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Letter From the Editor

Alicia Chancellor Hansen, MS
Chief Biostatistician

The Office of Health Statistics and Surveillance (OHSS) is pleased to introduce the first issue of the OHSS Zone!

This publication is planned for periodic release and will feature a snapshot of recent OHSS Staff projects. We regularly handle many interesting requests for data and compile other valuable reports. This publication was created as a means of sharing this useful information, as well as programmatic updates, with a larger audience of public health advocates and professionals. Please feel free to share this publication with anyone who might be interested.

With the recent reorganization of the State Health Division, The Center for Health Data and Research was merged with several surveillance, prevention, and control programs to form a central repository for data and surveillance activities. The Office of Health Statistics and Surveillance is part of the Bureau of Health Statistics, Planning, and Emergency Response (formerly the Bureau of Health Planning and Statistics) within the Nevada State Health Division. Staff in the OHSS perform data analysis and reporting, surveillance, and prevention and control activities in a broad spectrum of public health areas.

The OHSS includes:

- o STD Prevention and Control Program
- o HIV/AIDS Surveillance Program
- o Tuberculosis Elimination and Control Program
- o Adult Viral Hepatitis Program
- o Trauma Registry
- o Injury Prevention Program
- o Behavioral Risk Factor Surveillance System Program
- o Birth Outcomes Monitoring System
- o State Systems Development Initiative

Staff perform data management, analysis, and reporting for these programs, as well as others, such as:

- o Maternal and Child Health
- o Vital Statistics
- o Oral Health
- o Newborn Metabolic Screening
- o General Reportable Disease
- o Central Cancer Registry

We hope you enjoy this report and welcome your feedback.

For additional information or to provide comments or suggestions, please contact: Alicia Chancellor Hansen, MS, Chief Biostatistician at 775-684-4161 or ahansen@health.nv.gov.

Reports on related topics can be obtained from the Nevada State Health Division Website at: http://www.health.nv.gov/FP_Publications.htm.

Stay tuned for future issues!

Nevada State Trauma Registry Gets an Overhaul

Andrea R. Rivers
Health Resource Analyst

Staff to the Nevada State Trauma Registry are pleased to announce the impending implementation of a new data collection software which will move the Registry into the 21st century.

Pursuant to NRS 450B.238 and NAC 450B.768, the Nevada State Trauma Registry was established in 1987 to collect data on persons who sustain a physical (blunt or penetrating) injury caused by accident or violence.

Receiving nearly 10,000 submissions per year from 33 licensed hospital

facilities within the State of Nevada, it became apparent in early 2007 that the existing data collection software could no longer handle the volume of submissions being received.

Currently in final the stages of development, Central Site Software, developed by Digital Innovations, Inc. will allow 29 of the 33 facilities mandated by law to submit Trauma reports. This will move paper submissions, that are filled out by hand and then snail mailed to the Nevada State Health Division on a quarterly basis, to the utilization of a secure website, where data can be entered and securely sent directly to Nevada State Trauma Registry staff

for review and inclusion in the Registry. The other four hospitals which are licensed Trauma facilities within Nevada will continue to use their existing data collection software, which produces export files that will easily import into the new software.

Costs to upgrade the system are minimal in comparison to the savings of streamlining the process and eliminating the need for data entry personnel.

For more information on the Nevada State Trauma Registry and most recent Trauma data please visit: http://health.nv.gov/VS_Trauma.htm

Preliminary Report: Alcohol and Drug Induced Death Counts 2005-2009

Andrea R. Rivers & Christine Pool
Health Resource Analysts

Staff to the Injury Prevention Program, housed within the Office of Health Statistics and Surveillance, provides statistical analysis on many accidental and intentional injury types.

One of the more recent data requests received by injury prevention staff was from the Substance Abuse Prevention and Treatment Program within the Nevada Department of Health and Human Services. Working in collaboration with a Vital Statistics Analyst, we were asked to look at the number of underlying alcohol and drug induced deaths of Nevada Residents over a three year period. Finalized mortality data for 2005, as well as preliminary mortality data for 2006 and 2007 were used to complete the request.

It was noted that each year over half the alcohol induced deaths were attributed to Alcoholic Liver Disease between 2005 and 2007. Over 75% of drug induced deaths were attributed to accidental poisonings during that same time period.

