups. The male rate was significantly higher than that of females. Similar age and gender patterns have also been observed in 2004 national data. No significant racial or ethnic differences were indicated in the aggregated county data (Figure 2).

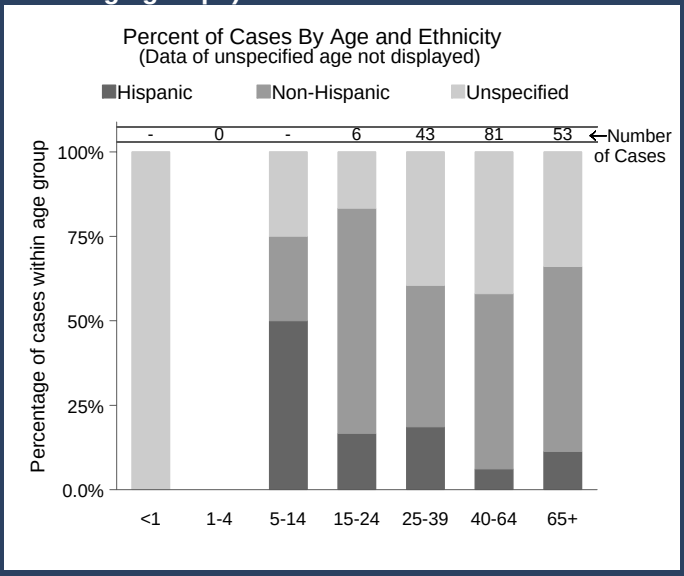
Figure 2: Age, Gender, Ethnicity and Race/Ethnicity Specific Incidence Rates (Cases per 100, 000)



Note: Suppressed data denoted by '(-)' .

From 2000 to 2004 in Clark County, the majority of reported cases have tended to be non-Hispanic for age groups of 15 years and older (Figure 3).

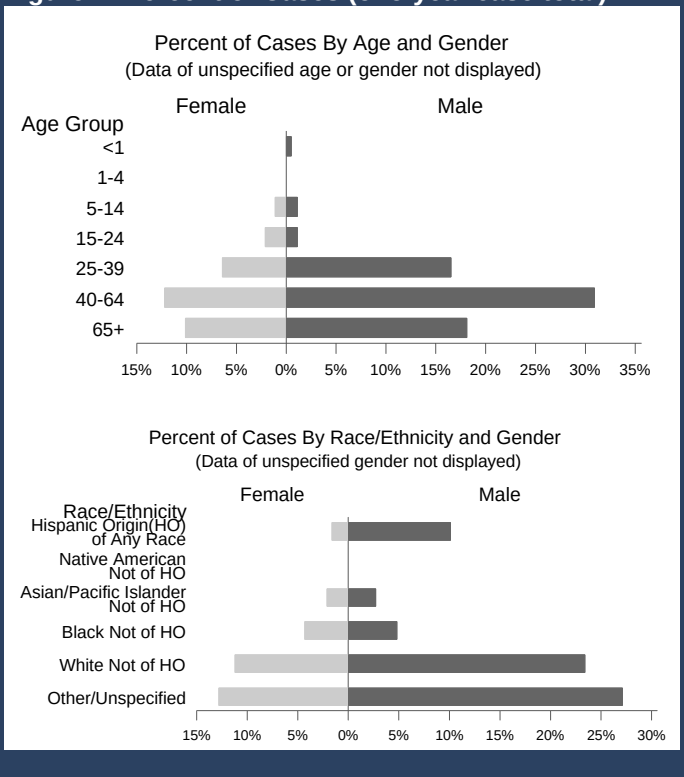
Figure 3: Percent of Cases (of 5-year case totals within age groups)



Note: Suppressed data denoted by '-' .

The age-gender and racial/ethnic-gender distributions of cases are provided in Figure 4. Annual age, gender, ethnicity specific incidence rates, percent of cases and mean/median age of reported cases are provided in the appendix.

Figure 4: Percent of Cases (of 5-year case total)



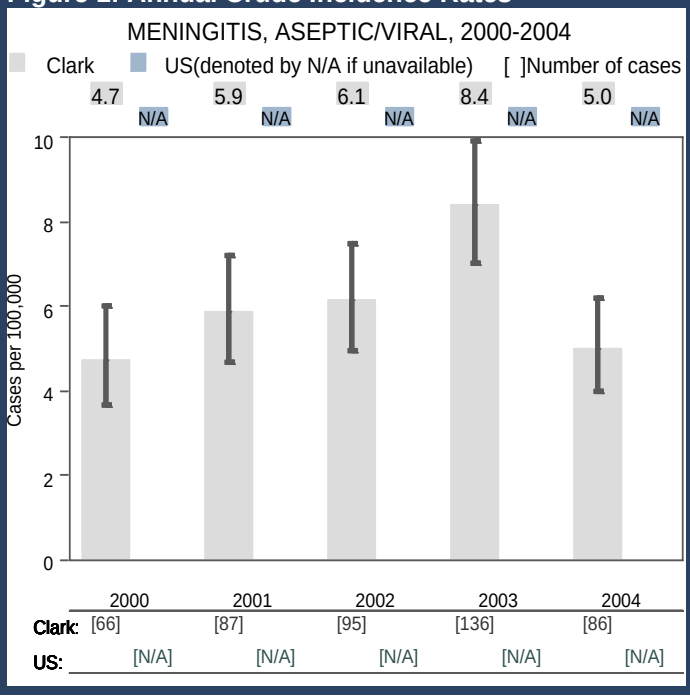
MENINGITIS, ASEPTIC/VIRAL

Introduction

Meningitis refers to an inflammation of the membrane surrounding the brain and spinal cord. Aseptic meningitis, also known as "viral" meningitis, is caused by a virus, and is more common than bacterial or fungal meningitis. Viruses commonly associated with aseptic meningitis include enterovirus, poliovirus, coxsackievirus, echovirus, arbovirus (eastern and western equine encephalitis viruses, California group viruses, St. Louis encephalitis virus, West Nile virus, Colorado tick fever) and many other viruses. Symptoms include fever, severe headache, stiff neck, nausea and vomiting. Infected individuals may also experience photophobia, or painful sensitivity to light. The mode of transmission is dependent on the virus causing the illness. Some are transmitted through respiratory secretions, while others can be transmitted via the fecal-oral route. While the viruses that can cause meningitis may be contagious, meningitis itself is not. As such, individuals who have contact with someone with viral meningitis may become infected with the same virus, but will probably have mild illness or no symptoms at all. Very few will progress to meningitis.

No specific treatment is available for aseptic meningitis. Most previously healthy individuals recover on their own. Medicine may be taken to relieve certain symptoms, such as fever and headache, which are associated with the illness. Practicing diligent hand hygiene and avoiding contact with ill individuals are helpful in preventing infection with the viruses that cause meningitis. A detailed recommendation of preventive measures is found at http://www.cdc.gov/ncidod/dvrd/revb/enterovirus/viral_meningitis.htm.

Figure 1: Annual Crude Incidence Rates



Summary of data

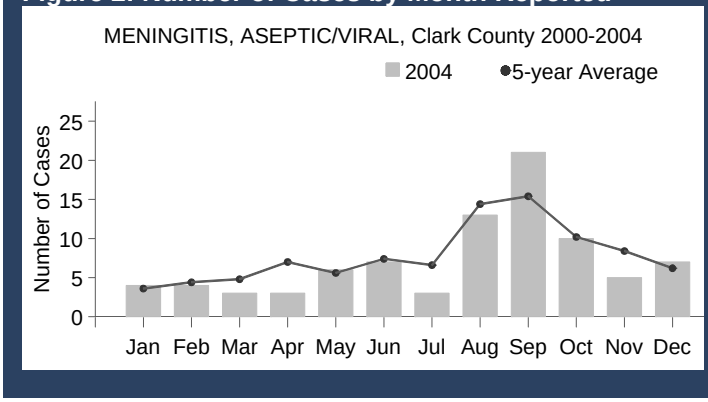
Trends

An upward trend was observed in the reported incidence of aseptic meningitis in Clark County between 2000 and 2003. However, the incidence rate in 2004 was not significantly different from that in 2000 (Figure 1).

Seasonality

An average of eight cases was reported monthly from 2000 to 2004 in Clark County. More cases were reported in fall and winter months (Figure 2).

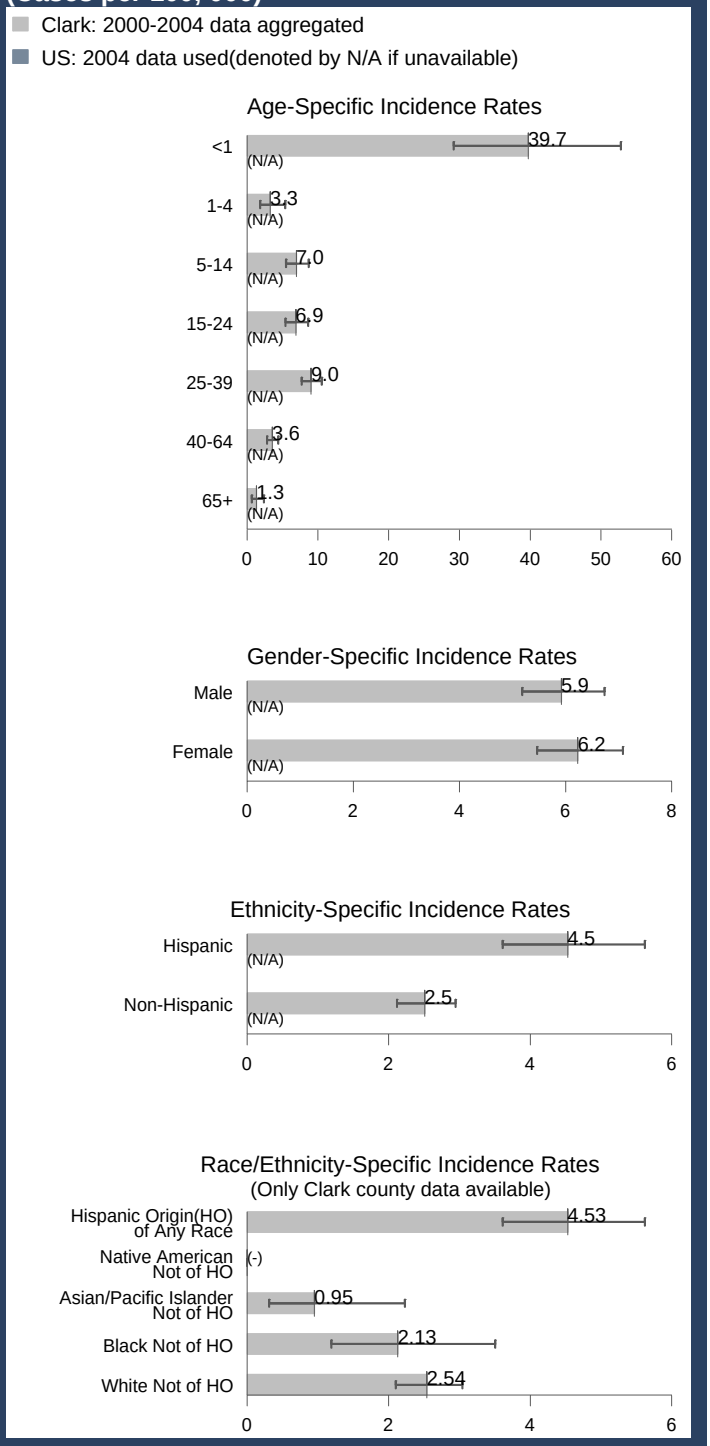
Figure 2: Number of Cases by Month Reported



Demographics

Based on aggregated Clark County data of 2000-2004, children less than one year old had a significantly higher incidence rate than other age groups. Hispanics had a significantly higher incidence rate than other racial/ethnic groups. No significant gender difference was indicated in the aggregated county data (Figure 3).

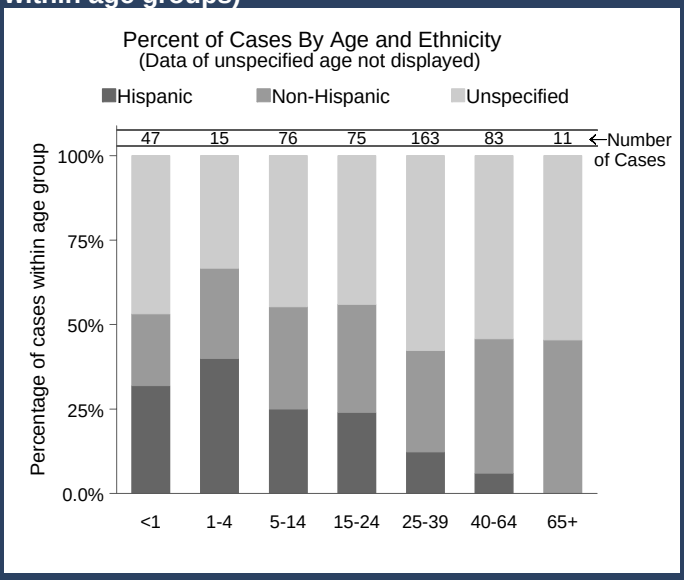
Figure 3: Age, Gender, Ethnicity and Race/Ethnicity Specific Incidence Rates (Cases per 100, 000)



Note: Suppressed data denoted by '(-)' .

