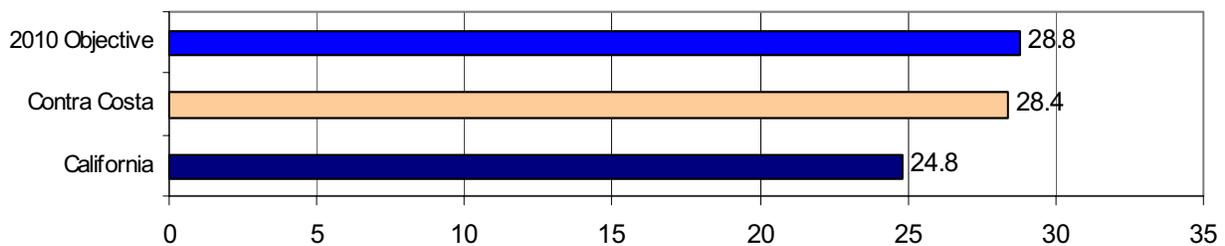


# Cancer – Prostate

**Contra Costa has successfully met the Healthy People 2010 objective of reducing the age-adjusted death rate from prostate cancer to no more than 28.8 deaths per 100,000 men.**



Figure 9. Age-adjusted death rates from prostate cancer



The age-adjusted death rates per 100,000 men for Contra Costa and California are nearly the same as the 2010 Objective. Contra Costa and California statistics were calculated for the three-year period 2000-2002.

## Prostate cancer is the second leading cause of cancer death among men

In Contra Costa, prostate cancer accounts for 6% of all cancer deaths, and 12% of the cancer deaths among men. Over a three-year period 2000-2002, there were 299 Contra Costa men who died of prostate cancer. This means that **approximately 100 Contra Costa men die of prostate cancer each year.**

The age-adjusted death rate from prostate cancer is similar among men living in Contra Costa (28.4 per 100,000) and California (24.8 per 100,000).

In Contra Costa, African American men are more likely to die from prostate cancer compared to the county overall. This difference is not due to the age of the population and is likely due to lack of health care or late detection of the cancer.

## There are unfair racial differences in prostate cancer deaths

**African American men are more likely to die from prostate cancer** compared to men living in Contra Costa as a whole.

Table 41. Prostate cancer deaths by race/ethnicity. Contra Costa, 2000-2002

	Rate	Percent (Number)	
African American	*80.4	17%	(51)
White	27.5	76%	(226)
Latino	--	5%	(16)
Asian	--	2%	(6)
Contra Costa	28.4	100%	(299)

[\*] Indicates that the age-adjusted death rate per 100,000 is significantly higher among African Americans compared to Contra Costa as a whole.  
 -- Due to small numbers (<20 deaths), rates could not be calculated for Latinos or Asians.

**The majority of deaths from prostate cancer occur among Whites (226, 76%), followed by African Americans (51, 17%), Latinos (16, 5%) and Asians (6, 2%).**

## Prostate cancer deaths occur in all Contra Costa communities

In this analysis, we found no statistically significant differences in the age-adjusted death rate from prostate cancer in the following communities compared to Contra Costa as a whole. It is likely that the local numbers are too small to detect such differences by community.

Table 42. Prostate cancer deaths in selected communities. Contra Costa, 2000-2002

	Rate	Percent	(Number)
Richmond	40.5	12%	(37)
Walnut Creek	31.9	19%	(56)
Concord	25.4	10%	(30)
<b>Contra Costa</b>	<b>28.4</b>	<b>100%</b>	<b>(299)</b>

Due to small numbers (<20 deaths), rates could not be calculated for men living in Antioch, Bay Point, Brentwood, Martinez, Oakley, Pinole, Pittsburg or San Pablo.

**The greatest number of the deaths from prostate cancer occur among men living in Walnut Creek (56, 19%), Concord (37, 12%) and Richmond (30, 10%).**

Nationally the distribution of prostate cancer death is similar to the local distribution. In 2001, African Americans had an age-adjusted death rate of 66.1 per 100,000 compared to 26.6 for Whites.

