

White males manifested the steepest curve of all racial-gender groups. Curves for black males and all females paralleled each other and were lower and less steep in slope than for white males (Figure 2.2.5).

From 1982 through 1987, 10% of AIDS cases among white males were diagnosed, compared to 5% among black males, 2% among white females and 3% among black females. Between 1988 and 1992, 50% of AIDS cases among white males had been reported, compared to 40% of cases among black males and 40% and 35% of cases among white and black females, respectively.

From 1993 through 1995, another 40% of AIDS cases among white males, 54% among black males, 59% among white females and 63% among black females were diagnosed. This reflects again the relative lag in case accrual for all groups save white males and the recent and rapid rise in case diagnosis and reporting among females, and black females, in particular (Table 2.2.4).

### **2.2.1. Time Trends by Region**

Table 2.2.5 shows the trends over time in AIDS cases among adults/adolescents in Tennessee Health Department Regions from 1982 through 1995. Annual AIDS case accrual differs by region, with larger metropolitan counties exhibiting sharper curves than non-metropolitan regions. Curves for each region are shown in Figures 2.2.6 a-c.

For the four large metropolitan regions and many non-metropolitan regions, the curves are virtually identical. Variations are observed in cumulative percentages of cases for Madison County and the Southwest region. They exhibited somewhat slower rates of increase over time. Conversely, two regions -- Northwest and Northeast -- showed decreasing case accrual, beginning in 1991 and 1992, respectively (Figures 2.2.6a-c). These fluctuations may be due to the instability associated with the small number of cases from these regions.

The sharp increases in cases and rates due to definitional changes in 1993 are evident. Some regions, such as Davidson, Shelby and Hamilton particularly, show the beginning of changes in reporting in 1992, before the official start date of 1993.

### **2.2.2. Year of Diagnosis Versus Year of Report**

In presenting and examining time trends for AIDS cases and rates, analysts may choose between documenting these trends by year of report to TDH and CDC or by year of diagnosis. By definition, using year of report produces a timely completeness of case counts. However, for etiologic purposes, and ultimately for prevention or delay of AIDS onset, using year of diagnosis is the preferable alternative because it more accurately captures incidence cases. Complicating the potentially greater utility of diagnostic data is the problem of reporting lag - the time discrepancy between actual case diagnosis and