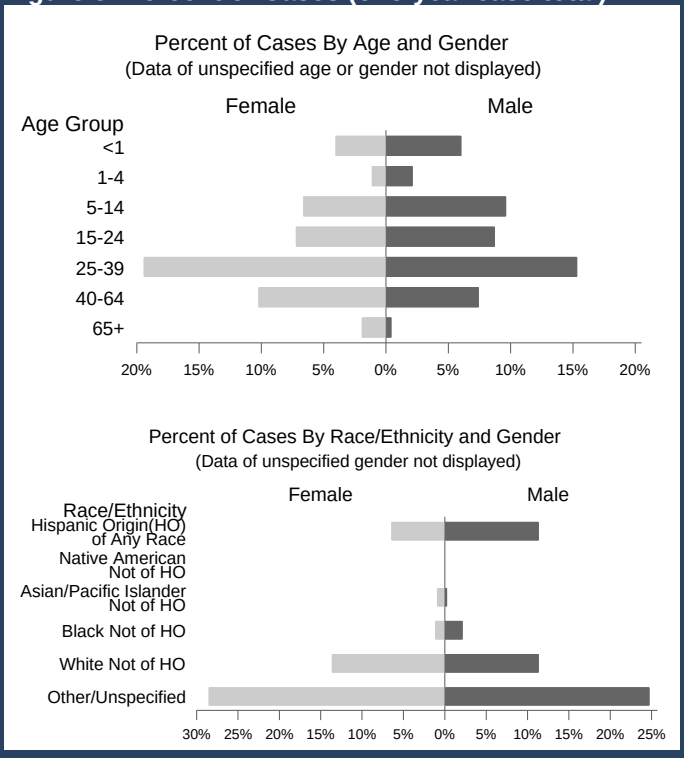
From 2000 to 2004 in Clark County, Hispanics contributed to a higher percentage of reported cases than non-Hispanics for those less than four years old (Figure 4).

Figure 4: Percent of Cases (of 5-year case totals within age groups)



The age-gender and racial/ethnic-gender distributions of cases are provided in Figure 5. Annual age, gender, ethnicity specific incidence rates, percent of cases and mean/median age of reported cases are provided in the appendix.

Figure 5: Percent of Cases (of 5-year case total)



MENINGITIS, BACTERIAL

Introduction

Bacterial meningitis is less common than viral meningitis but is usually much more serious and can be life-threatening if not treated promptly. The disease is most commonly expressed as severe swelling of the brain and spinal cord. Before the 1990s, *Haemophilus influenzae* type b (Hib) was the leading cause of bacterial meningitis, but the routine use of Hib vaccine has since reduced the occurrence of meningitis caused by Hib. *Neisseria meningitidis* (meningococcus) and *Strepococcus pneumoniae* (pneumococcus) are now more frequent causes of serious meningitis cases. High fever, headache, and stiff neck are common symptoms of meningitis. Other symptoms may include nausea, vomiting, painful sensitivity to light, confusion, and sleepiness. In newborns and infants, symptoms may include slowness, irritability, vomiting, or being fed poorly. As the disease progresses, patients of any age may have seizures. Some types of bacterial meningitis are contagious, such as those caused by *Neisseria meningitidis* or Hib. These two organisms are tracked separately (see sections on *Haemophilus influenzae* and meningococcal disease). The bacteria are spread through respiratory and throat secretions, thus anyone with direct contact with infected oral secretions are at increased risk of acquiring the infection.

Patients with bacterial meningitis typically remain contagious while they have symptoms. However in some instances, people may carry one of the bacteria that can cause meningitis without becoming ill at all. Even though they have no symptoms of disease, they can still spread the disease. Good hygiene such as washing hands frequently, avoiding close contact and sharing food, drinks, or eating utensils with ill persons can help prevent infection with meningitis. It's often recommended that close contacts of patients with certain types of bacterial meningitis receive prophylactic antibiotics. The vaccines against Hib and pneumococcus can protect against meningitis caused by these microorganisms. Vaccination against meningococcal meningitis is also recommended for preadolescents and people traveling to countries where meningitis is more common, although it does not provide protection against all meningococcus strains. Detailed vaccine recommendations can be found at http://www.dhpe.org/infect/Bacmeningitis.html.

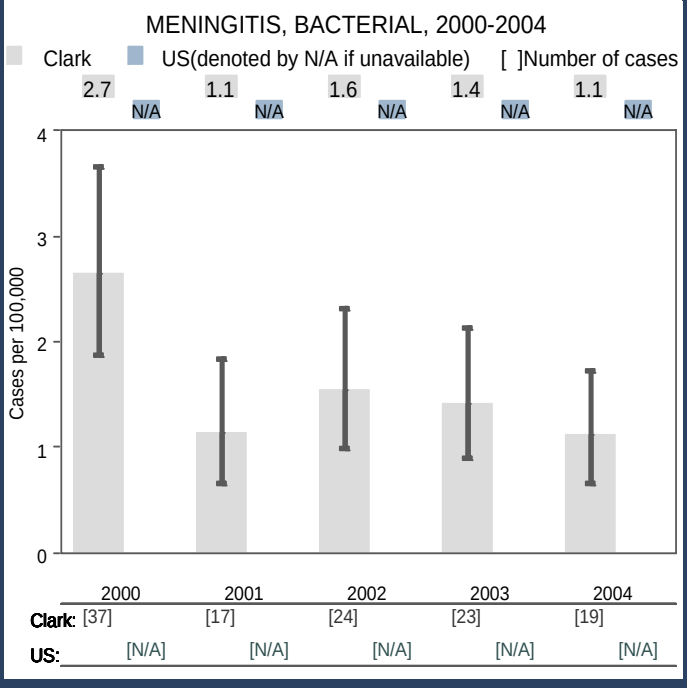
Summary of data

Please note that statistics presented are based on data not including cases caused by *Haemophilus influenzae* or *Neisseria meningitidis*.

Trends

A downward trend was observed in the reported incidence of bacterial meningitis in Clark County between 2000 and 2004 (Figure 1).

Figure 1: Annual Crude Incidence Rates



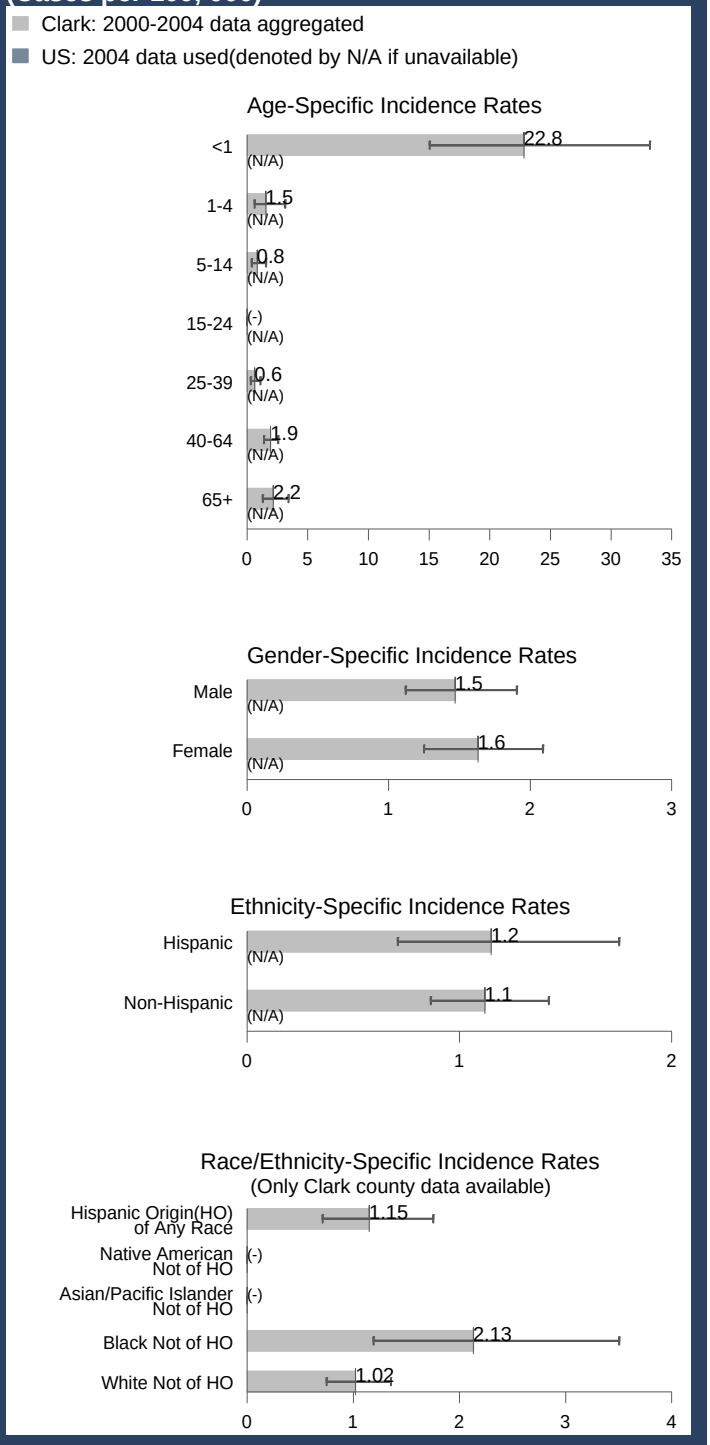
Seasonality

An average of two cases was reported monthly from 2000 to 2004 in Clark County. No seasonal pattern was apparent in the number of cases reported monthly.

Demographics

Based on aggregated Clark County data of 2000-2004, children less than one year old had a significantly higher incidence rate than other age groups. No significant gender or racial/ethnic differences were indicated in the aggregated county data (Figure 2).

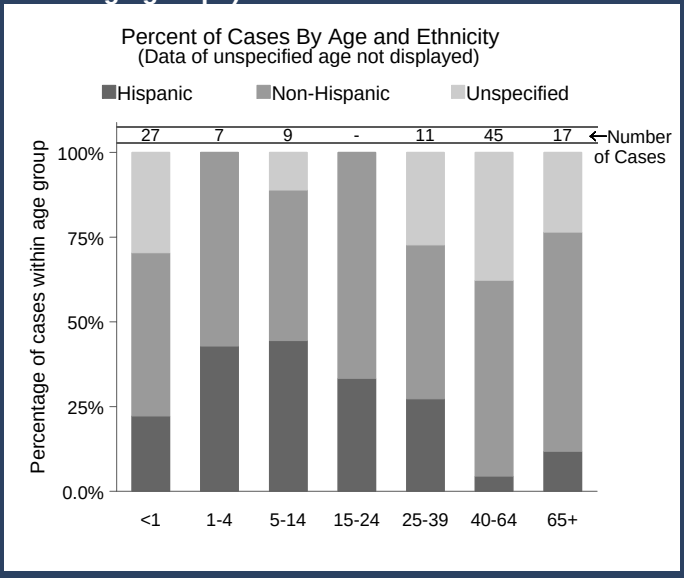
Figure 2: Age, Gender, Ethnicity and Race/Ethnicity Specific Incidence Rates (Cases per 100, 000)



Note: Suppressed data denoted by '(-)' .

From 2000 to 2004 in Clark County, non-Hispanics contributed to a higher percentage of reported cases than Hispanics for almost all age groups (Figure 3).

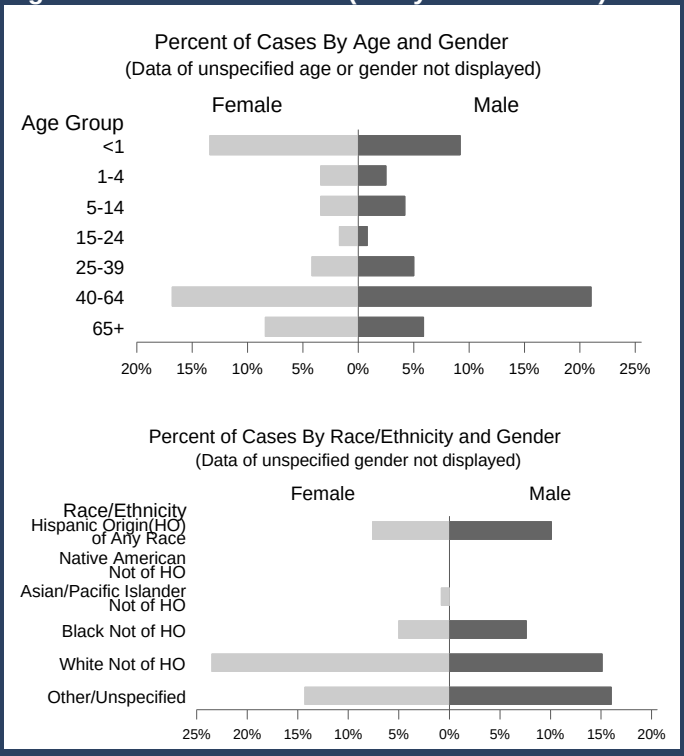
Figure 3: Percent of Cases (of 5-year case totals within age groups)



Note: Suppressed data denoted by '-'.

The age-gender and racial/ethnic-gender distributions of cases are provided in Figure 4. Mean and median ages of reported cases are provided in the appendix.

Figure 4: Percent of Cases (of 5-year case total)



MENINGOCOCCAL DISEASE

Introduction

Meningococcal disease is a serious bacterial infection caused by the bacterium *Neisseria meningitidis*, known as a meningococcus. The disease occurs in two main forms or it can occur as a combination of these two forms. Meningococcal septicaemia occurs when the bloodstream is infected, resulting in blood poisoning. Meningococcal meningitis occurs when the outer lining around the brain and spinal cord are infected, usually expressed as severe swelling. Rarely, meningococcal infection results in pneumonia. The onset of symptoms is sudden and death can follow within hours. The disease can be misdiagnosed as something less serious because symptoms are similar to the flu. The most common symptoms include high fever, headaches, neck stiffness, confusion, nausea, vomiting, lethargy and/or rashes. Meningococcal bacteria are transmitted through the air via droplets of respiratory secretions and direct contact with persons infected with the disease. Waning immunity, smoking, mucosal lesions and concomitant respiratory infections are considered risk factors that may contribute to the development of the disease. Overcrowding and certain climatic conditions such as dry seasons, prolonged drought and dust storms are also considered factors favoring the spread of the disease.

Meningococcal vaccines are available against the most common strains of *Neisseria meningitidis* in the United States. Antibiotics are available which can treat meningococcal disease. However the disease can progress very rapidly and urgent medical attention is required if meningococcal disease is suspected. Prophylactic antibiotics may be recommended for close contacts of patients with meningococcal disease. Detailed vaccine recommendations can be found at http://www.cdc.gov/nip/publications/VIS/vis-mening.pdf.