Even with 2007 mortality data still preliminary, there appears to be an increase of about 14% in deaths attributed to Alcoholic Liver Disease (ICD-10 Codes: K70-K70.9) from 2005, as well as, an increase of about 10% in Accidental Poisoning Drug related deaths (ICD-10 Codes: X40-X44.9) from 2005. It looks as if intentional self-poisoning in 2007 is down nearly 10% from 2005.

This information is important for programs targeting drug and alcohol prevention efforts to monitor for many different reasons, but the most relevant may be that it has been proven people are more likely to turn to alcohol and drug substance abuse during times of economic instability.

For more information related to injuries, please visit <http://health.nv.gov/Injury.htm>.

Preliminary Report: Alcohol and Drug Induced Death Counts, Nevada Residents, 2005 - 2007*

Counts of Alcohol Induced Deaths				
ICD-10 Code	ICD-10 Code Description	2005	2006*	2007*
F10-F10.9	Mental and Behavioral Disorders Due to Psychoactive Alcohol Use	87	93	82
G31.2	Degeneration of Nervous System Due to Alcohol	0	1	1
G62.1	Alcoholic Polyneuropathy	0	0	1
I42.6	Alcoholic Cardiomyopathy	1	3	2
K70-K70.9	Alcoholic Liver Disease	126	114	144
K86.0	Alcohol-Injured Chronic Pancreatitis	3	0	0
X45	Accidental Poisoning By and Exposure to Alcohol	1	0	7
X65	Intentional Self-Poisoning By and Exposure to Alcohol	0	0	1
Total		218	211	238

*Note: These counts are not final and are subject to changes

Counts of Drug Induced Deaths				
ICD-10 Code	ICD-10 Code Description	2005	2006*	2007*
F11-F19.9	Mental and Behavioral Disorders Due to Psychoactive Substance Use	9	15	15
T40-T40.9	Poisoning By Drugs, Medicament and Biological Substances	0	1	0
X40-X44.9	Accidental Poisoning By and Exposure to Noxious Substances	342	348	383
X60-X64.9	Intentional Self-Poisoning	84	81	76
X85	Assault by Drugs, Medicaments and Biological Substances	1	4	0
Y10-Y14.9	Poisoning, Undetermined Intent	15	18	14
Total		451	467	488

*Note: These counts are not final and are subject to changes

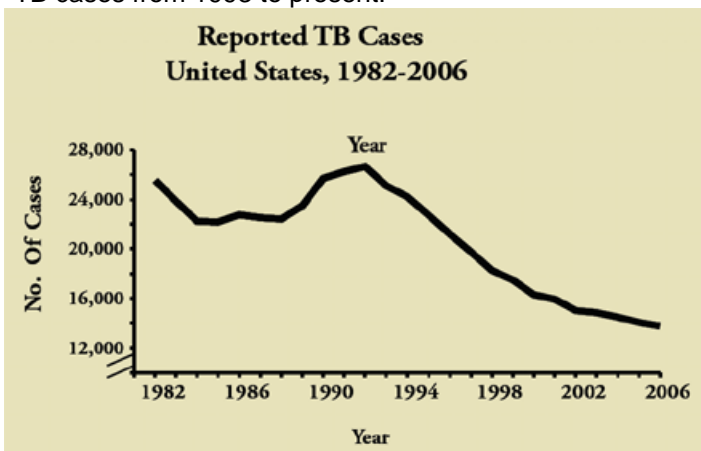
TB Elimination: Now is the Time!

Susanne Paulson
TB Program Coordinator

Tuberculosis (TB) is an airborne infectious disease that is preventable and curable. People ill with TB bacteria in their lungs can infect others when they cough. The World Health Organization (WHO) estimates that one third of the world's population is infected with TB, but the disease lies dormant or inactive in most people and is called Latent TB Infection (LTBI). People with TB disease are sick from active *M. tuberculosis* organisms in their body. People with Latent TB Infection (LTBI) have the TB organism in their body, but are not sick because the germ is lying inactive in their body. However, these people may develop TB disease in the future if their immune system is weakened and persons with LTBI often receive antibiotic treatment to reduce the likelihood of progressing to TB disease.

