STATISTICAL NEWS

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Incidence and Mortality Rates on the Decline

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Sexually transmitted diseases (STDs) are infections that are commonly spread through sexual activity. These diseases can be tough for public health to deal with because many people are reluctant to speak of STDs due to the stigma often associated with them. STDs can cause ulcers, sores, and pain. They can also have more serious health consequences, such as infertility and an increased risk of certain cancers.

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What Time of Day Are Babies Born in Pennsylvania?

The Distribution of Births Throughout the Day in 2012

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Prostate Cancer Statistics Reviewed

Pennsylvania Consistently Lower Than Corresponding U.S. Rates

Prostate cancer is the most common type of cancer diagnosed among men in the United States and in Pennsylvania. In this article, we summarize and highlight prostate cancer statistics among Pennsylvania residents. Although experts are currently debating the effectiveness and the proper types of screening and treatment for prostate cancer, the American Cancer Society (ACS) advises that men talk to their doctor about ...

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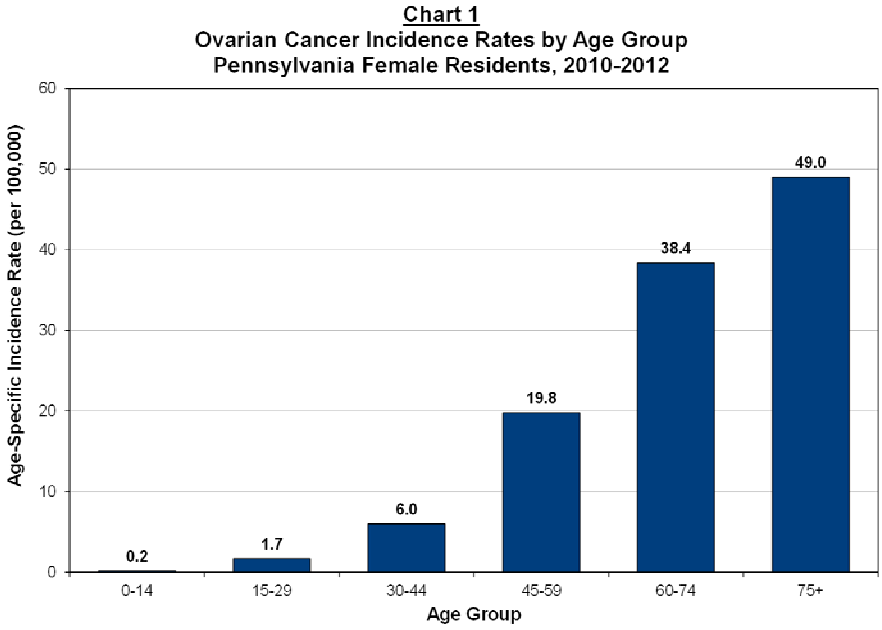
Ovarian Cancer Reviewed

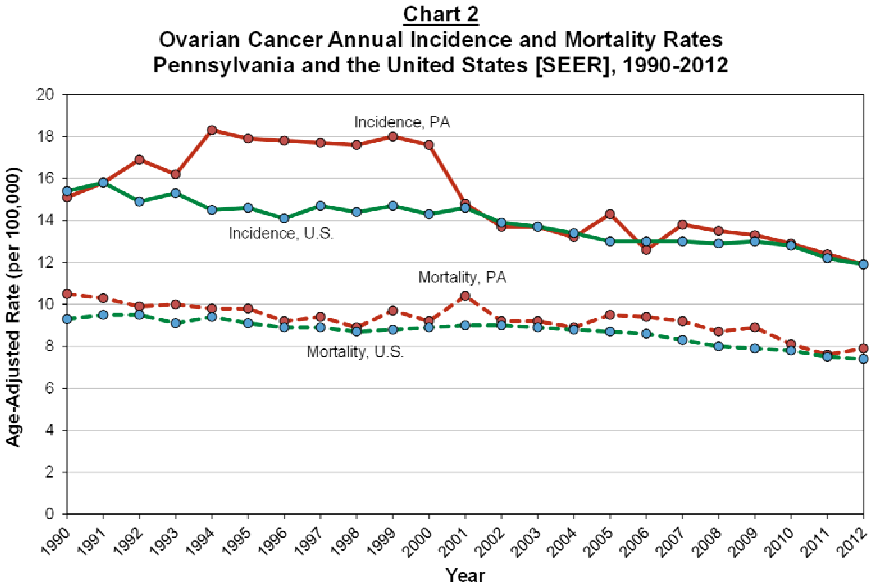
Incidence and Mortality Rates on the Decline

According to the American Cancer Society, an estimated 21,290 women will be diagnosed with ovarian cancer in 2015 and approximately 14,180 women will die from this disease in the United States. That will make it one of the deadliest cancers among women in the U.S. In fact, ovarian cancer will account for more deaths than any other cancer of the female reproductive system.

Data for Pennsylvania show that there were 3,112 new cases of invasive ovarian cancer during the three-year period 2010-2012, making it the ninth most commonly diagnosed cancer among female residents for the state. Ovarian cancer diagnoses accounted for 2.7 percent of all cancers diagnosed among females in 2010-2012. Cancer of the ovaries was responsible for 5.1 percent of all cancer deaths among women during 2010-2012 in Pennsylvania. It was ranked fifth in cancer deaths among women, accounting for 2,127 deaths, yielding an age-adjusted rate of 7.9 per 100,000.

Incidence rates by race/ethnicity for ovarian cancer were higher among whites compared to black, Asian/Pacific Islander (PI), and Hispanic residents of Pennsylvania. During the three-year period of 2010-2012, the age-adjusted incidence rate for white women (12.8) was 27 percent higher than the rate for black women (10.1) and 97 percent higher than the rate for Asian/PI women (6.5). However, the death rate for black women (8.6) during the three year period 2010-2012 was higher than the rates for white women (7.9), Asian/PI women (3.5), and Hispanic women (4.3).





Note: Age-adjusted rates are per 100,000 and are computed by the direct method using the 2000 U.S. standard million population. U.S. age-adjusted rates were calculated from the National Cancer Institute's SEER program (based on 9 registries).

Ovarian cancer can develop in women of all ages. However, ovarian cancer risk increases with age and mainly develops in older women. For 2010-2012, more than 91 percent of ovarian cancer cases were diagnosed among female residents 45 years of age or older. Chart 1 shows age-specific incidence rates among females of six different age groups. The rates among young women are quite small and increase drastically from 6.0 per 100,000 for women

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aged 30-44 to 19.8 per 100,000 for women aged 45-59. The incidence rates continue to grow for older women, reaching a high of 49.0 per 100,000 for women in the 75 years and older age group.