Summary of data

Disease Abstract, 2004*

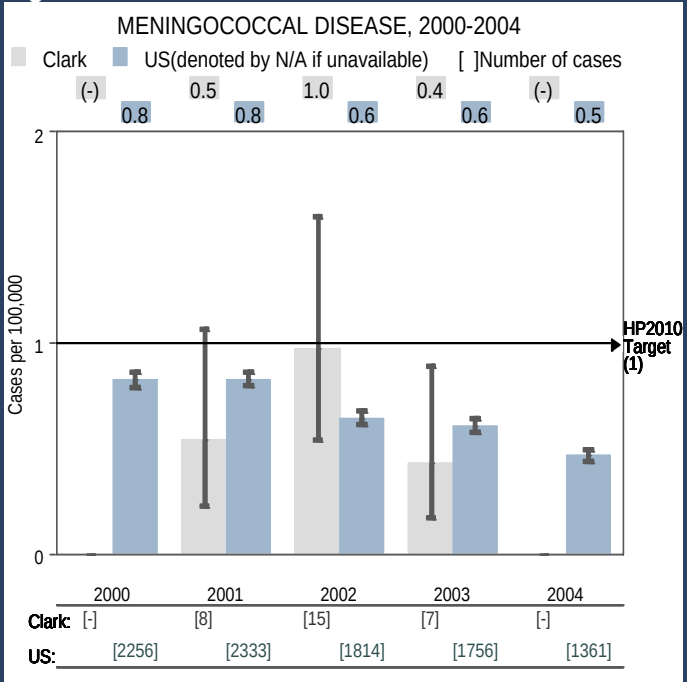
	Clark	Nevada	US
Number of cases reported	.	7	1,361
Rate (cases per 100,000)	.	0.3	0.5
Median age at time of event	28	N/A	N/A

*Numbers for both the state and nation were from the 2004 MMWR Summary Report. Time of event is not uniformly definable and can be that of onset, diagnosis, lab collection or reporting. Suppressed data denoted by '.'.

Trends

A slight decrease was observed in the reported incidence of meningococcal disease in Clark County between 2002 and 2004 (Figure 1).

Figure 1: Annual Crude Incidence Rates



Note: Suppressed data denoted by '(-)' or '[-]'.

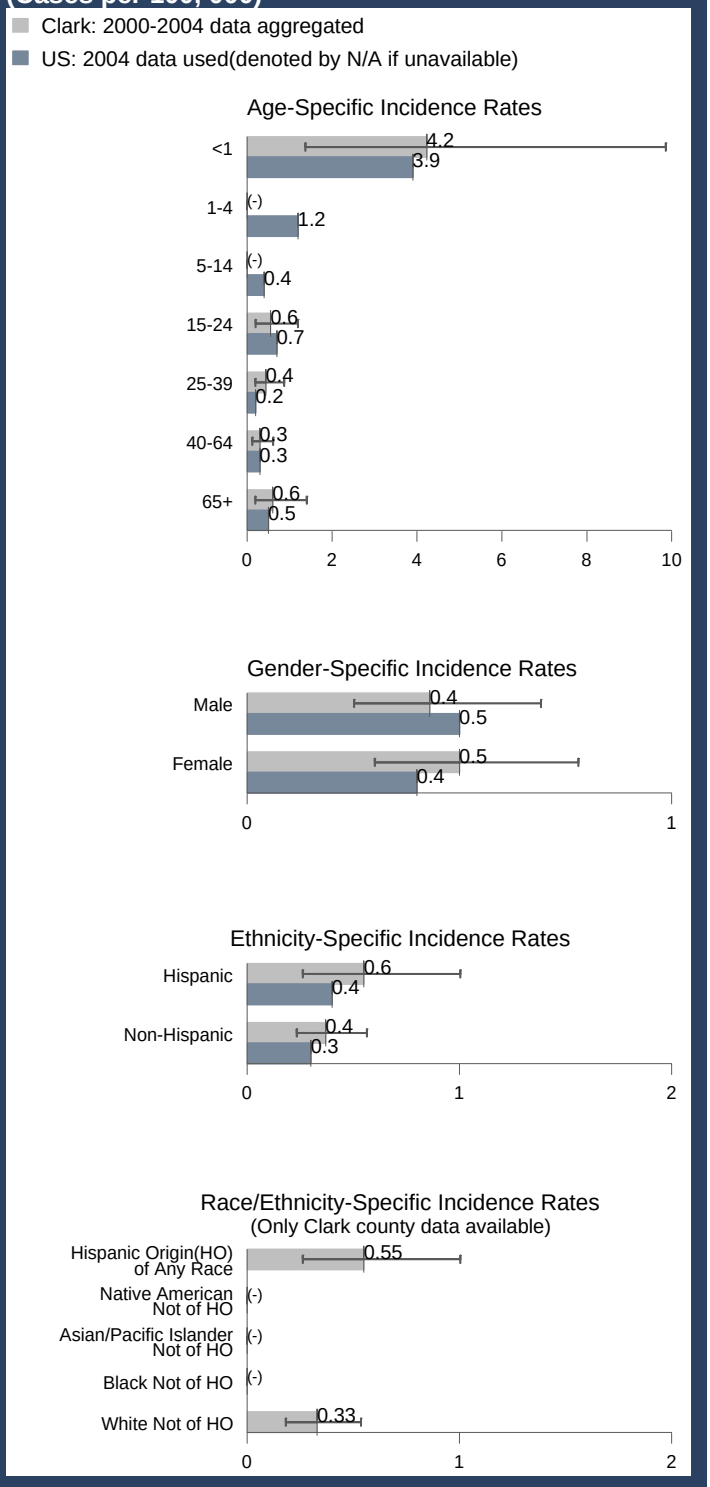
Seasonality

An average of one case was reported monthly from 2000 to 2004 in Clark County. More cases were reported in spring, although no seasonal pattern was apparent.

Demographics

Based on aggregated Clark County data of 2000-2004, children less than one year old had a significantly higher incidence rate than other age groups. A similar age pattern has also been observed in 2004 national data. No significant gender or racial/ethnic differences were indicated in the aggregated county data (Figure 2).

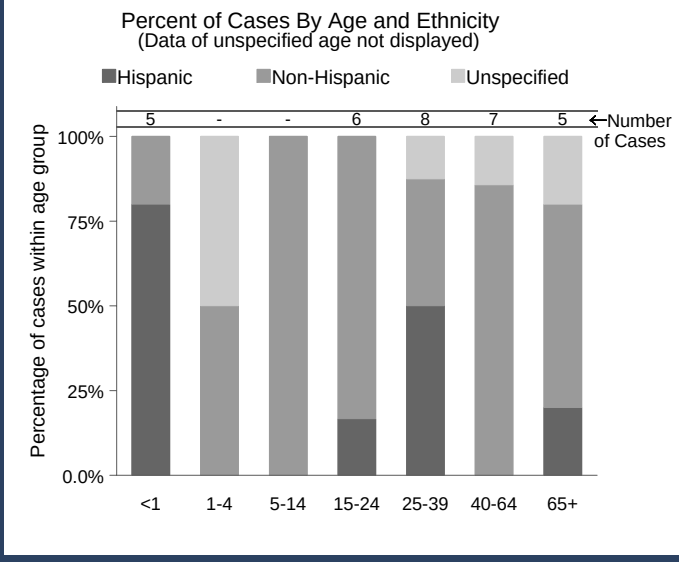
Figure 2: Age, Gender, Ethnicity and Race/Ethnicity Specific Incidence Rates (Cases per 100, 000)



Note: Suppressed data denoted by '(-)' .

From 2000 to 2004 in Clark County, the majority of reported cases tended to be non-Hispanic for almost all age groups beyond one year of age (Figure 3).

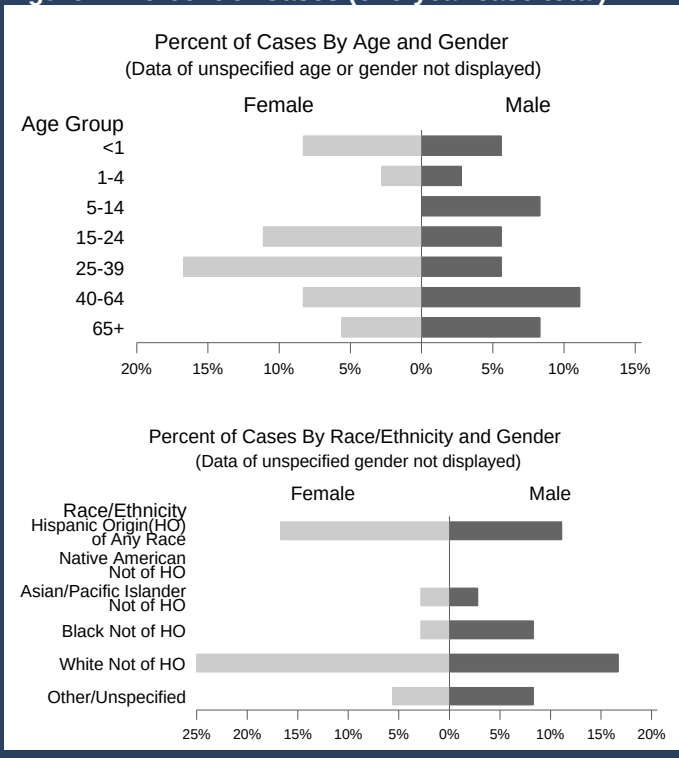
Figure 3: Percent of Cases (of 5-year case totals within age groups)



Note: Suppressed data denoted by '-'.

The age-gender and racial/ethnic-gender distributions of cases are provided in Figure 4. Mean and median ages of reported cases are provided in the appendix.

Figure 4: Percent of Cases (of 5-year case total)



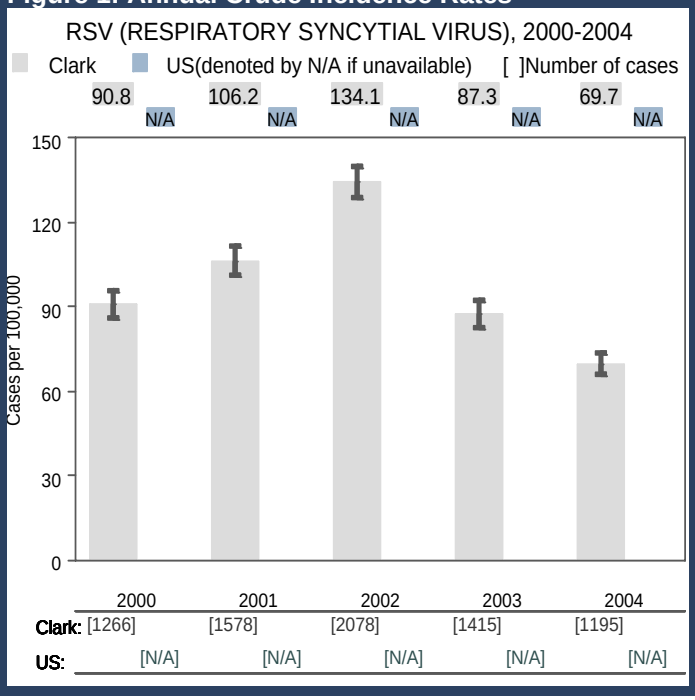
RESPIRATORY SYNCYTIAL VIRUS

Introduction

Respiratory Syncytial Virus (RSV) is a virus that causes infections of the lungs and respiratory tract. It is one of the most important causes of lower respiratory tract illness in infants and young children. RSV infections can range from very mild illness to serious lower respiratory tract infections, including pneumonia, that occur mostly in the very young, the very old, and those with weakened immune systems. In adults and healthy children, the signs and symptoms of RSV are similar to those of the common cold, including runny nose, coughing, low-grade fever, and/or ear infection. However, RSV infections may be severe and require hospitalization, especially in infants under six months of age, children with underlying conditions, such as congenital heart or lung disease, and children who were born prematurely. Signs of more serious infections may include difficult or rapid breathing, wheezing, irritability, restlessness, poor appetite or feeding (in babies). Symptoms usually start within one week of infection and can last for a few days to several weeks.

RSV is spread from respiratory secretions through close contact with infected persons or contact with contaminated surfaces. There is currently no RSV vaccine. Frequent hand washing and not sharing personal items with persons with RSV illness help decrease the spread of the virus to others. For persons with mild disease, no specific treatment is necessary other than the treatment of symptoms such as reducing fever, as most mild infections disappear on their own. Children with severe disease may require oxygen therapy and sometimes mechanical ventilation. Immune globulin intravenous treatment is available to prevent RSV infection in high-risk infants. A detailed recommendation of preventive measures is found at http://www.cdc.gov/ncidod/dvrd/revb/respiratory/rsvfeat.htm.

Figure 1: Annual Crude Incidence Rates



Summary of data

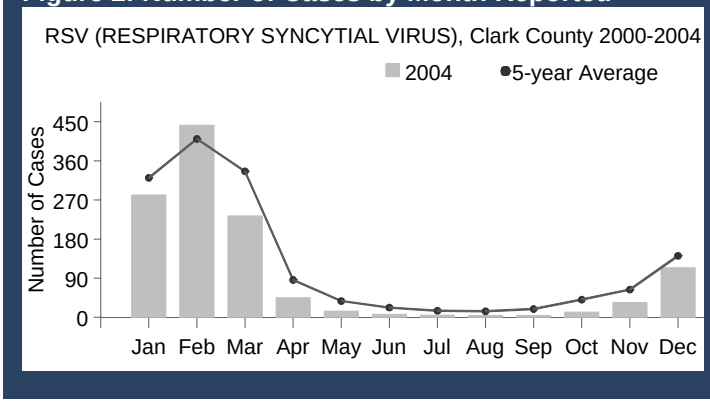
Trends

A downward trend was observed in the reported incidence of RSV between 2002 and 2004 in Clark County. The incidence rate in 2004 was significantly lower than that in 2000 (Figure 1).

Seasonality

An average of 126 cases was reported monthly from 2000 to 2004 in Clark County. Most cases were reported between November and April (Figure 2).