Many people think that tuberculosis (TB) is a disease of the past — an illness that no longer threatens us today. One reason for this belief is that we are currently experiencing a decline in TB in the United States. We are at an all-time low in the number of persons diagnosed with active TB disease. This success is due to the dedication of state and county TB programs that coordinate care for TB patients and the people they have contact with, utilizing standardized treatment regimens over jurisdictional borders to ultimately reduce the spread of this bacterium

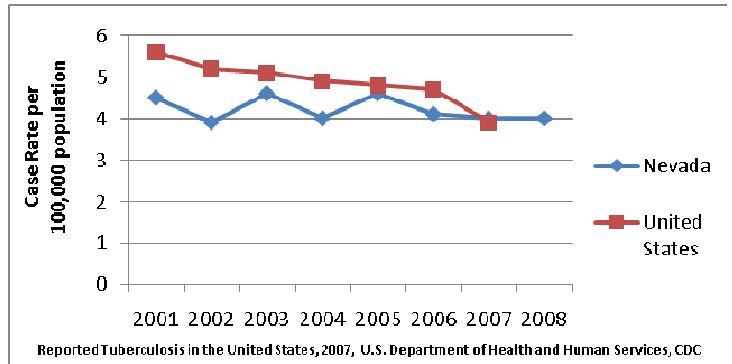
With the success of TB programs in the 1970s and early 1980s, the prospect of ultimately eliminating TB was on the horizon. Due to this, TB control and prevention funding was redirected to other programs. Complacency and neglect of the programs sparked a resurgence of TB, with a 20% increase in new cases reported between 1985 and 1992 (see graph below). As a result of this spike attention was once again directed towards TB prevention and control measures. The successful recommitment to TB elimination efforts has resulted in a steady decline of TB cases from 1993 to present.



Source: 2006 Surveillance Slides. [Slide 2. Reported TB Cases, United States, 1982-2006.](#)

Despite progress experienced nationally, TB remains a massive global public health problem, with nearly 9 million new cases and more than 1.5 million deaths each year. Approximately 72% of Nevada's TB cases occur in the foreign-born population versus 58% nationally. TB will not be a disease of the past until we prevent and control Tuberculosis today!

Nevada's Case Crude Rate Compared to National Case Crude Rate



The newest caveats in eliminating tuberculosis are the drug resistant forms of TB, which gained attention in 2007 when a multi-drug resistant (MDR) TB patient traveled on several international flights. In the United States, 1.2% of TB cases are drug-resistant and although the multi-drug resistant forms of TB are generally treatable, they do require a more extensive treatment regimen for a longer duration, making financing treatment and patient compliance serious issues which threaten our TB control and prevention efforts.

Now is the time to take decisive actions, beyond our current efforts, that will ensure that we reach this attainable goal and "Stop TB."

What can be done to Stop TB?

- **Patients can stop TB** by becoming active participants in their own cure and taking all their anti-TB drugs as prescribed.
- **Health workers can stop TB** by staying alert to the symptoms of the disease and providing prompt diagnosis and treatment.
- **Scientists can stop TB** by engaging in needed research to develop new diagnostics, new drugs and new vaccines.
- **Teachers can stop TB** by educating their students about ways they can help to prevent the spread of infectious disease.
- **Communities can stop TB** by sharing information to help prevent the disease and get treatment to those who need it.

Together, We Can Stop TB- World TB Day March 24, 2009!

References

- <http://www.cdc.gov/tb/WorldTBDay/default.htm>
- <http://www.who.int/tb/en/>
- <http://www.cdc.gov/tb/default.htm>
- http://www.who.int/tb/strategy/stop_tb_strategy/en/index.html

Risk Behaviors Associated with Sexually Transmitted Diseases

“Despite the fact that a great deal of progress has been made in STD prevention over the past four decades, the United States has the highest rates of STD infection in the industrialized world, making prevention as important as ever.”

-National Prevention Information Network (NPIN), 2009

Julia Spaulding, MHA
STD Prevention & Control Program Coordinator

Targeted prevention efforts are vital to reduce the rates of STDs in Nevada. In order to target populations at greatest risk for STD infection, data on behavioral risk factors are analyzed and these data are used to create prevention activities and interventions to reduce those behaviors. Overall, from 2000 to June of 2008, there were 47 distinct behavioral risk factors reported. Of those, the top 4 risk factors accounted for 69 percent of the total risk behaviors listed (17,649 of the 25,589). Expanding the analysis to include the top twenty behavioral risk factors encompasses 96 percent of all reported behaviors. The table below represents a compilation of the top twenty behavioral risk factors for those persons testing positive for gonorrhea, chlamydia, and/or syphilis reported to Disease Intervention Specialists (DIS) in Nevada by year, between 2000 and June of 2008. These data are the result of an analysis completed using the Nevada State Health Division’s Sexually Transmitted Disease Management Information System (STD*MIS) database. These data on behavioral trends have some inherent limitations. This information is self-reported and based on the client’s understanding of their personal risk behaviors and willingness to share information with a public health disease investigator (DIS). Many individuals will not report a risk behavior and some individuals will report multiple risk behaviors. Data are also reflective of current risk behavior and disease trends. For example, prior to 2005, there were few cases that reported to a DIS that they had a specific risk of “men who have sex with men” (MSM); however,