Chart 2 (page 2) shows a comparison of incidence and mortality rates for Pennsylvania and the United States, which uses data from the National Cancer Institute's Surveillance, Epidemiology, and End Results (SEER) Program. Pennsylvania's annual age-adjusted incidence rate for ovarian cancer was higher from 1992 to 2000; however, the rate in Pa. dropped from 17.6 in 2000 to 14.8 in 2001 and has since been much closer to the U.S. rate. In the 1990s, Pa. reporting included cases of benign and borderline ovarian cancer. This stopped in conjunction with the change to the ICD-O-3 classification. Both Pa. and the U.S. had a 2012 age-adjusted incidence rate of 11.9. Overall, both the U.S. and Pa. incidence rates have shown decreasing trends since 1990. Mortality rates for ovarian cancer in Pa. and the U.S. have also shown decreasing trends since 1990. In fact, in 2012, the Pennsylvania mortality rate for ovarian cancer was 7.9 per 100,000, which is 25 percent lower than the 1990 rate of 10.5 per 100,000. Comparatively, the 2012 U.S. death rate of 7.4 per 100,000 was 20 percent lower than its 1990 rate of 9.3 per 100,000. The death rate in Pennsylvania has been consistently higher every year than the national rate since 1990.

The National Cancer Institute estimates that the five-year relative overall survival rate for cancer of the ovaries is 45.6 percent for diagnoses made during the period of 2005-2011. Detection of ovarian cancer while it is in its early stages significantly improves prognosis. Unfortunately, no screening tests have proven to be effective among asymptomatic women. However, when ovarian cancer is detected at the local stage, the five-year relative survival rate is 92.1 percent, dropping to 73.2 percent for regional diagnoses and to

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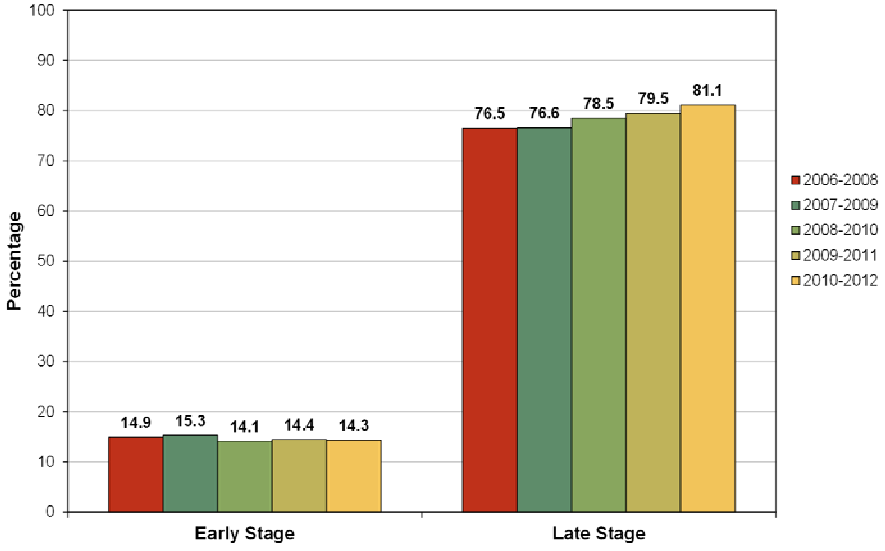
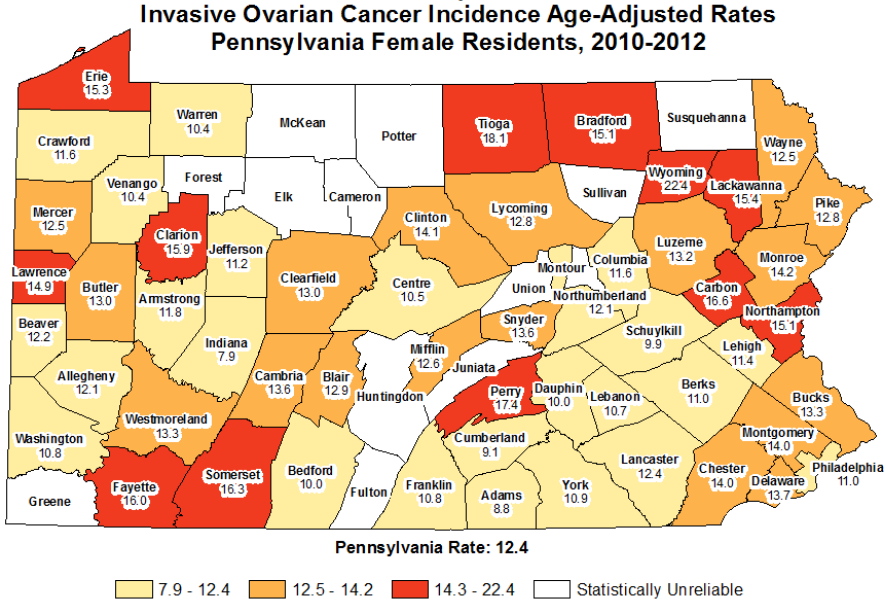
Chart 3
Stage of Disease at Time of Diagnosis, Ovarian Cancer
Pennsylvania Female Residents, 2006-2012



Map 1
Invasive Ovarian Cancer Incidence Age-Adjusted Rates
Pennsylvania Female Residents, 2010-2012



* Age-adjusted rates are per 100,000 and are computed by the direct method using the 2000 US standard million population.

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28.3 percent for cancers diagnosed at the distant stage of the disease. The symptoms of ovarian cancer are often subtle and easily confused with other ailments. Chart 3 (page 3) shows the percentage of ovarian cancers detected at the early stage (in situ and local) and late stage (regional and distant). Detection of early stage ovarian cancer fluctuated between a low of 14.1 percent during 2008-2010 to a high of 15.3 percent in 2007-2009. Late stage cancer experienced a low of 76.5 percent in 2006-2008 but has increased in each successive three-year period to a high of 81.1 percent in 2010-2012.