Prostate cancer is a chronic disease that is heavily influenced by age. This means that men become much more likely to develop and die from prostate cancer as they get older.

## Using this data to improve community health

In order to reduce health disparities, it is important to target the groups with the highest age-adjusted death rates from a given cause. For prostate cancer, these are African American men.

In order to reduce the overall number of deaths in the county (without regard to health disparities) it may be better to target interventions to the group that accounts

for the highest percentage of deaths from a given cause. For prostate cancer, these are White and African American men, as well as men living in Walnut Creek, Concord and Richmond.

Because a person's risk for developing or dying from a chronic disease like prostate cancer increases as they age, it is important to target ongoing environmental and behavioral interventions to the young and middle-aged, in addition to older populations. Examples include educating middle-aged and older men about the importance of screening.



### Why are age-adjusted rates important?

An age-adjusted rate controls for differences in age and population size. An age-adjusted rate is the best summary statistic for comparing the impact of chronic diseases, like prostate cancer, that are heavily influenced by age.

**For example**, the White population is older and the Latino population is younger than the county as a whole. Without age-adjustment, we would expect to see higher death rates among Whites than among Latinos, and we would expect that these differences would be largely due to age. An age-adjusted rate calculates what the death rates would look like if the White and Latino populations had the same age distribution. The age-adjusted death rate is useful in **identifying differences that are due to poor access to health care or environmental and behavioral risk factors** instead of age. (See the Methods section at the back of this report for more information about using rates.)

The differences highlighted above are statistically significant. This means that we are 95% certain that these differences are not due to chance.

## How to calculate the percentage and number of deaths

Percentages describe the proportion of countywide deaths from prostate cancer that occur within a particular race/ethnic group or community. The percentage is calculated by dividing the number of deaths that occur within a specific race/ethnic group or community by the total number of deaths countywide and multiplying that number by 100.

Numbers show the actual number of deaths from each cause over a three-year period. The number of deaths per year can be calculated by dividing the total number of deaths from 2000-2002, as shown in the tables, by three.

**Confidence intervals are available**

You may download and view all detailed tables with 95% confidence intervals, at [http://cchealth.org/health\\_data/hospital\\_council/](http://cchealth.org/health_data/hospital_council/)

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**Data sources**

Mortality data from the California Department of Health Services (CDHS), <http://www.dhs.ca.gov/>, Center for Health Statistics' Death Statistical Master File, 2000-2002. Any analyses, interpretations or conclusions of the data have been reached by CHAPE and are not from the CDHS.

Population data from the California Department of Finance, Race/ Ethnic Population with Age and Sex Detail, 2000-2050, and E-4 Population Estimates for Cities, Counties, and the State, 2001-2004, with DRU Benchmark, available online at: <http://www.dof.ca.gov/HTML/DEMOGRAP/Druhpar.htm>. Sacramento, California, May 2004.

Note: City-level denominators were extrapolated from the E-4 file to approximate the mid-year city-level population estimates that are needed to calculate city-level rates. For more information, please see our section on statistical methods.

ICD10 coding for malignant neoplasm of prostate (ICD C61) from the Centers for Disease Control and Prevention National Center for Health Statistics, available online at: [http://www.cdc.gov/nchs/data/nvsr/nvsr50/nvsr50\\_16.pdf](http://www.cdc.gov/nchs/data/nvsr/nvsr50/nvsr50_16.pdf).

Healthy People 2010 objectives from the US Department of Health and Human Services' Office of Disease Prevention and Health Promotion, available online at <http://www.healthypeople.gov/>.

Health, United States, 2003 Age-adjusted death rates for selected causes of death, according to sex, race, and Hispanic origin: United States, selected years 1950-2001, Table 29. Available online at <http://www.cdc.gov/nchs/fastats/prostate.htm>