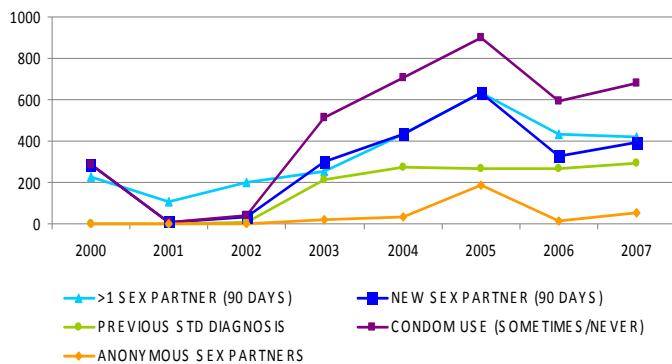
after a syphilis outbreak began in 2005, the number of persons reporting this risk increased substantially.

Sex of any kind has shown to be the most commonly reported risk factor for acquiring a STD. As expected, the most commonly reported behavior was having sex with a male (29.2 percent of interviewees reported this behavior) and having sex with a female (18.4 percent). When excluding having sex with a male or female, the greatest cumulative reported risk behaviors were having more than one sex partner in the last 90 days (11.2 percent) and having a new sex partner within the last 90 days (10.1 percent). Over 5.6 percent of respondents reported having a previous STD diagnosis. Approximately 8 percent of respondents reported that they either sporadically used or never used a condom. From 2000 to 2007, excluding 2001 and 2002 sporadically or never using a condom was the most commonly reported risk behavior for persons with an STD; however, in 2001 and 2002, the most commonly reported risk factor was having more than one sex partner in the past 90 days. Other risk factors that were found in the top twenty behaviors included: anonymous sex partners (1.4 percent), MSM (1.4 percent), oral sex (1.2 percent), rectal intercourse (1.2 percent), alcohol abuse (1.1 percent), sex for drugs/money (1.0 percent), MSM with HIV (0.7 percent), brothel worker (0.7 percent), sex with a MSM (0.7 percent), using intravenous drugs (0.6%), sex while using non-intravenous drugs (0.4 percent), and having sex in bathhouses/parks/bars (0.4 percent).

The graph below depicts the top five cumulatively reported risk factors (excluding sex with a male or a female) and the trends over the past eight years.

Top 5 Self-Reported STD Risk Factors, Nevada, 2000 – 2007*

*Excluding sex with a male and sex with a female



Top 20 STD Behavioral Trends by Type of Self-Reported Behavior and Year of Report, Nevada, 2000 - June 2008

	2000	2001	2002	2003	2004	2005	2006	2007	2008	Total
SEX WITH MALE	253	176	330	932	1118	1358	1366	1399	546	7478
SEX WITH FEMALE	248	132	224	581	714	1005	722	799	279	4704
>1 SEX PARTNER (90 DAYS)	225	108	198	255	433	633	431	417	171	2871
NEW SEX PARTNER (90 DAYS)	285	9	32	302	432	634	328	392	182	2596
STD DIAGNOSIS	0	1	7	213	272	264	265	291	113	1426
CONDOM USE (SOMETIMES)	333	17	42	55	101	337	27	90	70	1072
CONDOM USE (NEVER)	154	233	269	74	55	84	7	57	37	970
NO ACKNOWLEDGED RISK	0	0	4	236	212	152	18	1	0	623
ANONYMOUS SEX PARTNERS	0	0	2	22	31	184	13	53	56	361
MSM	0	0	0	0	0	119	78	102	47	346
ORAL SEX	0	0	0	7	6	150	9	80	49	301
RECTAL INTERCOURSE	24	12	16	24	40	96	13	47	25	297
ALCOHOL ABUSE	131	3	6	18	15	27	17	27	31	275
SEX FOR DRUGS/MONEY	28	16	23	37	50	45	31	22	10	262
MSM W/HIV+	0	0	0	0	0	22	64	68	32	186
BROTHEL WORKER	0	0	1	28	43	47	31	17	10	177
SEX WITH MSM	0	0	0	23	24	38	41	35	6	167
USED IV DRUGS	1	0	17	38	27	27	27	18	4	159
SEX WHILE USING NON-IVDU	0	0	2	9	10	1	4	70	19	115
BATHHOUSES/PARKS/BARS	0	0	0	0	1	60	0	12	31	104