There were no Pennsylvania counties that had a statistically significantly higher rate (at the 95% confidence level) than the state overall during the three-year period 2010-2012. Map 1 (page 3) shows the distribution of age-adjusted incidence rates across three groupings, with the higher rates in red and the lower rates in yellow. Only Cumberland County (9.1) and Philadelphia County (11.0) had significantly lower rates than the overall Pennsylvania rate. Counties in the eastern part of the state, in general, showed higher incidence rates than the state rate of 12.4. There were also groupings of counties in the northwest (Erie, Mercer, Lawrence, Butler, and Clarion), southwest (Fayette, Westmoreland, Somerset, Cambria, and Blair), and central/northcentral (Mifflin, Snyder, Perry, Clearfield, Clinton, Tioga, Lycoming, and Bradford) areas of the state that showed higher than average rates. The counties with the five highest rates were Wyoming (22.4), Tioga (18.1), Perry (17.4), Carbon (16.6) and Somerset (16.3). The counties with the five lowest incidence rates were Indiana (7.9), Adams (8.8), Cumberland (9.1), Schuylkill (9.9), and Dauphin (10.0). Thirteen counties (shown on the map in white) had fewer than 10 cases over the three-year period, and rates were not calculated due to statistical unreliability.

Additional ovarian cancer statistics among Pennsylvania residents, including mortalities due to ovarian cancer, can be obtained from the Health Statistics Web pages at www.statistics.health.pa.gov (select "Cancer Statistics" under the "My Health Statistics" menu option). Additional cancer statistics are also available via EDDIE, our online data dissemination tool. For questions about this article, please contact the Division of Health Informatics via the Contact Us form on the Health Statistics Web pages.

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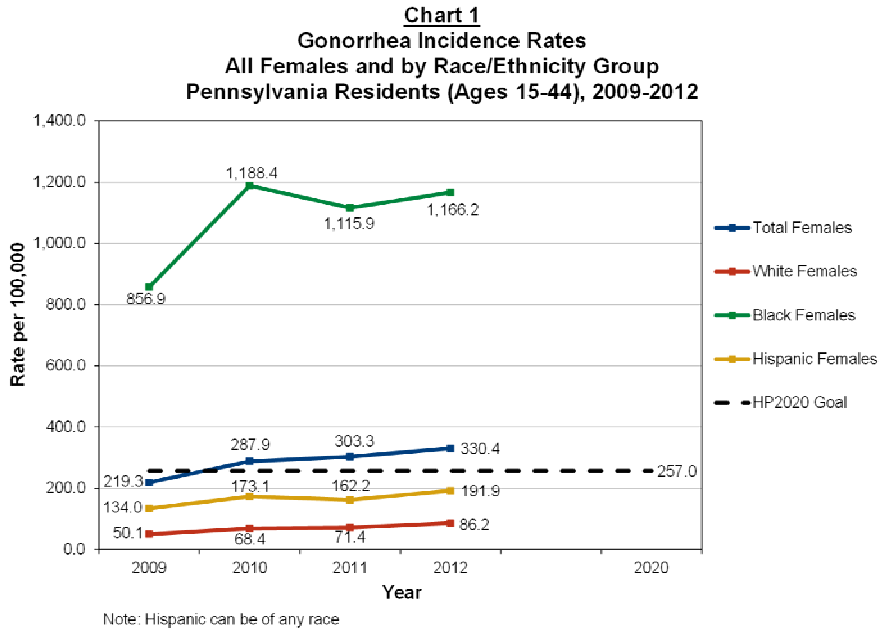
Healthy People 2020: Topic Area STD (Sexually Transmitted Diseases)

Gonorrhea and Syphilis Incidence Rates on the Rise

Sexually transmitted diseases (STDs) are infections that are commonly spread through sexual activity. These diseases can be tough for public health to deal with because many people are reluctant to speak of STDs due to the stigma often associated with them. STDs can cause ulcers, sores, and pain. They can also have more serious health consequences, such as infertility and an increased risk of certain cancers. According to the Centers for Disease Control and Prevention (CDC), some of the ways that STDs can be prevented or dramatically reduced include sexual abstinence, vaccination, mutual monogamy or by using a condom during sexual activity. If you or someone you know has a sexually transmitted disease, then CDC's STD Treatment Guidelines may be of help. Due to the importance of this health topic, Healthy People 2020 has devoted an entire topic area to sexually transmitted diseases. This article will focus on two of the objectives (reducing gonorrhea and syphilis incidence rates) in the STD topic area from a statistical point of view.



Gonorrhea

Gonorrhea is a curable sexually transmitted infection caused by a bacterium called Neisseria gonorrhoeae. These bacteria can infect the genital tract, the mouth, and the rectum. In women, the cervix usually is the first place of infection. According to the Pennsylvania Department of Health's Gonorrhea Facts, symptoms of gonorrhea for females may include painful or burning sensations when urinating, vaginal discharge that is yellow or bloody, or more advanced symptoms, such as cramps and pain, vomiting, and fever. Symptoms for males include severe burning sensations when urinating and anal itching that is accompanied by occasional bloody bowel movements. If a person is diagnosed with gonorrhea, it is recommended that any sexual partners be tested regardless of whether they show any symptoms. Gonorrhea is usually treated by doctors prescribing a single dose of the antibiotic, Ceftriaxone. It is important to treat this disease as soon as possible since untreated gonorrhea can lead to pelvic inflammatory disease (serious infection of the female reproductive tract) and can increase the risk of HIV infection.

STD-6.1: Gonorrhea Incidence Rates (females, ages 15-44)
{2020 Target: 257.0 per 100,000}

The incidence rate (per 100,000 population) for gonorrhea among Pennsylvania female residents ages 15-44 increased by more than 50 percent from 2009 to 2012 (from 219.3 to 330.4). The national Healthy People 2020 (HP2020) goal is a rate of 257.0 per 100,000, so the Pennsylvania rate is rapidly heading in the wrong direction (see Chart 1). Looking at the data by race/ethnicity shows that the rates for black females have been consistently and alarmingly high. The rates for black females (ages 15-44) were at least 13 times greater than the rates for white females (ages 15-44) for each year from 2009 through 2012. Females of Hispanic origin had higher rates than white women but much lower rates when compared to black women. The female rates for both whites and those of Hispanic ethnicity consistently met the HP2020 goal during the four-year period shown. Partitioning the age group 15-44 into smaller age groups showed much higher gonorrhea incidence for the younger age groups. The age group