Figure 2: Number of Cases by Month Reported



TUBERCULOSIS

Introduction

Tuberculosis (TB) is a bacterial infection usually affecting the lungs, although other organs and parts of the body can be involved as well. Most people who are infected harbor the bacterium without symptoms or have latent TB, but some will develop active TB disease. Symptoms of TB include a low-grade fever, night sweats, fatigue, weight loss and a persistent cough. Some people may not have obvious symptoms. According to World Health Organization (WHO) estimates, approximately two billion people worldwide are currently infected with TB, and each year, about eight million people worldwide develop active TB and nearly two million die. In 2004, the largest number of new TB cases occurred in WHO's South-East Asia region, accounting for about one-third of new cases globally. However, the estimated incidence rate was highest in Sub-Sahara Africa, at nearly 400 cases per 100,000 population. In the United States, the rate of new TB cases continues to decline since national reporting began in 1953. In 2004, the Centers for Disease Control and Prevention (CDC) reported 14,874 cases of active TB. In addition to those with active TB, an estimated 10 to 15 million people in the United States have latent TB according to CDC estimates.

TB spreads through airborne droplets when a person with active pulmonary TB disease coughs, talks or sneezes. Having latent TB causes no symptoms and is not contagious. In general, prolonged exposure to a person with active pulmonary TB usually is necessary for infection to occur. Individuals with active pulmonary TB who are treated with appropriate therapies must have three negative smears in order to be released from isolation and demonstrate non-infection. The most important way to stop the spread of TB is for TB patients to cover their mouth and nose when coughing, and to take all TB medicine exactly as prescribed. Recommendations about prevention are found at http://www.cdc.gov/mmwr/preview/mmwrhtml/rr5509a1.htm.

Summary of data

Disease Abstract, 2004*

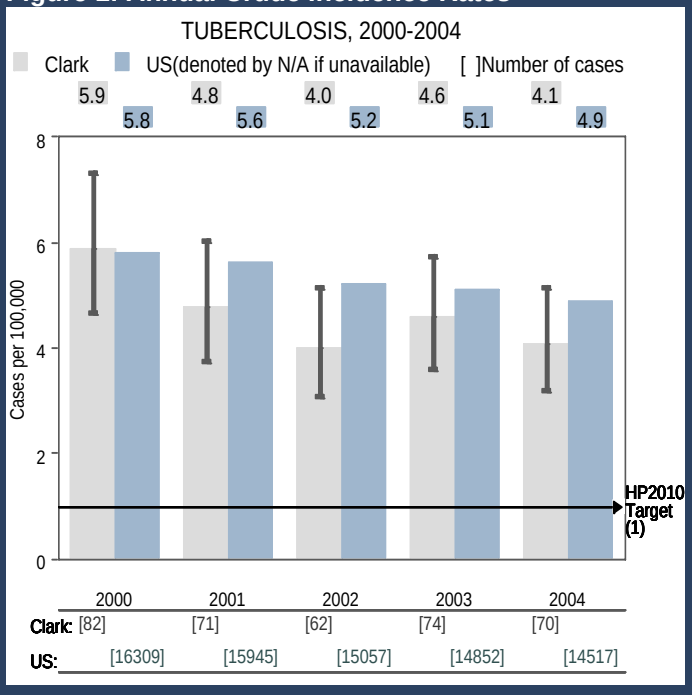
	Clark	Nevada	US
Number of cases reported	70	95	14,517
Rate (cases per 100,000)	4.1	4.1	4.9

*Numbers and rates for both the state and nation were from the 2004 National TB Surveillance Report.

Trends

A downward trend was observed in the reported incidence of TB between 2000 and 2004 in Clark County. However, the incidence rate in 2004 was not significantly different from that in 2000 (Figure 1).

Figure 1: Annual Crude Incidence Rates



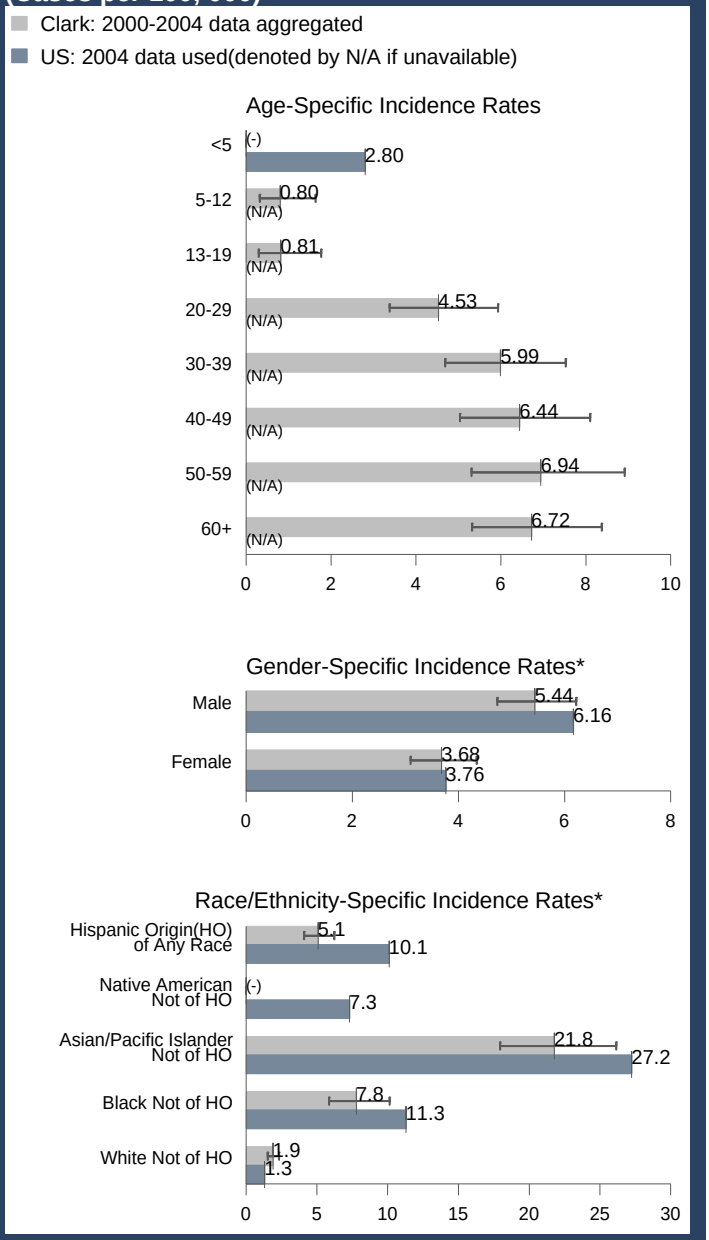
Seasonality

An average of six cases was reported monthly from 2000 to 2004 in Clark County. No seasonal pattern was apparent.

Demographics

Based on aggregated Clark County data of 2000-2004, Asian/Pacific Islanders had a significantly higher incidence rate than other race/ethnicity groups. The male rate was significantly higher than that of females. And those aged 50 years and older had higher incidence rates than other age groups. Similar gender and race/ethnicity patterns have been observed in 2004 national data (Figure 2).

Figure 2: Age, Gender, and Race/Ethnicity Specific Incidence Rates (Cases per 100, 000)



*Gender specific incidence rates and incidence rate for Asian/Pacific Islander for U.S. in year 2004 were calculated using national rates of different gender/race categories.

Note: Suppressed data denoted by '(-)' .

The number of cases by age, gender and racial/ethnic groups between 2000 and 2004 are provided in the appendix.

Site of Infection

Between 2000 and 2004, more than 90 percent of all TB cases in the county were pulmonary TB disease based on the National TB Surveillance case definitions (Table 1).

Table 1: TB Cases and Percentages by Site of Disease: Clark County and U.S., 2000-2004

	Clark				US			
	Pulmonary[1]		Extrapulmonary[2]		Pulmonary[1]		Extrapulmonary[2]	
	No.	%	No.	%	No.	%	No.	%
2000	79	96%	0	0%	13099	80%	3198	20%
2001	66	93%	8	11%	12732	80%	3209	20%
2002	61	98%	11	18%	11910	79%	3140	21%
2003	73	99%	15	20%	11830	80%	3014	20%
2004	68	97%	11	16%	11544	80%	2970	20%

[1]Includes cases of pulmonary, extrapulmonary and military TB disease.
[2]Includes cases of extrapulmonary only TB disease.

Drug Resistance

Nine cases of Isoniazid (INH)-resistant TB were reported in Clark County in 2004. From 2000 to 2004, an averaged 9.6% of all TB cases reported annually in Clark County were resistant to INH. In the state, an averaged 3.4% of all reported TB cases reported annually were resistant to both Isoniazid and Rifampin, or multi-drug resistant.

Appendix A: List of Reportable Diseases and Conditions in the State of Nevada

AIDS	Listerosis
Amebiasis	Lyme Disease
Animal bite from a rabies susceptible species *	Lymphogranuloma Venereum
Anthrax	Malaria
Botulism *†	Measles (rubeola) †
Brucellosis	Meningitis (specify type)
Campylobacteriosis	Meningococcal disease *
Chancroid	Mumps
Chlamydia	Pertussis
Cholera	Plague *†
Coccidioidomycosis	Poliomyelitis
Cryptosporidiosis	Psittacosis
Dengue	Q Fever
Diphtheria †	Rabies (human or animal) *†
E. coli 0157:H7	Relapsing Fever
Encephalitis	Respiratory Syncytial Virus (RSV)
Extraordinary occurence of illness (e.g. Smallpox, Dengue, SARS, etc.)*†	Rocky Mountain Spotted Fever
	Rotavirus
Foodborne disease outbreak *†	Rubella (including congenital) †
Giardiasis	Salmonellosis
Gonorrhea	Severe Reaction to Immunization
Granuloma Inguinale	Shigellosis
Haemophilus Influenzae (invasive)	Syphilis (including congenital)
Hansen's Disease (leprosy)	Tetanus
Hantavirus	Toxic Shock Syndrome
Hemolytic-uremic syndrome (HUS)	Trichinosis
Hepatitis A, B, C, delta, unspecified	Tuberculosis †
HIV infection	Tularemia
Influenza	Typhoid Fever
Legionellosis	West Nile Virus Infection
Leptospirosis	Yersiniosis

*Must be reported immediately.

†Must be reported when suspected.

Appendix B: Number of Cases and Rates of Selected Notifiable Diseases, Clark County 2000-2004*

	2000		2001		2002		2003		2004		5-yr Avg.	
DISEASE	Number	Rate	Number	Rate	Number	Rate	Number	Rate	Number	Rate	Number	Rate
VACCINE PREVENTABLE												
HAEMOPHILUS INFLUENZA (INVASIVE)	5	0.36	6	0.4	9	0.58	8	0.49	7	0.41	7.0	0.45
HEPATITIS A	69	4.95	49	3.3	26	1.68	17	1.05	7	0.41	33.6	2.28
HEPATITIS B (ACUTE)	41	2.94	39	2.62	53	3.42	62	3.83	53	3.09	49.6	3.18
INFLUENZA	25	1.79	29	1.95	59	3.81	207	12.77	58	3.38	75.6	4.74
MEASLES	5	0.36	.	.	.	.	0	0	0	0	1.4	0.10
MUMPS	.	.	.	.	5	0.32	.	.	0	0	2.8	0.19
PERTUSSIS	.	.	6	0.4	23	1.48	22	1.36	16	0.93	14.0	0.88
RUBELLA	0	0	0	0	.	.	0	0	0	0	0.2	0.01
SEXUALLY TRANSMITTED												
AIDS	228	16.35	171	11.51	239	15.42	251	15.49	253	14.75	228.4	14.70
CHLAMYDIA	2783	199.58	4100	275.94	4436	286.26	4694	289.62	5052	294.52	4213	269.2
GONORRHEA	1382	99.11	1837	123.63	1747	112.73	2083	128.52	2646	154.26	1939	123.7
HIV	271	19.43	240	16.15	276	17.81	203	12.53	299	17.43	257.8	16.67
SYPHILIS (EARLY LATENT)	7	0.5	6	0.4	6	0.39	21	1.3	12	0.7	10.4	0.66
SYPHILIS (PRIMARY & SECONDARY)	.	.	.	.	7	0.45	8	0.49	38	2.22	12.2	0.74
ENTERICS												
AMEBIASIS	.	.	.	.	23	1.48	17	1.05	13	0.76	12.0	0.76
BOTULISM-INTESTINAL (INFANT)	.	.	0	0	0	0	.	.	0	0	0.4	0.03
CAMPYLOBACTERIOSIS	108	7.75	135	9.09	111	7.16	103	6.36	101	5.89	111.6	7.25
CRYPTOSPORIDIOSIS	.	.	.	.	.	.	5	0.31	.	.	3.2	0.21
GIARDIA	148	10.61	141	9.49	119	7.68	94	5.8	74	4.31	115.2	7.58
ROTAVIRUS	493	35.35	567	38.16	459	29.62	442	27.27	673	39.23	526.8	33.93
SALMONELLOSIS	148	10.61	149	10.03	176	11.36	121	7.47	129	7.52	144.6	9.40
SHIGA-TOXIN PRODUCING E. COLI**	10	0.72	8	0.54	14	0.9	17	1.05	20	1.17	13.8	0.88
SHIGELLOSIS	104	7.46	54	3.63	33	2.13	53	3.27	64	3.73	61.6	4.04
TYPHOID FEVER	0	0	0	0	0	0	0	0	.	.	0.2	0.01
VIBRIO	0	0	0	0	0	0	.	.	.	.	1.0	0.06
YERSINIOSIS	.	.	0	0	0	0	.	.	.	.	1.6	0.10
OTHER												
COCCIDIOIDOMYCOSIS	24	1.72	37	2.49	39	2.52	33	2.04	55	3.21	37.6	2.40
ENCEPHALITIS	.	.	.	.	.	.	.	.	.	.	1.4	0.09
HEMOLYTIC UREMIC SYNDROME (HUS)	0	0	0	0	0	0	.	.	0	0	0.2	0.01
HEPATITIS C	0	0	0	0	.	.	.	.	.	.	1.6	0.10
HEPATITIS D	0	0	0	0	.	.	0	0	0	0	0.2	0.01
INVASIVE STREPTOCOCCAL DISEASE#	0	0	0	0	0	0	.	.	6	0.35	1.4	0.08
LEGIONELLOSIS	.	.	.	.	5	0.32	10	0.62	.	.	4.8	0.30
LEPROSY (HANSEN'S DISEASE)	0	0	.	.	0	0	0	0	.	.	0.4	0.03
LISTERIOSIS	6	0.43	5	0.34	.	.	.	.	5	0.29	4.0	0.26
LYME DISEASE	.	.	.	.	.	.	.	.	.	.	2.2	0.15
MALARIA	.	.	.	.	.	.	.	.	5	0.29	3.0	0.19
MENINGITIS, ASEPTIC/VIRAL	66	4.73	87	5.86	95	6.13	136	8.39	86	5.01	94.0	6.02
MENINGITIS, BACTERIAL	37	2.65	17	1.14	24	1.55	23	1.42	19	1.11	24.0	1.57
MENINGOCOCCAL DISEASE	.	.	8	0.54	15	0.97	7	0.43	.	.	7.2	0.46
Q FEVER	0	0	0	0	.	.	0	0	0	0	0.2	0.01
RELAPSING FEVER	.	.	0	0	0	0	0	0	0	0	0.6	0.04
ROCKY MOUNTAIN SPOTTED FEVER	.	.	.	.	.	.	0	0	0	0	1.0	0.07
RSV (RESPIRATORY SYNCYTIAL VIRUS)	1266	90.79	1578	106.2	2078	134.09	1415	87.31	1195	69.67	1506	97.61
STREPTOCOCCUS PNEUMONIAE (DRUG-RESISTANT, INVASIVE)#	0	0	0	0	0	0	.	.	17	0.99	3.8	0.22
TOXIC SHOCK SYN	.	.	0	0	.	.	.	.	.	.	1.2	0.07
TOXIC SHOCK SYN (STREPTOCOCCAL)	0	0	0	0	0	0	0	0	.	.	0.6	0.03
TUBERCULOSIS	82	5.88	71	4.78	62	4	74	4.57	70	4.08	71.8	4.66
UNUSUAL ILLNESS	0	0	0	0	.	.	.	.	.	.	1.0	0.06
WEST NILE VIRUS (ENCEPHALITIS)	0	0	0	0	0	0	0	0	12	0.7	2.4	0.14
WEST NILE VIRUS (FEVER)	0	0	0	0	0	0	0	0	11	0.64	2.2	0.13