Source: Nevada State Health Division Sexually Transmitted Disease Management Information System (STD*MIS), 2008.

Preliminary Report: New HIV/AIDS Trends in Nevada 2007-2008

Bob Salcido, MPH
HIV/AIDS Surveillance Coordinator

The largest groups affected by HIV disease in Nevada have been Whites; men who have sex with men (MSM), and Injection Drug Users. Ethnic disparities exist for Blacks and Hispanics in Nevada whose infection rates exceed their population distribution. Heterosexuals and females, with and without identifiable risk, have shown increases in HIV disease incidence in recent years.

In 2008, new HIV cases decreased 25% (N=393) after increasing steadily for the previous 5 years. In 2008, new AIDS cases decreased by 11% (N=284). The number of new HIV cases in rural Nevada more than doubled in 2007 from 10 to 21 new cases. This trend did not continue in 2008, with 9 new HIV cases reported.

Although this is preliminary data for 2008, these trends are not expected to change widely within age, race, ethnicity, sex and mode of exposure groups. This sharp

decrease in new HIV cases in 2008 makes it difficult to interpret significant changes in HIV disease incidence trends.

Risk factor ascertainment improved in 2008. Only 3% (18 cases) of new HIV cases reported and 4% (13 cases) of new AIDS cases were identified with No Identified Risk (NIR). In 2006, NIR cases accounted for 23.8% (115 cases) of new HIV cases reported. This decreased to 8.9% (47 cases) in 2007. In 2006, NIR cases accounted for 17.7% (45 cases) of new AIDS cases reported. That decreased to 8.3% (27 cases) in 2007. The percentage of new female HIV cases in 2008, 16% of the total, remained virtually unchanged from the 17% reported in 2007.

Is this just a spurious decrease in new HIV/AIDS cases or are we seeing a real downward trend in HIV disease incidence in 2008? The State HIV/AIDS Surveillance Program will be analyzing the available data to see what factors may account for these recent changes.

**Nevada AIDS Diagnoses Comparative Analysis,
 January through December of 2007 versus 2008**

By County of Residence	2007		2008*		% Change
	N	%	N	%	
All Other Counties	21	7%	9	3%	-57%
Clark	264	83%	245	86%	-7%
Washoe	33	10%	29	10%	-12%
Unknown	0	0%	1	0%	0%
Total	318	100%	284	100%	-11%

By Mode of Exposure	2007		2008*		% Change
	N	%	N	%	
Homo-Bi Male	201	63%	188	66%	-6%
IV Drug User	26	8%	33	12%	27%
Homo & IDU	16	5%	11	4%	-31%
Adult Hemophiliac	0	0%	0	0%	0%
Hetsx Contact	62	19%	44	15%	-29%
Transfusion/Transplant	0	0%	0	0%	0%
Not Specified	13	4%	7	2%	-46%
M w HIV HIV-Risk	0	0%	1	0%	0%
Ped Oth/ Und	0	0%	0	0%	0%
Total	318	100%	284	100%	-11%

**Nevada HIV Diagnoses Comparative Analysis,
 January through December of 2007 versus 2008**

By County of Residence	2007		2008*		% Change
	N	%	N	%	
All Other Counties	29	6%	9	2%	-69%
Clark	453	86%	351	89%	-23%
Washoe	43	8%	32	8%	-26%
Unknown	1	0%	1	0%	0%
Total	526	100%	393	100%	-25%

By Mode of Exposure	2007		2008*		% Change
	N	%	N	%	
Homo-Bi Male	337	64%	258	66%	-23%
IV Drug User	29	6%	30	8%	3%
Homo & IDU	25	5%	18	5%	-28%
Adult Hemophiliac	0	0%	1	0%	0%
Hetsx Contact	114	22%	75	19%	-34%
Transfusion/Transplant	0	0%	0	0%	0%
Not Specified	18	3%	11	3%	-39%
M w HIV HIV-Risk	2	0%	0	0%	-100%
Ped Oth/ Und	1	0%	0	0%	-100%
Total	526	100%	393	100%	-25%

Source: Nevada State Health Division HIV/AIDS Reporting System (eHARS), (January 2009).