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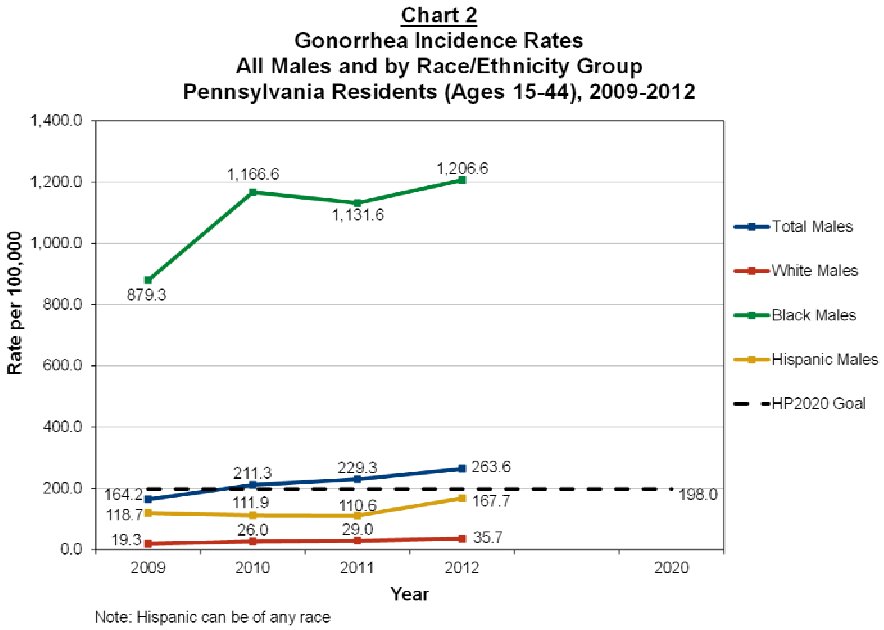
15-24 had a rate of 665.0 in 2012 for female Pennsylvania residents. This was almost three times greater than the gonorrhea incidence rate for females ages 25-34 (rate of 238.0 in 2012), and almost 13 times as great as the rate (52.3) for 35-44 year olds.

STD-6.2: Gonorrhea Incidence Rates (males, ages 15-44)
{2020 Target: 198.0 per 100,000}

The gonorrhea incidence rate (per 100,000 population) for Pennsylvania male residents ages 15-44 increased by 44 percent from 2009 to 2012 (from 164.2 to 236.6). The HP2020 goal is a rate of 198.0 per 100,000, so Pennsylvania again is headed in the wrong direction (see Chart 2). Examining the data by race/ethnicity for Pennsylvania males shows similar results as with Pennsylvania females. The rates for black males (ages 15-44) were between 34 to 46 times higher than the rates for white males (ages 15-44) for each year from 2009 to 2012. This disparity is very concerning as the rates for black males are nowhere near the HP2020 goal. Males (ages 15-44) of Hispanic ethnicity had higher gonorrhea incidence rates than white men but much lower rates when compared to black men. The male rates for both whites and those of Hispanic origin have been increasing in recent years, but have met the HP2020 goal each year during the four-year period. Splitting the age group 15-44 into smaller age groupings for males shows a similar outcome as the female age groups, with the younger age groups consistently showing much higher gonorrhea incidence rates than older groupings.



Syphilis

According to the Pennsylvania Department of Health's Syphilis Facts, syphilis is a sexually transmitted infection caused by a bacterium named Treponema pallidum. It is spread from an ulcer of an infected person to his or her uninfected sexual partner. It can also be spread from a pregnant woman to her unborn child. To help prevent the disease, it is recommended to use latex male condoms during sexual intercourse. It is also important for a pregnant woman to obtain early prenatal care that includes testing for syphilis and getting the proper treatment, if necessary. Syphilis has been divided into four stages: primary, secondary, latent, and tertiary (late).

An infected person who has not been treated may infect others during the first two stages, which generally last one or two years. The first symptom of syphilis in its primary stage is an ulcer called a chancre. It is usually located on the part of the body exposed to the infected partner's ulcer about two to six weeks after exposure. If not treated during the primary stage, the disease may move to the secondary stage. In secondary syphilis, a skin rash (with penny size brown sores) often appears. It usually is present on the palms of the hands and the soles of the feet about three to six weeks after the chancre appears. Other symptoms during the secondary stage include, but are not limited to, mild fever, fatigue, patchy hair loss, and swollen lymph glands throughout the body. Syphilis may (if untreated) move to the latent stage. At this point, the disease is no longer contagious and no symptoms are present. The disease may then move to a final (tertiary) stage. This stage can last for years and can result in mental illness, blindness, heart disease, and even death. Syphilis can be tough to diagnose because its early symptoms are similar to many other diseases. Once diagnosed, doc-

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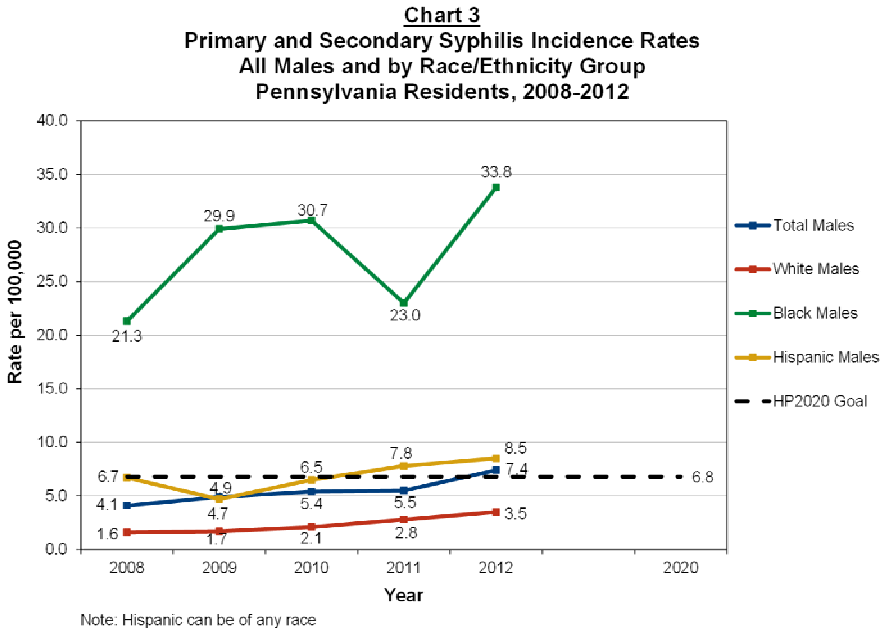
tors will usually treat patients with penicillin. Proper treatment has been proven to cure the disease, although any damage done to body organs (during tertiary stage) generally cannot be reversed.