*5-year averaged rates are unweighted averages across the annual rates of 2000 to 2004. Data suppression applied where the number of cases was less than 5 (see data sources and methods section). #Strep-pneumo & Strep-inv reported starting Sep-05. Some cases dated back to prior years. Children <5 years with Strep-pneumo invasive disease are reported under Strep-inv if not drug resistant. **E. COLI 015:H7 instead of STEC was reported prior to 2006.

Appendix C: Disease Statistics by Year

Table 1: Haemophilus Influenza (Invasive), Clark County 2000-2004
Mean and Median Age at Time of Event

Category		2000		2001		2002		2003		2004	
		Mean	Median	Mean	Median	Mean	Median	Mean	Median	Mean	Median
Overall		*51*	*67*	*41*	*35*	*18*	*4*	*46*	*63*	*33*	*6*
Gender	Male	71	71	19	19	14	2	29	1	34	6
	Female	38	42	51	54	25	19	57	67	32	32
Ethnicity	Hispanic	N/A	N/A	8	8	19	10	N/A	N/A	0.5	0.5
	Non-Hispanic	45	55	33	30	14	2	30	1	42	40
	Unspecified	75	75	69	69	29	29	74	77	62	62
Race/ Ethnicity	Hispanic Origin(HO),of any race	N/A	N/A	8	8	19	10	N/A	N/A	0.5	0.5
	Asian/Pacific Islander,not of HO	N/A	N/A	N/A	N/A	4	4	N/A	N/A	79	79
	Black,not of HO	69	69	40	40	N/A	N/A	N/A	N/A	N/A	N/A
	White,not of HO	37	42	29	29	17	0	30	1	5	5
	Other/Unspecified	75	75	69	69	29	29	74	77	62	62

Table 2: Hepatitis A, Clark County 2000-2004
Mean and Median Age at Time of Event

Category		2000		2001		2002		2003		2004	
		Mean	Median	Mean	Median	Mean	Median	Mean	Median	Mean	Median
Overall		*28*	*28*	*25*	*26*	*32*	*29*	*28*	*24*	*36*	*33*
Gender	Male	27	29	29	34	23	25	31	29	29	29
	Female	28	25	19	11	41	44	24	19	39	33
Ethnicity	Hispanic	16	11	12	10	18	10	17	15	19	20
	Non-Hispanic	36	35	37	37	49	48	38	36	54	54
	Unspecified	33	33	36	36	35	35	N/A	N/A	62	62
Race/ Ethnicity	Hispanic Origin(HO),of any race	16	11	12	10	18	10	17	15	19	20
	Native American,not of HO	N/A	N/A	28	28	N/A	N/A	N/A	N/A	N/A	N/A
	Asian/Pacific Islander,not of HO	23	23	N/A	N/A	N/A	N/A	22	22	N/A	N/A
	Black,not of HO	48	56	22	21	N/A	N/A	N/A	N/A	N/A	N/A
	White,not of HO	36	35	39	43	49	48	39	36	54	54
	Other/Unspecified	33	33	36	36	35	35	48	48	62	62

Table 3: Hepatitis B (Acute), Clark County 2000-2004
Number, Rate and Percentages of Cases

		2000			2001			2002			2003			2004		
		Number	Rate	%Case	Number	Rate	%Case	Number	Rate	%Case	Number	Rate	%Case	Number	Rate	%Case
Age Group	5-14	.	.	.	0	.	.	0	.	.	.	.	.	.	.	.
	15-24	7	3.6	17%	.	.	.	7	3.2	13%	7	3.05	11%	5	2.1	9.4%
	25-39	16	4.81	39%	22	6.29	56%	25	6.91	47%	25	6.67	40%	22	5.69	42%
	40-64	17	4.09	41%	12	2.69	31%	15	3.2	28%	28	5.68	45%	23	4.45	43%
	65+	.	.	.	.	.	.	6	3.6	11%	.	.	.	.	.	.
Ethnicity	Hispanic	5	1.63	12%	9	2.64	23%	7	1.91	13%	12	3.04	19%	11	2.61	21%
	Non-Hispanic	34	3.13	83%	24	2.1	62%	36	3.04	68%	37	3.02	60%	38	3	72%
	Unspecified	2	N/A	.	6	N/A	15%	10	N/A	19%	13	N/A	21%	4	N/A	.
Gender	Male	36	5.07	88%	32	4.23	82%	41	5.2	77%	43	5.22	69%	38	4.43	72%
	Female	5	0.73	12%	7	0.96	18%	12	1.58	23%	19	2.38	31%	15	1.81	28%
Race/ Ethnicity	Hispanic Origin(HO),of any race	5	1.63	12%	9	2.64	23%	7	1.91	13%	12	3.04	19%	11	2.61	21%
	Asian/Pacific Islander,not of HO	.	.	.	.	.	.	.	.	.	.	.	.	5	4.19	9.4%
	Black,not of HO	5	3.89	12%	.	.	.	.	.	.	.	.	.	7	4.58	13%
	White,not of HO	26	3.03	63%	20	2.23	51%	29	3.14	55%	27	2.83	44%	24	2.45	45%
	Other/Unspecified	.	.	.	7	N/A	18%	10	N/A	19%	14	N/A	23%	6	N/A	11%

Note: Suppressed data denoted by '.' .

Table 4: Hepatitis B (Acute), Clark County 2000-2004
Mean and Median Age at Time of Event

Category		2000		2001		2002		2003		2004	
		Mean	Median	Mean	Median	Mean	Median	Mean	Median	Mean	Median
Overall		*37*	*35*	*38*	*36*	*40*	*36*	*40*	*39*	*40*	*37*
Gender	Male	35	34	40	37	40	36	39	39	39	40
	Female	50	50	32	30	42	37	41	40	40	35
Ethnicity	Hispanic	39	45	33	32	32	33	41	42	37	36
	Non-Hispanic	37	36	41	37	43	37	41	40	41	40
	Unspecified	32	32	38	37	35	36	35	34	35	35
Race/ Ethnicity	Hispanic Origin(HO),of any race	39	45	33	32	32	33	41	42	37	36
	Asian/Pacific Islander,not of HO	59	63	34	31	29	29	46	48	35	33
	Black,not of HO	36	35	N/A	N/A	41	42	39	42	34	33
	White,not of HO	35	34	42	39	44	36	41	40	44	42
	Other/Unspecified	32	32	38	37	35	36	35	34	37	36

Table 5: Influenza, Clark County 2000-2004
Number, Rate and Percentages of Cases

		2000			2001			2002			2003			2004		
		Number	Rate	%Case	Number	Rate	%Case	Number	Rate	%Case	Number	Rate	%Case	Number	Rate	%Case
Age	<1	.	.	.	.	.	.	.	.	.	28	114.83	14%	16	61.3	28%
Group	1-4	0	.	.	.	.	.	17	18.47	29%	70	73.08	34%	19	19.23	33%
	5-14	.	.	.	.	.	.	.	.	.	42	18.38	20%	9	3.79	16%
	15-24	.	.	.	5	2.38	17%	11	5.03	19%	21	9.16	10%	5	2.1	8.6%
	25-39	12	3.61	48%	7	2	24%	16	4.42	27%	17	4.54	8.2%	.	.	.
	40-64	6	1.44	24%	7	1.57	24%	8	1.71	14%	20	4.06	9.7%	.	.	.
	65+	.	.	.	.	.	.	.	.	.	9	5.14	4.3%	.	.	.
Ethnicity	Hispanic	5	1.63	20%	8	2.34	28%	15	4.09	25%	46	11.66	22%	10	2.38	17%
	Non-Hispanic	16	1.47	64%	17	1.49	59%	36	3.04	61%	130	10.6	63%	28	2.21	48%
	Unspecified	4	N/A	.	4	N/A	.	8	N/A	14%	31	N/A	15%	20	N/A	34%
Gender	Male	12	1.69	48%	18	2.38	62%	26	3.3	44%	115	13.96	56%	32	3.73	55%
	Female	13	1.9	52%	11	1.51	38%	33	4.33	56%	92	11.55	44%	26	3.13	45%
Race/	Hispanic Origin(HO),of any race	5	1.63	20%	8	2.34	28%	15	4.09	25%	46	11.66	22%	10	2.38	17%
Ethnicity	Asian/Pacific Islander,not of HO	.	.	.	.	.	.	.	.	.	11	9.77	5.3%	.	.	.
	Black,not of HO	.	.	.	.	.	.	.	.	.	11	7.47	5.3%	.	.	.
	White,not of HO	13	1.51	52%	15	1.67	52%	25	2.71	42%	100	10.5	48%	20	2.04	34%
	Other/Unspecified	4	N/A	.	4	N/A	.	9	N/A	15%	39	N/A	19%	23	N/A	40%

Note: Suppressed data denoted by '.' .

Table 6: Influenza, Clark County 2000-2004
Mean and Median Age at Time of Event

Category		2000		2001		2002		2003		2004	
		Mean	Median	Mean	Median	Mean	Median	Mean	Median	Mean	Median
Overall		*36*	*34*	*31*	*29*	*23*	*23*	*15*	*5*	*11*	*2*
Gender	Male	37	36	27	25	27	26	14	5	11	2.5
	Female	34	34	37	36	20	20	16	6	11	2
Ethnicity	Hispanic	44	39	24	20	17	15	7.9	2.5	3.8	0.5
	Non-Hispanic	36	32	35	35	23	24	13	4.5	11	3
	Unspecified	25	30	25	26	36	36	31	26	15	4
Race/ Ethnicity	Hispanic Origin(HO),of any race	44	39	24	20	17	15	7.9	2.5	3.8	0.5
	Asian/Pacific Islander,not of HO	37	37	1	1	26	26	10	4	0.5	0.5
	Black,not of HO	23	23	43	43	27	27	4.7	2	12	16
	White,not of HO	37	32	37	35	22	23	15	5	13	3
	Other/Unspecified	25	30	25	26	34	25	26	19	13	3

Table 7: Pertussis, Clark County 2000-2004
Mean and Median Age at Time of Event

Category		2000		2001		2002		2003		2004	
		Mean	Median	Mean	Median	Mean	Median	Mean	Median	Mean	Median
Overall		*5.3*	*1*	*7*	*6.5*	*17*	*2*	*7.9*	*0*	*9.7*	*0*
Gender	Male	7.5	7.5	11	14	20	0	2	0	4.4	0
	Female	1	1	0	0	16	12	13	7.5	14	2
Ethnicity	Hispanic	N/A	N/A	0	0	15	0	6.5	0	5.6	0
	Non-Hispanic	5.3	1	8.4	13	21	11	8.7	0	18	9
	Unspecified	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	0	0
Race/ Ethnicity	Hispanic Origin(HO),of any race	N/A	N/A	0	0	15	0	6.5	0	5.6	0
	Asian/Pacific Islander,not of HO	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	28	28
	Black,not of HO	N/A	N/A	0	0	N/A	N/A	N/A	N/A	9	9
	White,not of HO	5.3	1	14	14	21	11	8.7	0	16	16
	Other/Unspecified	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	0	0

Table 8: Chlamydia, Clark County 2000-2004
Number, Rate and Percentages of Cases

		2000			2001			2002			2003			2004		
		Number	Rate	%Case	Number	Rate	%Case	Number	Rate	%Case	Number	Rate	%Case	Number	Rate	%Case
Age Group	<1	6	28.26	0.2%	15	65.61	0.4%	9	37.89	0.2%	10	41.01	0.2%	14	53.64	0.3%
	1-4	0	.	.	0	.	.	0	.	.	0	.	.	.	.	.
	5-14	69	34.97	2.5%	103	49.13	2.5%	99	45.33	2.2%	100	43.76	2.1%	83	34.94	1.6%
	15-24	1991	1024.58	72%	2843	1354.62	69%	3018	1379.39	68%	3150	1374.58	67%	3321	1393.15	66%
	25-39	617	185.36	22%	985	281.48	24%	1108	306.26	25%	1198	319.61	26%	1366	353.42	27%
	40-64	66	15.88	2.4%	95	21.29	2.3%	125	26.7	2.8%	146	29.61	3.1%	184	35.62	3.6%
	65+	8	5.35	0.3%	6	3.77	0.1%	6	3.6	0.1%	9	5.14	0.2%	28	15.3	0.6%
	Unspecified	26	N/A	0.9%	53	N/A	1.3%	71	N/A	1.6%	81	N/A	1.7%	.	.	.
Ethnicity	Hispanic	641	208.49	23%	682	199.71	17%	687	187.46	15%	696	176.42	15%	622	147.85	12%
	Non-Hispanic	1567	144.16	56%	1852	161.84	45%	1616	136.58	36%	1604	130.81	34%	1495	118.08	30%
	Unspecified	575	N/A	21%	1566	N/A	38%	2133	N/A	48%	2394	N/A	51%	2935	N/A	58%
Gender	Male	513	72.31	18%	931	123.16	23%	1082	137.29	24%	1118	135.68	24%	1237	144.3	24%
	Female	2268	331.1	81%	3169	434.16	77%	3353	440.29	76%	3566	447.58	76%	3803	458.43	75%
	Unspecified	2	N/A	0.1%	0	.	.	1	N/A	0.0%	10	N/A	0.2%	12	N/A	0.2%
Race/ Ethnicity	Hispanic Origin(HO),of any race	641	208.49	23%	682	199.71	17%	687	187.46	15%	696	176.42	15%	622	147.85	12%
	Native American,not of HO	21	180.15	0.8%	5	39.97	0.1%	8	61.09	0.2%	15	109.28	0.3%	13	90.71	0.3%
	Asian/Pacific Islander,not of HO	116	130.86	4.2%	99	100.79	2.4%	81	77.1	1.8%	86	76.38	1.8%	98	82.21	1.9%
	Black,not of HO	645	501.56	23%	848	624.02	21%	861	609.59	19%	827	561.69	18%	766	501.19	15%
	White,not of HO	777	90.55	28%	893	99.47	22%	660	71.44	15%	668	70.12	14%	607	61.96	12%
	Other/Unspecified	583	N/A	21%	1573	N/A	38%	2139	N/A	48%	2402	N/A	51%	2946	N/A	58%

Note: Suppressed data denoted by '.' .