* 2008 HIV/AIDS data is provisional and subject to change.

Teen Pregnancy in Nevada 2005

Michelle Khau
Biostatistician

In 2005, teen pregnancies among Nevada Residents (10-19 yrs old) resulted in 70.8% births, 28.7% abortions and 0.5% fetal deaths. More than 73% of teen pregnancies (10-19 yrs old) were to Clark County Residents. This is in line with approximately 70% of the population of the state residing in Clark County. The lowest teen pregnancy rate was among 10-14 year olds residing in Washoe County, while the highest teen pregnancy rate was among 18-19 year olds residing in Clark County. A sharp increase is seen in the number of pregnancies among 18-19 year olds, who have attained legal age, compared to 15-17 year olds. Between 2000 and 2005, the overall trend in teen pregnancy has been a gradual decrease in rate, with occasional small increases in specific groups. Additional information on trends can be found in the 2004 Nevada Vital Statistics Report, which can be obtained from the Nevada State Health Division website at: <http://www.health.nv.gov/VS/Reports/vs0104.pdf>.

Teen Pregnancy (10-19 yrs old) Counts by Age Groups and County of Residence, Nevada Residents, 2005				
County of Residence	Age Groups			
	10-14	15-17	18-19	15-19
Clark	73	1,477	2,618	4,095
%	77.7%	76.1%	73.0%	74.1%
Rate	1.2	41.3	107.1	68.0
Washoe	11	288	579	867
%	11.7%	14.8%	16.1%	15.7%
Rate	0.8	33.6	102.7	61.0
All Other Counties	10	176	390	566
%	10.6%	9.1%	10.9%	10.2%
Rate	1.0	25.5	91.7	50.7
Total	94	1,941	3,587	5,528
%	100.0%	100.0%	100.0%	100.0%
Rate	1.1	37.9	104.5	64.6

Note: Abortion counts are based only on cases reported to the Nevada State Health Division.

Note: Rates are per 1,000 female age-specific population.

Note: Fetal Deaths are greater than or equal to 20 weeks of gestation.

Teen pregnancy counts are based on the summation of events occurring to age-specific female Nevada Residents from three data sets: births, abortions, and fetal deaths. The age-specific groupings are designed to be comparable to national rates. Abortion counts are based only on cases reported to the Nevada State Health Division. Fetal Death Counts are based on deaths with an estimated gestation age greater than or equal to twenty weeks.

Rates are calculated by taking teen pregnancy counts, dividing by the estimated age-specific female population, and then multiplying by one thousand.

The population size of counties in Nevada is widely varied, from one thousand to over one million. Caution should be used when interpreting rate comparisons for counties in Nevada because of these differences.

Sickle Cell Disease In Nevada

Brad Towle, MA, MPH
Health Program Specialist

Sickle cell disease (SCD) is one of the most common genetic diseases in the United States. All fifty states have screening programs which test all newborns for sickle cell disease. Sickle cell disease is particularly common among people whose ancestors come from Sub-Saharan Africa, Spanish-speaking regions in the Western Hemisphere (South America, Cuba and Central America), Saudi Arabia, India, and Mediterranean countries such as Turkey, Greece, and Italy. In the United States, SCD affects about 72,000 people, most of whose ancestors came from Africa. Nevada's Newborn Screening Program tracks both sickle cell disease (SS) and the less severe sickle cell "C" disease (SC). Individuals with SC disease often suffer some of the complications associated with sickle cell disease, but to a milder degree.

In the five-year period from 2003 through 2007, 49 infants were identified with sickle cell disease through Nevada's Newborn Screening Program: 43 African-Americans and 6 Hispanics.

This translates to about 1.4 in every 500 African-American live births; slightly higher than the national estimate of 1 in 500 live births. Nevada's incidence rate for Hispanic newborns with SCD is about 1 in every 12,000 live births; much lower than the national estimate of 1 in every 1,000 to 1,400 live births.