STD-7.1: Primary and Secondary Syphilis Incidence Rates (females) {2020 Target: 1.4 per 100,000}

Primary and secondary syphilis incidence (rate per 100,000) increased from 0.3 in 2008 to 0.5 in 2012 for Pennsylvania resident females. However, in recent years the rate has dropped (0.6 in 2010 compared to 0.5 in 2012). The national HP2020 goal is a rate of 1.4 per 100,000, so Pennsylvania's rate has easily met the target. Due to low counts of syphilis among females, demographic comparisons are limited. It can be stated nonetheless that the primary/secondary syphilis rates for Pennsylvania black female residents are much higher than for white female residents. For example, the state incidence rate among black females was 3.5 in 2010, while the corresponding rate for white females was 0.2 per 100,000.

STD-7.2: Primary and Secondary Syphilis Incidence Rates (males) {2020 Target: 6.8 per 100,000}

The syphilis (primary and secondary) incidence rate among Pennsylvania resident males increased by over 80 percent from 2008 to 2012 (from 4.1 per 100,000 to 7.4). The national HP2020 goal is a rate of 6.8 per 100,000, so Pennsylvania's rate is no longer meeting the 2020 goal (see Chart 3). A glimpse at race/ethnicity data shows some definite disparities. The rates for black males have been considerably higher than the rates for white males. The rates for males of Hispanic origin have been consistently higher than the rates for white males, but at the same time, consistently lower than the rates for black males. White males met the HP2020 target each year from 2008 to 2012, Hispanic males met the goal for a time but are no longer achieving it, and black males have constantly fallen far short of the goal during this time period. It is also worth noting that the primary and secondary syphilis rates for Pennsylvania resident males have been on the rise for each of the race/ethnicity groups in more recent years.



The data discussed in this article as well as data for additional Healthy People objectives can be found at the Department of Health's Healthy People 2020 statistical Web page. Data sets at the state and county level can be viewed and downloaded. There is also a link to the national Healthy People 2020 website. Please note that more recent statistics related to STDs can also be found by visiting our online data dissemination tool, EDDIE.

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What Time of Day Are Babies Born in Pennsylvania?

The Distribution of Births Throughout the Day in 2012

As interventions such as cesarean deliveries and induction of labor have become more common, an increasing proportion of births occur during daytime hours. This article will show how the distribution of Pennsylvania resident births in 2012 during the day varied by day of the week, method of delivery and induction status, whether trial of labor was attempted, and place of delivery.

If births were distributed uniformly throughout the day, an average of 4.2 percent of births would occur each hour. However, the percentage of births is greater than 4.2 percent for each hour from 7:00 a.m. to 6:59 p.m. on weekdays and from 8:00 a.m. to 5:59 p.m. (with an exception at the noon hour) on weekends (see Chart 1). The highest percentage of births occurred during the 8 a.m. hour on weekdays (6.3 percent) and among all days (5.9 percent), while the distribution of births on the weekends was more uniform throughout the day. There was also dramatically fewer births that occurred during the evening and early morning hours of 6:00 p.m. to 5:59 a.m. on the weekdays. This pattern was less evident during the weekends.

The distribution of births throughout the day varies dramatically by method of delivery. The percentage of cesarean births that occurred from 7:00 a.m. to 1:59 p.m. was significantly higher than the percentage of both non-induced and induced vaginal births during the same time period (see Chart 2). The most noticeable difference in the percentage of births between cesarean and vaginal births occurred at the 8 a.m. hour when 10.6 percent of cesarean births occurred, compared to 3.8 and 3.1 percent of non-induced and induced vaginal births, respectively. And similar to the distribution of births throughout the day on weekdays, there was a pattern of fewer births that occurred during the evening and early morning hours than during the normal daytime hours for all methods of delivery, although cesarean births followed this pattern to a greater degree.

Among cesarean births, whether or not trial of labor was attempted had a large effect on the distribution

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Chart 1
Percent Distribution of Births, by Hour and Day of the Week of Delivery; Pennsylvania Residents, 2012

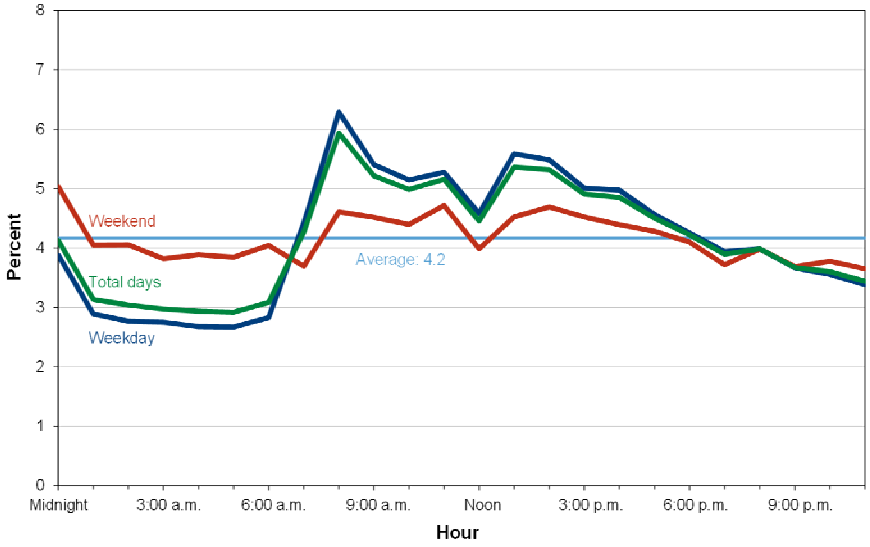
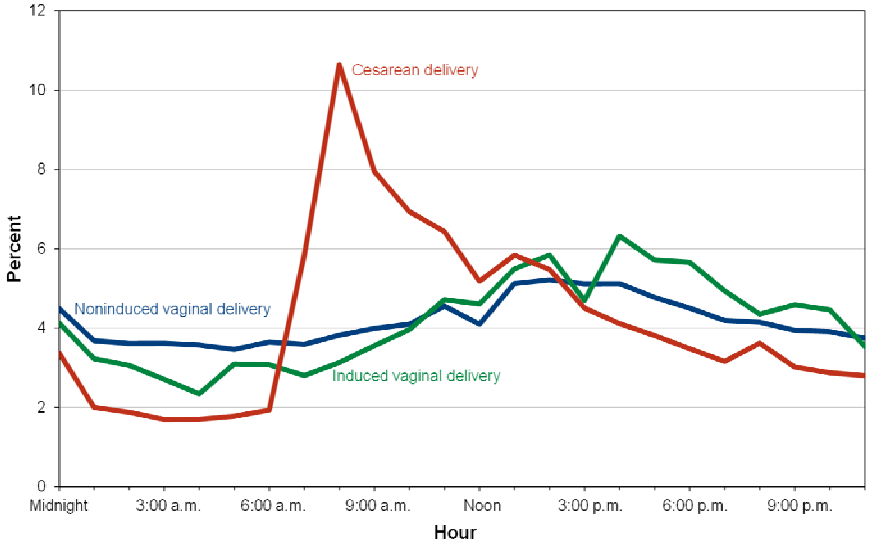