Table 9: Chlamydia, Clark County 2000-2004
Mean and Median Age at Time of Event

Category		2000		2001		2002		2003		2004	
		Mean	Median	Mean	Median	Mean	Median	Mean	Median	Mean	Median
Overall		*22*	*21*	*22*	*21*	*23*	*21*	*23*	*21*	*23*	*22*
Gender	Male	25	23	24	23	25	23	25	23	26	23
	Female	22	20	22	20	22	20	22	21	23	21
Ethnicity	Hispanic	22	21	22	21	22	21	23	22	23	22
	Non-Hispanic	22	20	22	20	22	21	22	21	23	21
	Unspecified	23	20	23	21	23	21	23	21	24	22
Race/ Ethnicity	Hispanic Origin(HO),of any race	22	21	22	21	22	21	23	22	23	22
	Native American,not of HO	22	20	21	20	23	21	25	22	25	21
	Asian/Pacific Islander,not of HO	25	22	24	23	25	23	24	23	24	22
	Black,not of HO	21	20	22	20	22	20	22	21	22	21
	White,not of HO	22	21	22	21	22	21	23	21	23	21
	Other/Unspecified	23	20	23	21	23	21	23	21	24	22

Table 10: Gonorrhea, Clark County 2000-2004
Number, Rate and Percentages of Cases

		2000			2001			2002			2003			2004		
		Number	Rate	%Case	Number	Rate	%Case	Number	Rate	%Case	Number	Rate	%Case	Number	Rate	%Case
Age	<1	0	.	.	.	.	.	6	25.26	0.3%	.	.	.	.	.	.
Group	1-4	0	.	.	.	.	.	.	.	.	.	.	.	.	.	.
	5-14	27	13.69	2.0%	35	16.69	1.9%	32	14.65	1.8%	20	8.75	1.0%	29	12.21	1.1%
	15-24	710	365.37	51%	992	472.66	54%	885	404.49	51%	1025	447.28	49%	1231	516.4	47%
	25-39	475	142.7	34%	607	173.46	33%	636	175.8	36%	770	205.43	37%	1045	270.37	39%
	40-64	152	36.57	11%	169	37.88	9.2%	163	34.81	9.3%	245	49.69	12%	315	60.98	12%
	65+	7	4.68	0.5%	.	.	.	.	.	.	5	2.86	0.2%	5	2.73	0.2%
	Unspecified	11	N/A	0.8%	27	N/A	1.5%	21	N/A	1.2%	14	N/A	0.7%	16	N/A	0.6%
Ethnicity	Hispanic	153	49.76	11%	162	47.44	8.8%	183	49.94	10%	220	55.77	11%	262	62.28	9.9%
	Non-Hispanic	1080	99.36	78%	1205	105.3	66%	949	80.21	54%	1080	88.07	52%	1224	96.67	46%
	Unspecified	149	N/A	11%	470	N/A	26%	615	N/A	35%	783	N/A	38%	1160	N/A	44%
Gender	Male	861	121.36	62%	1031	136.39	56%	902	114.45	52%	1095	132.89	53%	1438	167.74	54%
	Female	521	76.06	38%	804	110.15	44%	845	110.96	48%	987	123.88	47%	1205	145.26	46%
	Unspecified	0	.	.	2	N/A	0.1%	0	.	.	1	N/A	0.0%	3	N/A	0.1%
Race/	Hispanic Origin(HO),of any race	153	49.76	11%	162	47.44	8.8%	183	49.94	10%	220	55.77	11%	262	62.28	9.9%
Ethnicity	Native American,not of HO	.	.	.	.	.	.	0	.	.	.	.	.	6	41.87	0.2%
	Asian/Pacific Islander,not of HO	20	22.56	1.4%	25	25.45	1.4%	11	10.47	0.6%	16	14.21	0.8%	44	36.91	1.7%
	Black,not of HO	739	574.65	53%	827	608.56	45%	652	461.62	37%	687	466.6	33%	791	517.55	30%
	White,not of HO	313	36.48	23%	347	38.65	19%	283	30.63	16%	370	38.84	18%	378	38.58	14%
	Other/Unspecified	.	.	.	.	.	.	618	N/A	35%	.	.	.	1165	N/A	44%

Note: Suppressed data denoted by '.' .

Table 11: Gonorrhea, Clark County 2000-2004
Mean and Median Age at Time of Event

		2000		2001		2002		2003		2004	
Category		Mean	Median	Mean	Median	Mean	Median	Mean	Median	Mean	Median
Overall		*27*	*24*	*26*	*23*	*26*	*24*	*27*	*24*	*27*	*25*
Gender	Male	29	26	28	26	28	26	30	28	30	28
	Female	23	21	22	20	24	21	24	22	24	22
Ethnicity	Hispanic	26	24	26	22	26	24	27	24	26	24
	Non-Hispanic	27	24	26	23	26	23	27	24	27	25
	Unspecified	27	24	26	23	26	24	27	24	27	25
Race/ Ethnicity	Hispanic Origin(HO),of any race	26	24	26	22	26	24	27	24	26	24
	Native American,not of HO	19	18	15	19	N/A	N/A	27	26	25	24
	Asian/Pacific Islander,not of HO	24	24	27	25	26	28	23	24	29	29
	Black,not of HO	25	23	25	22	25	23	26	24	26	24
	White,not of HO	30	29	28	26	28	25	29	27	30	27
	Other/Unspecified	27	24	26	23	26	24	27	24	27	25

Table 12: Number, Rate and Percentages of HIV Cases, Clark County 2000-2004

		2000			2001			2002			2003			2004		
		Number	Rate	%Case	Number	Rate	%Case	Number	Rate	%Case	Number	Rate	%Case	Number	Rate	%Case
Age	<1	0	.	.	.	.	.	0	.	.	0	.	.	0	.	.
Group	1-4	0	.	.	0	.	.	0	.	.	0	.	.	0	.	.
	5-14	0	.	.	.	.	.	0	.	.	.	.	.	0	.	.
	15-24	22	11.3	8.1%	34	16.2	14.2%	34	15.5	12.3%	30	13.1	14.8%	.	.	.
	25-39	159	47.8	58.7%	130	37.2	54.2%	154	42.6	55.8%	92	24.5	45.3%	156	40.4	52.2%
	40-64	85	20.5	31.4%	70	15.7	29.2%	85	18.2	30.8%	75	15.2	36.9%	98	19.0	32.8%
	65+	5	3.3	1.8%	.	.	.	.	.	.	.	.	.	.	.	.
	Unspecified	0	.	.	0	.	.	.	.	.	.	.	.	0	.	.
Ethnicity	Hispanic	41	13.3	15.1%	30	8.8	12.5%	50	13.6	18.1%	45	11.4	22.2%	62	14.7	20.7%
	Non-Hispanic	229	21.1	84.5%	210	18.4	87.5%	226	19.1	81.9%	157	12.8	77.3%	232	18.3	77.6%
	Unspecified	1	N/A	.	0	.	.	0	.	.	1	N/A	.	5	N/A	1.7%
Gender	Male	217	30.6	80.1%	205	27.1	85.4%	231	29.3	83.7%	168	20.4	82.8%	242	28.2	80.9%
	Female	54	7.9	19.9%	35	4.8	14.6%	45	5.9	16.3%	35	4.4	17.2%	57	6.9	19.1%
Race/	Hispanic Origin(HO),of any race	41	13.3	15.1%	30	8.8	12.5%	50	13.6	18.1%	45	11.4	22.2%	62	14.7	20.7%
Ethnicity	Native American,not of HO	.	.	.	.	.	.	.	.	.	.	.	.	.	.	.
	Asian/Pacific Islander,not of HO	.	.	.	.	.	.	.	.	.	.	.	.	.	.	.
	Black,not of HO	81	63.0	29.9%	89	65.5	37.1%	81	57.3	29.3%	53	36.0	26.1%	76	49.7	25.4%
	White,not of HO	142	16.5	52.4%	110	12.3	45.8%	136	14.7	49.3%	96	10.1	47.3%	152	15.5	50.8%
	Other/Unspecified	1	N/A	.	0	.	.	0	.	.	1	N/A	.	5	N/A	1.7%

Note: Suppressed data denoted by '.' .

Table 13: Number, Rate and Percentages of AIDS Cases, Clark County 2000-2004

		2000			2001			2002			2003			2004		
		Number	Rate	%Case	Number	Rate	%Case	Number	Rate	%Case	Number	Rate	%Case	Number	Rate	%Case
Age	<1	.	.	.	0	.	.	0	.	.	0	.	.	0	.	.
Group	1-4	0	.	.	0	.	.	0	.	.	0	.	.	0	.	.
	5-14	.	.	.	0	.	.	0	.	.	0	.	.	.	.	.
	15-24	9	4.6	3.9%	9	4.3	5.3%	.	.	.	13	5.7	5.2%	8	3.4	3.2%
	25-39	131	39.4	57.5%	95	27.1	55.6%	128	35.4	53.6%	122	32.5	48.6%	111	28.7	43.9%
	40-64	83	20.0	36.4%	63	14.1	36.8%	104	22.2	43.5%	113	22.9	45.0%	129	25.0	51.0%
	65+	.	.	.	.	.	.	.	.	.	.	.	.	.	.	.
	Unspecified	0	.	.	.	.	.	0	.	.	.	.	.	1	N/A	.
Ethnicity	Hispanic	45	14.6	19.7%	33	9.7	19.3%	49	13.4	20.5%	50	12.7	19.9%	54	12.8	21.3%
	Non-Hispanic	183	16.8	80.3%	138	12.1	80.7%	190	16.1	79.5%	201	16.4	80.1%	195	15.4	77.1%
	Unspecified	0	.	.	0	.	.	0	.	.	0	.	.	4	N/A	.
Gender	Male	183	25.8	80.3%	139	18.4	81.3%	198	25.1	82.8%	213	25.8	84.9%	206	24.0	81.4%
	Female	45	6.6	19.7%	32	4.4	18.7%	41	5.4	17.2%	38	4.8	15.1%	47	5.7	18.6%
Race/	Hispanic Origin(HO),of any race	45	14.6	19.7%	33	9.7	19.3%	49	13.4	20.5%	50	12.7	19.9%	54	12.8	21.3%
Ethnicity	Native American,not of HO	.	.	.	.	.	.	.	.	.	0	.	.	.	.	.
	Asian/Pacific Islander,not of HO	.	.	.	.	.	.	.	.	.	7	6.2	2.8%	8	6.7	3.2%
	Black,not of HO	59	45.9	25.9%	56	41.2	32.7%	59	41.8	24.7%	80	54.3	31.9%	72	47.1	28.5%
	White,not of HO	119	13.9	52.2%	75	8.4	43.9%	123	13.3	51.5%	114	12.0	45.4%	111	11.3	43.9%
	Other/Unspecified	0	.	.	0	.	.	0	.	.	0	.	.	.	.	.

Note: Suppressed data denoted by '.' .