Estimated Incidence Rates for Sickle Cell Disease in Nevada: 2003-2007

Race/Ethnicity	Cases	* Estimated Rates per 10,000 Live Births	95% Confidence Intervals for Rates	
			Low	High
African-American				
SS Disease	28	18.43	11.60	25.26
SC Disease	15	9.87	4.88	14.87
SS & SC Disease	43	28.30	19.84	36.76
Hispanic				
SS Disease	4	0.56	0.11	1.11
SC Disease	2	0.28	0.00	0.67
SS & SC Disease	6	0.84	0.17	1.51
Total SS & SC	49	5.66	4.08	7.24

* Incidence rates based on a preliminary total for African American live births of 15,193 and Hispanic live births of 71,378 for the period of 2003 through 2007 (Bureau of Health Statistics, Planning, and Emergency Response). Please note, these totals are preliminary and subject to change.

Preliminary Report: Nevada Communicable Disease Surveillance 2008

Carmen Cruz, MD, MPH
Biostatistician

Public health surveillance is the ongoing collection, analysis and interpretation of data that impacts the public's health. A surveillance system can be utilized for routine tracking of disease trends, identifying outbreaks of disease, research purposes, and for the overall control of disease and public health planning.

The following analysis reflects the top ten most frequently reported communicable diseases in Nevada (excluding HIV, STDs, and TB) in 2008. These data are broken down based on health authority jurisdiction reporting the case. Hepatitis is tracked differently in each health jurisdiction. Clark and Washoe Counties do not track chronic hepatitis B and C cases in their surveillance systems, so the table reflects zero cases reported for those conditions.

Nevada's metropolitan counties have a greater frequency of rotavirus, salmonellosis, shigellosis, and giardiasis, due to higher concentration of population.

Respiratory diseases (influenza, respiratory syncytial virus and rotavirus) are the most common communicable diseases reported statewide, with influenza being the most reported among them. Due to a nationwide influenza outbreak in the winter of 2007/2008, reported cases doubled from previous years. Nevada observed a typical seasonal presentation of respiratory syncytial virus, with a small rise in late-winter 2008 (2nd through 3rd week of March). Further information on the influenza outbreak and respiratory syncytial virus cases in 2008 are shown in the figure on page 8.

Top Ten Reportable Communicable Diseases**, Preliminary 2008

	Condition	Health Jurisdiction										Nevada	
		FAR-Rurals		SNHD-Clark		WCDHD-Washoe		CCHHS-Carson		Prisons		Num of Cases	Rate x 100,000Po p***
		Num of Cases	Rate x 100,000Po p***	Num of Cases	Rate x 100,000Po p***	Num of Cases	Rate x 100,000Pop**	Num of Cases	Rate x 100,000Po p***	Num of Cases	Rate x 100,000Po p*		
1	Influenza (All types)	611	212.0	282	14.4	827	197.8	150	259.9	13	99.9	1883	69.3
	Influenza type A	233		0		303		73		10		619	
	Influenza type B	177		1		316		42		3		539	
	Influenza type unknown	201		1		208		35		0		445	
	Influenza, human isolates	0		280		0		0		0		280	
2	Respiratory syncytial virus infection	95	33.0	1034	52.9	290	69.4	51	88.4	0	0.0	1473	54.2
3	Hepatitis C Virus Infection, chronic or resolved	423	146.8	6	0.3	0	0.0	97	168.0	182	1398.7	708	26.0
4	Rotavirus	37	12.8	283	14.5	115	27.5	10	17.3	0	0.0	445	16.4
5	Salmonellosis	17	5.9	183	9.4	38	9.1	3	5.2	0	0.0	241	8.9
6	Shigellosis	4	1.4	218	11.2	5	1.2	1	1.7	0	0.0	228	8.4
7	Campylobacteriosis	37	12.8	108	5.5	37	8.9	6	10.4	0	0.0	188	6.9
8	Giardiasis	9	3.1	87	4.5	25	6.0	0	0.0	0	0.0	121	4.5
9	Hepatitis B virus infection, Chronic	89	30.9	0	0.0	0	0.0	6	10.4	18	138.3	113	4.2
10	Strep pneumoniae, invasive	10	3.5	40	2.0	37	8.9	1	1.7	1	7.7	89	3.3
	Total	1422	493.4	2582	132.1	1474	352.6	334	578.6	235	1806.0	6,050	222.6

* NDOC Monthly Population Stats year End, 2008

*** 2008 Population Estimates are not currently available. 2007 Interim Population Estimates were used to calculate rates.