Chart 2
Percent Distibution of Births, by Hour and Method of Delivery and Induction Status; Pennsylvania Residents, 2012



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What Time of Day Are Babies Born in Pennsylvania?

of births throughout the day. A majority of cesarean births with no trial of labor occurred between 8:00 a.m. and 2:59 p.m., which was a sharp contrast to the much smaller percentage of cesarean births with a trial of labor that occurred during the same time period (see Chart 3). The percentage of births that occurred during the 8 a.m. hour (14.6 percent) for cesarean births with no trial of labor was significantly higher than for cesarean births with a trial of labor (3.6 percent). In contrast to cesarean births with no trial of labor, the percentage of cesarean births with a trial of labor was highest during the evening hours and peaked at the 8 p.m. hour at 5.9 percent.

The distribution of births that occurred at hospitals, which accounted for almost 97 percent of all births, followed a similar pattern to that of all births, where births occurred more often during the daytime hours. The percentage of births at hospitals peaked at the 8 a.m. hour at 6.0 percent of births (see Chart 4). The distribution of births not delivered at a hospital followed a more unique pattern, where the percentage of births actually peaked at the 1 a.m. hour at 5.3 percent and, for the most part, declined throughout the day after this peak.

This article showed that there is a non-uniform pattern to the distribution of births throughout the day. Births to Pennsylvania resident mothers in 2012 occurred more often in the normal daytime hours than during the evening and early morning hours. This may be partly due to cesarean deliveries and induction of labor which are used in a significant percentage of pregnancies. Births on weekdays, cesarean deliveries, and births delivered in hospitals occurred more often during the normal regular daytime hours.

For additional birth statistics, visit the Health Statistics Web pages on the Pennsylvania Department of Health website. Birth data among Pa. residents are also available on EDDIE, the department's interactive data dissemination tool. If you have questions about the data presented in this article, contact the Division of Health Informatics by sending us a message using our Contact Us page.

Chart 3
Percent Distribution of Cesarean Births, by Hour of Delivey and Whether Trial of Labor Was Attempted; Pennsylvania Residents, 2012

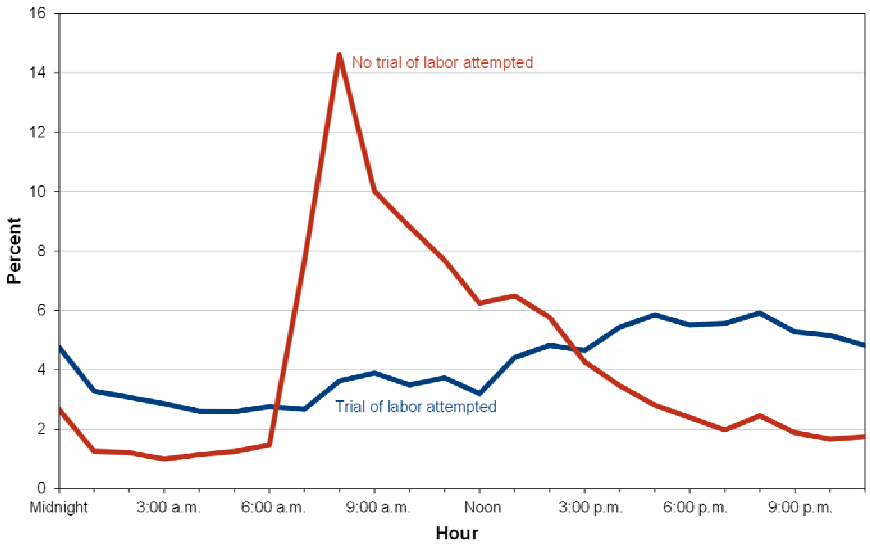
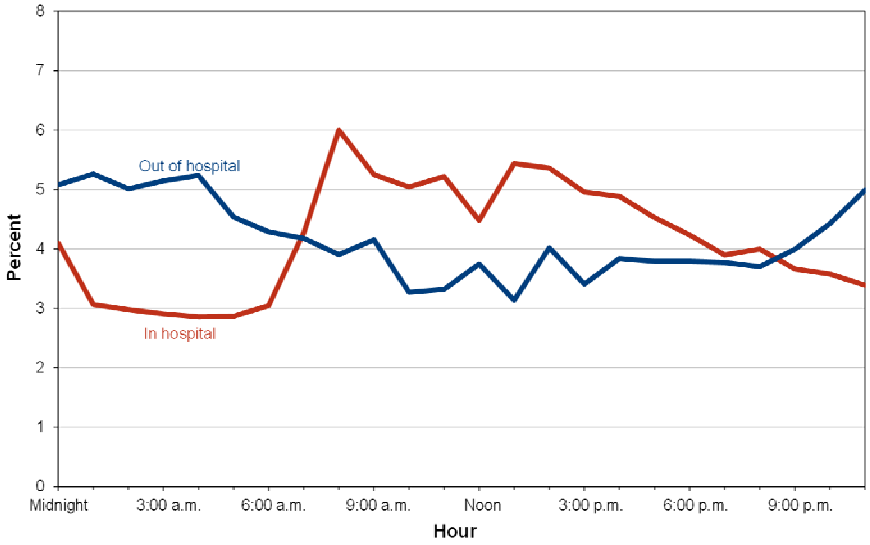


Chart 4
Percent Distribution of Births, by Hour and Place of Delivery Pennsylvania Residents, 2012



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Prostate Cancer Statistics Reviewed