Table 14: Syphilis (Primary & Secondary), Clark County 2000-2004
Mean and Median Age at Time of Event

Category		2000		2001		2002		2003		2004	
		Mean	Median	Mean	Median	Mean	Median	Mean	Median	Mean	Median
Overall		*36*	*37*	*35*	*37*	*37*	*40*	*33*	*34*	*31*	*29*
Gender	Male	35	35	35	37	37	40	35	36	33	33
	Female	37	37	N/A	N/A	N/A	N/A	16	16	24	25
Ethnicity	Hispanic	N/A	N/A	35	38	21	21	23	23	29	25
	Non-Hispanic	34	34	35	35	41	41	33	32	30	28
	Unspecified	39	39	N/A	N/A	33	33	38	38	34	34
Race/ Ethnicity	Hispanic Origin(HO),of any race	N/A	N/A	35	38	21	21	23	23	29	25
	Asian/Pacific Islander,not of HO	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	28	28
	Black,not of HO	29	29	N/A	N/A	N/A	N/A	32	32	29	26
	White,not of HO	37	37	35	35	41	41	33	34	32	33
	Other/Unspecified	39	39	N/A	N/A	33	33	38	38	34	34

Table 15: Syphilis (Early Latent), Clark County 2000-2004
Mean and Median Age at Time of Event

Category		2000		2001		2002		2003		2004	
		Mean	Median	Mean	Median	Mean	Median	Mean	Median	Mean	Median
Overall		*31*	*30*	*29*	*26*	*27*	*24*	*27*	*28*	*30*	*32*
Gender	Male	26	26	28	31	29	24	30	29	35	37
	Female	33	30	30	19	23	23	23	20	26	23
Ethnicity	Hispanic	30	30	20	20	20	21	24	23	33	33
	Non-Hispanic	31	30	34	32	26	26	30	29	33	36
	Unspecified	N/A	N/A	N/A	N/A	38	38	35	35	24	23
Race/ Ethnicity	Hispanic Origin(HO),of any race	30	30	20	20	20	21	24	23	33	33
	Native American,not of HO	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	36	36
	Asian/Pacific Islander,not of HO	21	21	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
	Black,not of HO	47	47	18	18	N/A	N/A	30	29	29	35
	White,not of HO	29	30	39	33	26	26	29	29	37	37
	Other/Unspecified	N/A	N/A	N/A	N/A	38	38	35	35	24	23

Table 16: Amebiasis, Clark County 2000-2004
Mean and Median Age at Time of Event

Category		2000		2001		2002		2003		2004	
		Mean	Median	Mean	Median	Mean	Median	Mean	Median	Mean	Median
Overall		*42*	*38*	*42*	*38*	*28*	*32*	*39*	*34*	*32*	*34*
Gender	Male	42	38	45	39	28	32	39	34	32	30
	Female	N/A	N/A	32	32	29	31	39	36	32	36
Ethnicity	Hispanic	N/A	N/A	46	46	23	28	31	36	28	28
	Non-Hispanic	42	38	36	36	39	38	41	33	39	39
	Unspecified	N/A	N/A	39	39	N/A	N/A	69	69	44	44
Race/ Ethnicity	Hispanic Origin(HO),of any race	N/A	N/A	46	46	23	28	31	36	28	28
	Asian/Pacific Islander,not of HO	N/A	N/A	N/A	N/A	32	32	N/A	N/A	N/A	N/A
	Black,not of HO	38	38	N/A	N/A	38	38	28	28	N/A	N/A
	White,not of HO	57	57	36	36	41	39	43	34	39	39
	Other/Unspecified	30	30	39	39	N/A	N/A	62	62	44	44

Table 17: Campylobacteriosis, Clark County 2000-2004
Number, Rate and Percentages of Cases

		2000			2001			2002			2003			2004		
		Number	Rate	%Case	Number	Rate	%Case	Number	Rate	%Case	Number	Rate	%Case	Number	Rate	%Case
Age	<1	8	37.67	7.4%	10	43.74	7.4%	.	.	.	.	.	.	.	.	.
Group	1-4	28	33.53	26%	22	24.93	16%	16	17.38	14%	18	18.79	17%	25	25.3	25%
	5-14	16	8.11	15%	21	10.02	16%	22	10.07	20%	18	7.88	17%	17	7.16	17%
	15-24	8	4.12	7.4%	20	9.53	15%	13	5.94	12%	12	5.24	12%	7	2.94	6.9%
	25-39	20	6.01	19%	31	8.86	23%	24	6.63	22%	19	5.07	18%	24	6.21	24%
	40-64	24	5.77	22%	27	6.05	20%	27	5.77	24%	24	4.87	23%	14	2.71	14%
	65+	.	.	.	.	.	.	5	3	4.5%	9	5.14	8.7%	10	5.47	9.9%
	Unspecified	.	.	.	.	.	.	.	.	.	.	.	.	.	.	.
Ethnicity	Hispanic	38	12.36	35%	45	13.18	33%	32	8.73	29%	28	7.1	27%	31	7.37	31%
	Non-Hispanic	61	5.61	56%	81	7.08	60%	78	6.59	70%	65	5.3	63%	56	4.42	55%
	Unspecified	9	N/A	8.3%	9	N/A	6.7%	1	N/A	.	10	N/A	9.7%	14	N/A	14%
Gender	Male	63	8.88	58%	68	9	50%	54	6.85	49%	54	6.55	52%	55	6.42	54%
	Female	45	6.57	42%	67	9.18	50%	57	7.48	51%	49	6.15	48%	46	5.55	46%
Race/	Hispanic Origin(HO),of any race	38	12.36	35%	45	13.18	33%	32	8.73	29%	28	7.1	27%	31	7.37	31%
Ethnicity	Native American,not of HO	.	.	.	0	.	.	.	.	.	.	.	.	.	.	.
	Asian/Pacific Islander,not of HO	5	5.64	4.6%	.	.	.	7	6.66	6.3%	6	5.33	5.8%	.	.	.
	Black,not of HO	.	.	.	.	.	.	.	.	.	.	.	.	5	3.27	5.0%
	White,not of HO	53	6.18	49%	72	8.02	53%	65	7.04	59%	54	5.67	52%	45	4.59	45%
	Other/Unspecified	10	N/A	9.3%	10	N/A	7.4%	5	N/A	4.5%	13	N/A	13%	16	N/A	16%

Note: Suppressed data denoted by '.' .

Table18: Campylobacteriosis, Clark County 2000-2004
Mean and Median Age at Time of Event

		2000		2001		2002		2003		2004	
	Category	Mean	Median	Mean	Median	Mean	Median	Mean	Median	Mean	Median
Overall		*23*	*20*	*25*	*22*	*28*	*25*	*28*	*25*	*25*	*16*
Gender	Male	20	10	29	26	32	30	26	15	28	26
	Female	27	29	21	18	23	15	31	32	22	16
Ethnicity	Hispanic	13	4	14	6	13	6.5	15	11	15	7
	Non-Hispanic	27	25	30	33	34	33	34	33	32	31
	Unspecified	35	43	27	21	8	8	29	28	23	16
Race/ Ethnicity	Hispanic Origin(HO),of any race	13	4	14	6	13	6.5	15	11	15	7
	Native American,not of HO	7	7	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
	Asian/Pacific Islander,not of HO	9.6	3	21	18	25	23	37	37	13	11
	Black,not of HO	53	53	36	36	24	24	27	27	40	38
	White,not of HO	29	31	31	32	35	34	36	37	31	31
	Other/Unspecified	35	40	25	21	25	11	23	14	29	33

Table 19: E. coli O157:H7, Clark County 2000-2004
Mean and Median Age at Time of Event

		2000		2001		2002		2003		2004	
	Category	Mean	Median	Mean	Median	Mean	Median	Mean	Median	Mean	Median
Overall		*32*	*15*	*28*	*28*	*14*	*7.5*	*22*	*17*	*18*	*12*
Gender	Male	34	21	42	40	7.2	5	18	18	15	9.5
	Female	28	15	14	16	26	28	23	17	21	13
Ethnicity	Hispanic	7	7	32	32	7	7	N/A	N/A	3.5	3.5
	Non-Hispanic	29	15	27	24	16	8	24	17	21	13
	Unspecified	78	78	N/A	N/A	1	1	6	6	11	11
Race/ Ethnicity	Hispanic Origin(HO),of any race	7	7	32	32	7	7	N/A	N/A	3.5	3.5
	Asian/Pacific Islander,not of HO	6	6	N/A	N/A	N/A	N/A	N/A	N/A	4	4
	Black,not of HO	6	6	42	42	N/A	N/A	29	29	16	16
	White,not of HO	37	27	25	22	16	8	23	17	23	12
	Other/Unspecified	78	78	N/A	N/A	1	1	6	6	18	13

Table 20: Giardiasis, Clark County 2000-2004
Number, Rate and Percentages of Cases

		2000			2001			2002			2003			2004		
		Number	Rate	%Case	Number	Rate	%Case	Number	Rate	%Case	Number	Rate	%Case	Number	Rate	%Case
Age	<1	.	.	.	.	.	.	0	.	.	.	.	.	.	.	.
Group	1-4	37	44.31	25%	28	31.73	20%	18	19.56	15%	23	24.01	24%	13	13.16	18%
	5-14	28	14.19	19%	29	13.83	21%	19	8.7	16%	17	7.44	18%	12	5.05	16%
	15-24	9	4.63	6.1%	10	4.76	7.1%	9	4.11	7.6%	10	4.36	11%	.	.	.
	25-39	45	13.52	30%	36	10.29	26%	25	6.91	21%	22	5.87	23%	22	5.69	30%
	40-64	21	5.05	14%	29	6.5	21%	37	7.9	31%	16	3.24	17%	18	3.48	24%
	65+	.	.	.	.	.	.	11	6.6	9.2%	.	.	.	.	.	.
Ethnicity	Hispanic	45	14.64	30%	55	16.11	39%	48	13.1	40%	32	8.11	34%	24	5.7	32%
	Non-Hispanic	93	8.56	63%	81	7.08	57%	60	5.07	50%	54	4.4	57%	46	3.63	62%
	Unspecified	10	N/A	6.8%	5	N/A	3.5%	11	N/A	9.2%	8	N/A	8.5%	4	N/A	.
Gender	Male	89	12.54	60%	79	10.45	56%	71	9.01	60%	56	6.8	60%	45	5.25	61%
	Female	59	8.61	40%	62	8.49	44%	48	6.3	40%	38	4.77	40%	29	3.5	39%
Race/	Hispanic Origin(HO),of any race	45	14.64	30%	55	16.11	39%	48	13.1	40%	32	8.11	34%	24	5.7	32%
Ethnicity	Native American,not of HO	.	.	.	.	.	.	0	.	.	0	.	.	.	.	.
	Asian/Pacific Islander,not of HO	.	.	.	.	.	.	0	.	.	7	6.22	7.4%	.	.	.
	Black,not of HO	.	.	.	7	5.15	5.0%	8	5.66	6.7%	7	4.75	7.4%	8	5.23	11%
	White,not of HO	85	9.91	57%	73	8.13	52%	52	5.63	44%	39	4.09	41%	29	2.96	39%
	Other/Unspecified	12	N/A	8.1%	5	N/A	3.5%	11	N/A	9.2%	9	N/A	9.6%	9	N/A	12%

Note: Suppressed data denoted by '.' .

Table 21: Giardiasis, Clark County 2000-2004
Mean and Median Age at Time of Event

		2000		2001		2002		2003		2004	
	Category	Mean	Median	Mean	Median	Mean	Median	Mean	Median	Mean	Median
Overall		*21*	*19*	*25*	*26*	*32*	*33*	*22*	*20*	*27*	*31*
Gender	Male	21	23	25	26	31	32	26	27	26	29
	Female	21	17	25	18	33	37	16	9.5	29	32
Ethnicity	Hispanic	14	8	18	8	17	7.5	14	9.5	24	22
	Non-Hispanic	25	27	29	31	42	43	26	27	30	33
	Unspecified	18	7.5	31	40	41	38	26	31	17	13
Race/ Ethnicity	Hispanic Origin(HO),of any race	14	8	18	8	17	7.5	14	9.5	24	22
	Native American,not of HO	35	35	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
	Asian/Pacific Islander,not of HO	44	44	19	19	N/A	N/A	14	11	25	24
	Black,not of HO	25	25	19	18	32	34	19	10	44	40
	White,not of HO	24	27	31	33	44	45	29	31	30	32
	Other/Unspecified	19	7.5	31	40	41	38	29	35	15	4

Table 22: Salmonellosis, Clark County 2000-2004
Number, Rate and Percentages of Cases

		2000			2001			2002			2003			2004		
		Number	Rate	%Case	Number	Rate	%Case	Number	Rate	%Case	Number	Rate	%Case	Number	Rate	%Case
Age	<1	15	70.64	10%	11	48.12	7.4%	22	92.61	13%	15	61.52	12%	10	38.31	7.8%
Group	1-4	23	27.55	16%	24	27.2	16%	30	32.59	17%	19	19.84	16%	19	19.23	15%
	5-14	21	10.64	14%	25	11.92	17%	26	11.91	15%	21	9.19	17%	31	13.05	24%
	15-24	11	5.66	7.4%	11	5.24	7.4%	17	7.77	9.7%	9	3.93	7.4%	10	4.19	7.8%
	25-39	36	10.82	24%	31	8.86	21%	26	7.19	15%	20	5.34	17%	20	5.17	16%
	40-64	28	6.74	19%	36	8.07	24%	32	6.83	18%	24	4.87	20%	27	5.23	21%
	65+	14	9.36	9.5%	11	6.91	7.4%	22	13.2	13%	13	7.43	11%	12	6.56	9.3%
	Unspecified	0	.	.	0	.	.	1	N/A	.	0	.	.	0	.	.
Ethnicity	Hispanic	34	11.06	23%	39	11.42	26%	33	9	19%	26	6.59	21%	34	8.08	26%
	Non-Hispanic	100	9.2	68%	102	8.91	68%	132	11.16	75%	86	7.01	71%	81	6.4	63%
	Unspecified	14	N/A	9.5%	8	N/A	5.4%	11	N/A	6.3%	9	N/A	7.4%	14	N/A	11%
Gender	Male	79	11.14	53%	68	9	46%	83	10.53	47%	62	7.52	51%	60	7	47%
	Female	69	10.07	47%	81	11.1	54%	93	12.21	53%	59	7.41	49%	69	8.32	53%
Race/	Hispanic Origin(HO),of any race	34	11.06	23%	39	11.42	26%	33	9	19%	26	6.59	21%	34	8.08	26%
Ethnicity	Native American,not of HO	.	.	.	.	.	.	0	.	.	.	.	.	.	.	.
	Asian/Pacific Islander,not of HO	.	.	.	.	.	.	15	14.28	8.5%	.	.	.	.	.	.
	Black,not of HO	8	6.22	5.4%	6	4.42	4.0%	13	9.2	7.4%	9	6.11	7.4%	6	3.93	4.7%
	White,not of HO	89	10.37	60%	92	10.25	62%	99	10.72	56%	68	7.14	56%	65	6.63	50%
	Other/Unspecified	14	N/A	9.5%	9	N/A	6.0%	16	N/A	9.1%	15	N/A	12%	17	N/A	13%

Note: Suppressed data denoted by '.' .