** Excludes STD,HIV, and TB.

Note: The counts are not final and are subject to change.

Data Sources:

- 1.- NEDSS (National Electronic Diseases Surveillance System) Information system: 2005 to date- except Clark County.
- 2.- NETSS (National Electronic Telecommunications System for Surveillance) Information System: 2000 to 2004 for all Counties and 2000 to date for Clark County.
- 3.- CDC. Guidelines for Evaluating Surveillance, MMWR1988:37(S-5);1-18.
- 4.- 2007-NVHD-Interim Population Estimates by County. Note: The Interim 2007 Population Estimates are based on 2006 Interim Population Estimates. They were updated in July 2008 by the Nevada State Health Division, Bureau of Health Planning and Statistics based on the 2007 Total Population Estimates provided by the Nevada State Demographer in March 2008.

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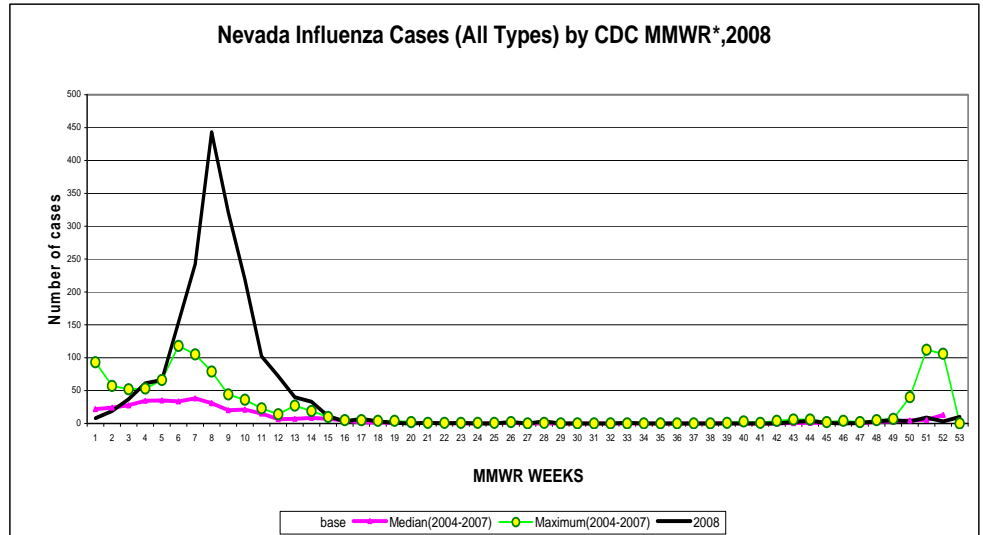
Luana J. Ritch, PhD
Chief
Health Statistics,
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Health Division

Department of Health and
Human Services

Preliminary Report: Nevada Communicable Disease Surveillance 2008- Cont.

Nevada Influenza Cases (All Types) by CDC MMWR*, 2008



*CDC MMWR week is the week of the epidemiologic year for which the National Notifiable Diseases Surveillance System (NNDSS) is assigned for the purposes of MMWR (Morbidity and Mortality Weekly Report) disease incidence reporting and publishing. For the year 2008, week #1 corresponds to Dec. 30, 2007 to Jan. 5, 2008.

Preliminary Report: Most Popular Baby Names for Nevada Residents 2008

Christine Pool
Health Resource Analyst

Since 2000, Anthony has been the top baby name for boys. Emily was the top girl name from 2000 to 2003, losing her top spot in 2004 to Ashley, and regaining it during 2005 to 2007.

In 2008, Isabella has shot to the top from number two in 2007.

Let's see what 2009 will bring...

Trivia Question:
What were the top boy and girl names in 1970?

Top Ten Baby Names of 2008*	
Boy Names	Girl Names
1. ANTHONY	1. ISABELLA
2. DANIEL	2. EMILY
3. ALEXANDER	3. SOPHIA
4. ANGEL	4. OLIVIA
5. MICHAEL	5. MADISON
6. JACOB	6. NATALIE
7. CHRISTOPHER	7. SAMANTHA
8. JOSHUA	8. MIA
9. DAVID	9. ABIGAIL
10. AIDEN	10. AVA

*Note: These rankings are not final and are subject to changes.