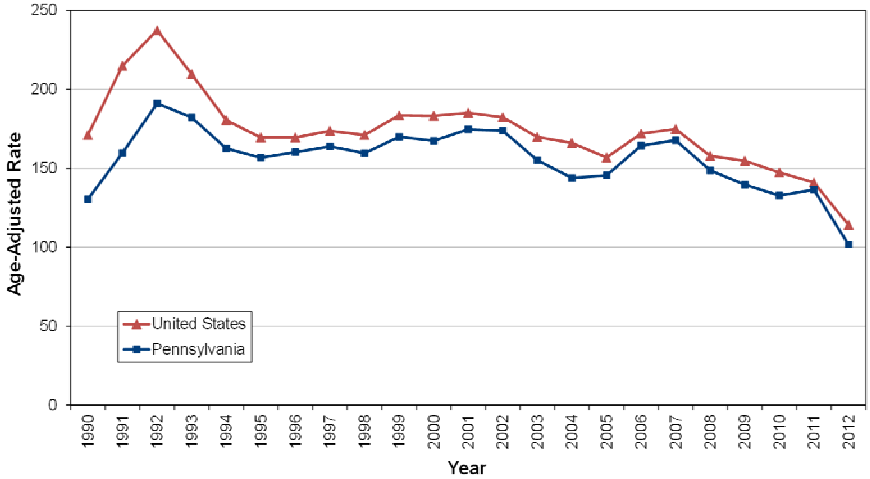
Pennsylvania Consistently Lower Than Corresponding U.S. Rates

Prostate cancer is the most common type of cancer diagnosed among men in the United States and in Pennsylvania. In this article, we summarize and highlight prostate cancer statistics among Pennsylvania residents. Although experts are currently debating the effectiveness and the proper types of screening and treatment for prostate cancer, the American Cancer Society (ACS) advises that men talk to their doctor about whether or not testing and the type of test for prostate cancer is right for them. In fact, in 2012 the United States Preventive Services Task Force (USPSTF) recommended against Prostate Specific Antigen (PSA) based screening for prostate cancer.

Unlike most other types of cancer, prostate cancer can be diagnosed and treated at non-hospital facilities such as urology offices. These non-hospital cases tend to make complete reporting of prostate cancer incidence difficult. However, the Pennsylvania Cancer Registry has made additional efforts over the years to capture cancer cases from non-hospital sources.

In 2012, prostate cancer accounted for 21 percent of all invasive cancer types diagnosed among Pennsylvania males. Specifically, there were 7,841 invasive cases of prostate cancer for an age-adjusted incidence rate of 101.7 per 100,000. The 2012 age-adjusted incidence rate was 25 percent lower than the previous 2011 age-adjusted rate of 136.5. The drop in the age-adjusted rate may be due to concerns about over diagnosis and overtreatment, which are reflected in the 2012 revision by the USPSTF on the use of the PSA test. Compared to the United States, Pennsylvania's annual age-adjusted incidence rates for invasive prostate cancer were consistently lower during the period 1990 through 2012.

Chart 1
Age-Adjusted Incidence Rates* of Invasive Prostate Cancer
Pennsylvania and the United States, Males, 1990 Through 2012



* Age-adjusted rates are per 100,000 and are computed by the direct method using the 2000 U.S. standard million population. U.S. age-adjusted rates were obtained from the National Cancer Institute's SEER program (based on 9 registries).

As shown in Chart 1, incidence trends for prostate cancer fluctuated during the period 1990 through 2012 for both Pa. and the U.S. Prostate cancer incidence increased from 7,037 cases for an age-adjusted incidence rate of 130.4 in 1990, rising to 11,077 cases for an age-adjusted incidence rate of 191.1 in 1992. The increase was most likely due to the introduction of the PSA test in 1990. After 1992, the prostate cancer age-adjusted incidence rate decreased to a low of 156.7 in 1995 followed by an increasing trend, peaking at 173.8 per 100,000 in 2002. Another low point was reached in 2004 when there were 9,254 cases reported for an age-adjusted incidence rate of 143.9. After 2004, the number of prostate cancer incidence rose to a high in 2007 with an age-adjusted incidence rate of 167.7 per 100,000. Following 2007, the prostate cancer incidence rate had an overall decrease, dramatically so in 2012.

Approximately 89 percent of prostate cancer cases were diagnosed among male residents aged 55 and older in Pa. during the five-year period of 2008 through 2012. The age-specific rate for prostate cancer dramatically increases at age 45 and peaks for men aged 65 to 74. Incidences of prostate cancer for males under the age of 40 are rare. There is also an increase in the percentage of unknown stage diagnosis for males above the age of 70. This may be due to recommendations to end screening in men whose life expectancy is lower than 10 years.

In Pennsylvania, age-adjusted incidence rates for invasive prostate cancer have been consistently higher among blacks compared to whites during the period 1990 through 2012. In 2012, black residents had a rate

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Prostate Cancer Statistics Reviewed

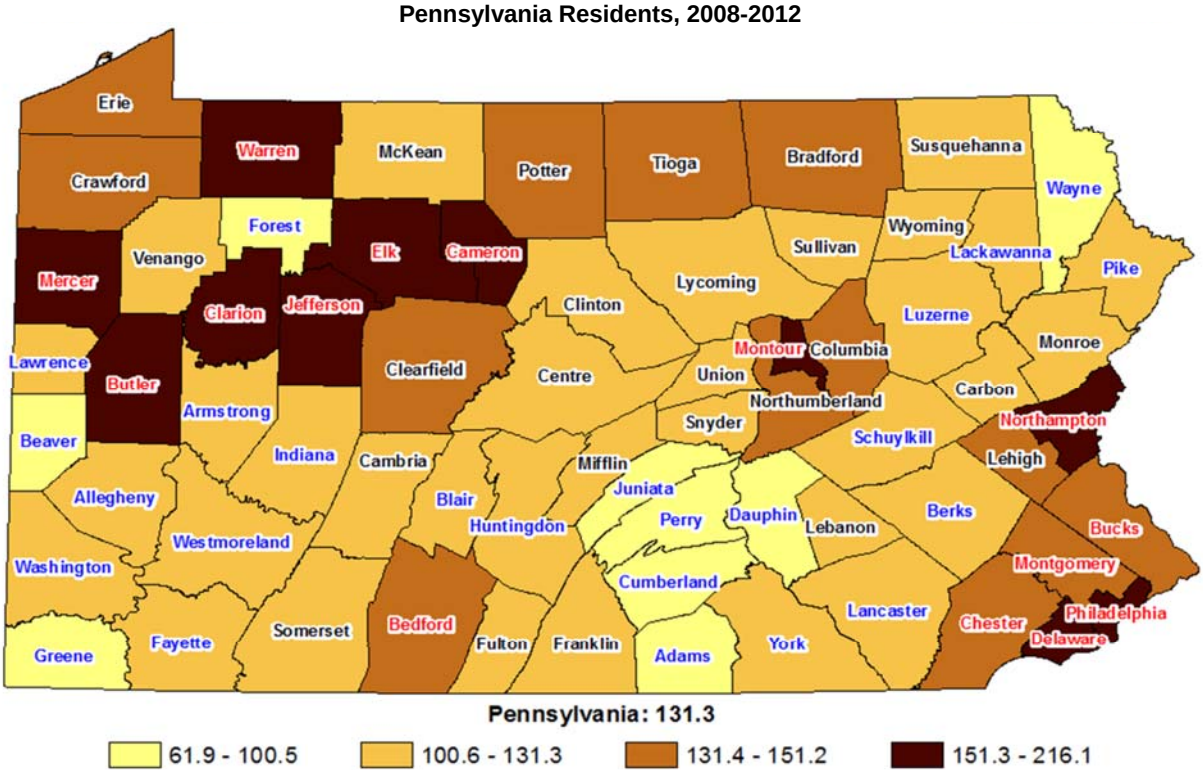
over 58 percent higher than whites (145.7 compared to 92.2, respectively). According to the ACS the difference could be related to social economic factors as well as biological predispositions. The incidence rates for both black and white males have been decreasing since 2007, and both have experienced a considerable drop by the year 2012.