Table 23: Salmonellosis, Clark County 2000-2004
Mean and Median Age at Time of Event

		2000		2001		2002		2003		2004	
	Category	Mean	Median	Mean	Median	Mean	Median	Mean	Median	Mean	Median
Overall		*28*	*27*	*27*	*26*	*27*	*20*	*26*	*18*	*26*	*19*
Gender	Male	27	23	25	18	25	15	27	22	22	12
	Female	30	31	29	32	29	23	26	16	30	26
Ethnicity	Hispanic	18	10	19	6	20	8	8.3	2	16	8
	Non-Hispanic	31	30	30	32	28	22	32	29	32	29
	Unspecified	38	35	33	40	38	38	23	5	22	12
Race/ Ethnicity	Hispanic Origin(HO),of any race	18	10	19	6	20	8	8.3	2	16	8
	Native American,not of HO	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	0	0
	Asian/Pacific Islander,not of HO	30	27	12	14	21	10	27	3	30	20
	Black,not of HO	20	4	27	24	22	23	24	27	19	17
	White,not of HO	31	31	31	32	31	25	35	33	34	29
	Other/Unspecified	38	35	33	36	27	28	21	9	22	13

Table 24: Shigellosis, Clark County 2000-2004
Mean and Median Age at Time of Event

		2000		2001		2002		2003		2004	
	Category	Mean	Median	Mean	Median	Mean	Median	Mean	Median	Mean	Median
Overall		*15*	*7*	*15*	*5.5*	*17*	*7*	*16*	*7*	*16*	*7*
Gender	Male	16	7.5	19	5	21	16	13	7	13	5.5
	Female	14	6.5	10	6	12	5	21	11	19	9
Ethnicity	Hispanic	11	5	7.8	4	11	4	11	5	12	6
	Non-Hispanic	18	12	28	33	34	33	21	15	24	28
	Unspecified	23	26	26	6	20	20	19	23	29	33
Race/ Ethnicity	Hispanic Origin(HO),of any race	11	5	7.8	4	11	4	11	5	12	6
	Asian/Pacific Islander,not of HO	N/A	N/A	N/A	N/A	N/A	N/A	3	3	N/A	N/A
	Black,not of HO	13	7.5	11	4	N/A	N/A	13	13	15	14
	White,not of HO	23	27	36	36	34	33	31	31	32	42
	Other/Unspecified	23	26	21	7	20	20	8.9	4	26	32

Table 25: Coccidioidomycosis, Clark County 2000-2004
Number, Rate and Percentages of Cases

		2000			2001			2002			2003			2004		
		Number	Rate	%Case	Number	Rate	%Case	Number	Rate	%Case	Number	Rate	%Case	Number	Rate	%Case
Age	<1	0	.	.	0	.	.	.	.	.	0	.	.	0	.	.
Group	5-14	.	.	.	.	.	.	.	.	.	.	.	.	.	.	.
	15-24	.	.	.	.	.	.	.	.	.	.	.	.	.	.	.
	25-39	6	1.8	25%	10	2.86	27%	9	2.49	23%	10	2.67	30%	8	2.07	15%
	40-64	11	2.65	46%	14	3.14	38%	18	3.84	46%	15	3.04	45%	23	4.45	42%
	65+	.	.	.	11	6.91	30%	9	5.4	23%	6	3.43	18%	23	12.57	42%
Ethnicity	Hispanic	.	.	.	5	1.46	14%	6	1.64	15%	.	.	.	7	1.66	13%
	Non-Hispanic	16	1.47	67%	29	2.53	78%	16	1.35	41%	11	0.9	33%	22	1.74	40%
	Unspecified	.	.	.	3	N/A	.	17	N/A	44%	.	.	.	26	N/A	47%
Gender	Male	16	2.26	67%	26	3.44	70%	28	3.55	72%	22	2.67	67%	36	4.2	65%
	Female	8	1.17	33%	11	1.51	30%	11	1.44	28%	11	1.38	33%	19	2.29	35%
Race/	Hispanic Origin(HO),of any race	.	.	.	5	1.46	14%	6	1.64	15%	.	.	.	7	1.66	13%
Ethnicity	Asian/Pacific Islander,not of HO	.	.	.	.	.	.	.	.	.	0	.	.	.	.	.
	Black,not of HO	.	.	.	8	5.89	22%	.	.	.	.	.	.	.	.	.
	White,not of HO	12	1.4	50%	17	1.89	46%	13	1.41	33%	6	0.63	18%	17	1.74	31%
	Other/Unspecified	6	N/A	25%	.	.	.	17	N/A	44%	22	N/A	67%	26	N/A	47%

Note: Suppressed data denoted by '.' .

Table 26: Coccidioidomycosis, Clark County 2000-2004
Mean and Median Age at Time of Event

		2000		2001		2002		2003		2004	
	Category	Mean	Median	Mean	Median	Mean	Median	Mean	Median	Mean	Median
Overall		*49*	*50*	*52*	*48*	*51*	*51*	*48*	*47*	*57*	*61*
Gender	Male	47	43	53	53	48	49	49	47	57	63
	Female	52	59	48	44	57	60	46	44	56	54
Ethnicity	Hispanic	42	42	48	48	48	49	31	31	47	38
	Non-Hispanic	44	43	53	51	59	62	55	57	57	60
	Unspecified	64	65	44	39	44	47	46	45	59	62
Race/ Ethnicity	Hispanic Origin(HO),of any race	42	42	48	48	48	49	31	31	47	38
	Asian/Pacific Islander,not of HO	60	60	71	67	69	69	N/A	N/A	44	41
	Black,not of HO	26	21	49	49	29	29	58	63	60	60
	White,not of HO	47	51	53	47	59	62	54	51	59	66
	Other/Unspecified	64	65	45	44	44	47	47	47	59	62

Table 27: Aseptic Meningitis, Clark County 2000-2004
Number, Rate and Percentages of Cases

		2000			2001			2002			2003			2004		
		Number	Rate	%Case	Number	Rate	%Case	Number	Rate	%Case	Number	Rate	%Case	Number	Rate	%Case
Age	<1	5	23.55	7.6%	9	39.37	10%	8	33.68	8.4%	15	61.52	11%	10	38.31	12%
Group	1-4	.	.	.	.	.	.	.	.	.	.	.	.	.	.	.
	5-14	5	2.53	7.6%	14	6.68	16%	11	5.04	12%	26	11.38	19%	20	8.42	23%
	15-24	9	4.63	14%	19	9.05	22%	11	5.03	12%	27	11.78	20%	9	3.78	10%
	25-39	27	8.11	41%	30	8.57	34%	40	11.06	42%	39	10.4	29%	27	6.99	31%
	40-64	14	3.37	21%	12	2.69	14%	20	4.27	21%	23	4.66	17%	14	2.71	16%
	65+	.	.	.	.	.	.	.	.	.	.	.	.	.	.	.
Ethnicity	Hispanic	10	3.25	15%	8	2.34	9.2%	11	3	12%	37	9.38	27%	17	4.04	20%
	Non-Hispanic	42	3.86	64%	27	2.36	31%	18	1.52	19%	24	1.96	18%	37	2.92	43%
	Unspecified	14	N/A	21%	52	N/A	60%	66	N/A	69%	75	N/A	55%	32	N/A	37%
Gender	Male	37	5.22	56%	39	5.16	45%	39	4.95	41%	78	9.47	57%	40	4.67	47%
	Female	29	4.23	44%	48	6.58	55%	56	7.35	59%	58	7.28	43%	46	5.55	53%
Race/	Hispanic Origin(HO),of any race	10	3.25	15%	8	2.34	9.2%	11	3	12%	37	9.38	27%	17	4.04	20%
Ethnicity	Asian/Pacific Islander,not of HO	0	.	.	.	.	.	.	.	.	0	.	.	.	.	.
	Black,not of HO	6	4.67	9.1%	.	.	.	.	.	.	.	.	.	.	.	.
	White,not of HO	32	3.73	48%	21	2.34	24%	14	1.52	15%	21	2.2	15%	29	2.96	34%
	Other/Unspecified	18	N/A	27%	54	N/A	62%	67	N/A	71%	.	.	.	35	N/A	41%

Note: Suppressed data denoted by '.' .

Table 28: Aseptic Meningitis, Clark County 2000-2004
Mean and Median Age at Time of Event

		2000		2001		2002		2003		2004	
	Category	Mean	Median	Mean	Median	Mean	Median	Mean	Median	Mean	Median
Overall		*30*	*30*	*24*	*24*	*29*	*30*	*24*	*24*	*25*	*25*
Gender	Male	25	27	23	24	23	27	21	21	25	25
	Female	35	32	25	25	32	32	29	31	25	25
Ethnicity	Hispanic	26	30	19	17	15	15	16	13	16	9
	Non-Hispanic	31	31	26	23	36	34	21	24	30	29
	Unspecified	27	29	24	26	29	30	30	31	24	23
Race/ Ethnicity	Hispanic Origin(HO),of any race	26	30	19	17	15	15	16	13	16	9
	Asian/Pacific Islander,not of HO	N/A	N/A	83	83	33	33	N/A	N/A	27	27
	Black,not of HO	20	17	8	7	23	23	13	13	28	30
	White,not of HO	33	31	27	25	36	34	22	24	32	30
	Other/Unspecified	29	33	23	25	29	30	30	31	23	22

Table 29: Bacterial Meningitis, Clark County 2000-2004
Mean and Median Age at Time of Event

		2000		2001		2002		2003		2004	
	Category	Mean	Median	Mean	Median	Mean	Median	Mean	Median	Mean	Median
Overall		*34*	*41*	*32*	*34*	*37*	*44*	*35*	*45*	*31*	*35*
Gender	Male	36	46	27	34	40	47	29	41	41	48
	Female	32	36	37	29	35	41	39	51	24	20
Ethnicity	Hispanic	26	11	6	6	15	1	29	5	16	10
	Non-Hispanic	38	44	34	34	40	45	35	37	33	41
	Unspecified	0	0	39	43	49	50	37	46	38	46
Race/ Ethnicity	Hispanic Origin(HO),of any race	26	11	6	6	15	1	29	5	16	10
	Asian/Pacific Islander,not of HO	N/A	N/A	62	62	N/A	N/A	N/A	N/A	N/A	N/A
	Black,not of HO	32	36	41	41	70	70	1	1	49	49
	White,not of HO	43	45	30	17	41	45	40	47	29	31
	Other/Unspecified	16	0	39	43	43	48	37	46	38	46

Table 30: Meningococcal Disease, Clark County 2000-2004
Mean and Median Age at Time of Event

Category		2000		2001		2002		2003		2004	
		Mean	Median	Mean	Median	Mean	Median	Mean	Median	Mean	Median
Overall		*9.5*	*9.5*	*24*	*20*	*33*	*37*	*38*	*26*	*35*	*28*
Gender	Male	N/A	N/A	28	18	23	20	40	42	43	43
	Female	9.5	9.5	17	21	39	38	35	19	28	28
Ethnicity	Hispanic	0	0	24	15	18	18	26	26	24	24
	Non-Hispanic	19	19	24	20	34	38	48	58	27	27
	Unspecified	N/A	N/A	N/A	N/A	44	44	3	3	66	66
Race/ Ethnicity	Hispanic Origin(HO),of any race	0	0	24	15	18	18	26	26	24	24
	Asian/Pacific Islander,not of HO	N/A	N/A	12	12	N/A	N/A	N/A	N/A	27	27
	Black,not of HO	N/A	N/A	21	21	0	0	66	66	N/A	N/A
	White,not of HO	19	19	32	32	37	40	45	45	N/A	N/A
	Other/Unspecified	N/A	N/A	N/A	N/A	44	44	10	10	66	66

Table 31: Tuberculosis, Clark County 2000-2004
Number, Rate and Percentages of Cases

		2000			2001			2002			2003			2004		
		Number	Rate	%Case	Number	Rate	%Case	Number	Rate	%Case	Number	Rate	%Case	Number	Rate	%Case
Age	<5	.	.	.	.	.	.	0	.	.	.	.	.	.	.	.
Group	5 to 12	.	.	.	.	.	.	0	.	.	0	.	.	.	.	.
	13 to 19	.	.	.	.	.	.	0	.	.	0	.	.	.	.	.
	20 to 29	9	4.36	11%	8	3.62	11.3%	6	2.61	9.7%	14	5.81	18.9%	15	5.99	21.4%
	30 to 39	20	8.82	24.4%	17	7.17	23.9%	12	4.91	19.4%	14	5.55	18.9%	10	3.86	14.3%
	40 to 49	14	7.01	17.1%	15	7.01	21.1%	14	6.25	22.6%	18	7.65	24.3%	11	4.48	15.7%
	50 to 59	14	8.99	17.1%	11	6.57	15.5%	15	8.52	24.2%	13	7.02	17.6%	8	4.11	11.4%
	60+	16	7.63	19.5%	14	6.25	19.7%	14	5.97	22.6%	13	5.25	17.6%	22	8.48	31.4%
	Unspecified	2	N/A	.	2	N/A	.	1	N/A	.	.	.	.	0	.	.
Gender	Male	56	7.89	68.3%	42	5.56	59.2%	28	3.55	45.2%	44	5.34	59.5%	44	5.13	62.9%
	Female	24	3.5	29.3%	27	3.7	38%	33	4.33	53.2%	30	3.77	40.5%	26	3.13	37.1%
	Unspecified	2	N/A	.	2	N/A	.	1	N/A	.	0	.	.	0	.	.
Race/	Hispanic Origin(HO),of any race	23	7.48	28%	12	3.51	16.9%	13	3.55	21%	20	5.07	27%	25	5.94	35.7%
Ethnicity	Native American,not of HO	.	.	.	0	.	.	0	.	.	0	.	.	.	.	.
	Asian/Pacific Islander,not of HO	20	22.56	24.4%	25	25.45	35.2%	23	21.89	37.1%	33	29.31	44.6%	13	10.91	18.6%
	Black,not of HO	14	10.89	17.1%	14	10.3	19.7%	8	5.66	12.9%	9	6.11	12.2%	.	.	.
	White,not of HO	20	2.33	24.4%	17	1.89	23.9%	17	1.84	27.4%	12	1.26	16.2%	21	2.14	30%
	Other/Unspecified	.	.	.	3	N/A	.	1	N/A	.	0	.	.	0	.	.

Note: Suppressed data denoted by '.' .