The majority of prostate cancers are diagnosed at an early stage of the disease. Screenings include the PSA blood test or a digital rectal exam (DRE). In 2012, 74 percent of prostate cancers were diagnosed at the local stage among male residents, an increase from the 66 percent found at the local stage in 1990. Late staged diagnoses (regional and distant stages) have declined from 24.8 percent in 1990 to 17.7 percent in 2012.

Map 1 shows the counties in Pennsylvania that had a higher age-adjusted incidence rate than the state as a whole during the five-year period 2008-2012 (shown in the darker orange shades). The five counties with the highest prostate cancer incidence rates were Cameron (216.1), Elk (200.0), Warren (178.8), Montour (168.8), and Butler (168.4). Additionally, the five counties with the highest prostate cancer death rates in 2008-2012 (not shown on a figure) were Wyoming (33.2), Philadelphia (32.4), Potter (31.1), Snyder (28.9), and Perry (27.2).

In 2012, there were 1,282 deaths due to prostate cancer among male residents in Pennsylvania for an age-adjusted rate of 19.1 per 100,000. Prostate cancer was the third leading cause of cancer deaths among males in Pennsylvania, accounting for 9 percent of all cancer deaths among men in 2012. During the period 1990 through 2012, the number of prostate

Map 1
Age-Adjusted Incidence Rates* of Invasive Prostate Cancer by County
Pennsylvania Residents, 2008-2012



Pennsylvania: 131.3

61.9 - 100.5 | 100.6 - 131.3 | 131.4 - 151.2 | 151.3 - 216.1

* Age-adjusted rates are per 100,000 and are computed by the direct method using the 2000 U.S. standard million population.

Note: County names shown in red are for rates that are significantly higher at the 95% confidence interval than the rate for Pennsylvania. County names shown in blue have rates that are significantly lower than the rate for Pennsylvania.

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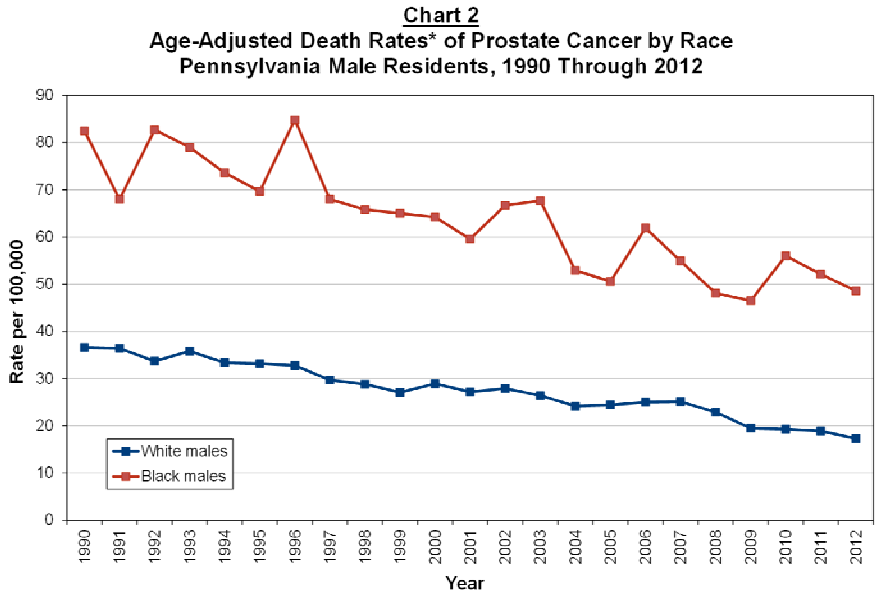
Prostate Cancer Statistics Reviewed

cancer deaths and rates among males in Pennsylvania has declined. In Pennsylvania, the age-adjusted death rates have declined from 39.1 in 1990 to 19.1 in 2012. The prostate cancer death rates have also decreased for the United States over the period 1990 through 2012. These figures suggest that men diagnosed now are living longer than men diagnosed in the early 1990s. Age-adjusted death rates for prostate cancer have been consistently higher among black men compared to white men throughout this 23-year period. In 2012, the prostate cancer death rate among blacks (48.6) was nearly three times the rate among whites (17.3). To illustrate this point, Chart 2 compares white and black prostate cancer death rates over the period of 1990 through 2012.



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For additional prostate cancer statistics, please visit the Health Statistics website. Additionally, the American Cancer Society's website (www.cancer.org) is a useful source for information on prostate cancer, including their Cancer Facts & Figures report series. The ACS website includes information on factors that influence survival, known risk factors for the disease, prevention details, early detection and treatment methods, and research currently being conducted on prostate cancer. Cancer data among Pennsylvania residents are also available on the department's new interactive data dissemination tool, EDDIE. If you have any questions about the data presented in this article, please contact the Division of Health Informatics by using our Contact Us link, or by calling 717-782-2448.

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