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Prevalence of refractive error in the United States, 1999–2004

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Abstract

Objective—To describe the prevalence of refractive error in the United States.

Methods—The 1999–2004 National Health and Nutrition Examination Survey (NHANES) used an autorefractor to obtain refractive error data on a nationally representative sample of the U.S. non-institutionalized, civilian population aged ≥ 12 years. Using data from the eye with greater absolute spherical equivalent (SphEq) value, we defined clinically important refractive error as: hyperopia: SphEq $\geq +3.0$ D; myopia: SphEq ≤ -1.0 D; and astigmatism: cylinder ≥ 1.0 D in either eye.

Results—Of 14,213 participants aged ≥ 20 years who had an NHANES examination, refractive error data were obtained for 12,010 (84.5%). The age-standardized prevalences of hyperopia, myopia, and astigmatism were 3.6% (95% confidence interval (CI), 3.2–4.0%), 33.1% (95% CI, 31.5–34.7%), and 36.2% (95% CI, 34.9–37.5%), respectively. Myopia was more prevalent in females (40%) than in males (33%; $p < 0.0001$) among 20–39-year-olds. Persons aged ≥ 60 years were less likely to have myopia and more likely to have hyperopia and/or astigmatism than younger persons. Myopia was more common in non-Hispanic whites (35.2%) than in non-Hispanic blacks (28.6%; $p < 0.0001$) or Mexican Americans (25.1%; $p < 0.0001$).

Conclusions—Estimates based on the 1999–2004 NHANES vision examination data indicate that clinically important refractive error affects half of the U.S. population aged ≥ 20 years.

Introduction

Refractive error is recognized as one of the most important causes of correctable visual impairment (1,2,3,4), accounting for nearly 80% of the visual impairment in persons aged 12 years and older in the United States (5). Providing eye care services to the large number of persons who use or need refractive correction involves substantial expense: the direct annual cost of refractive correction for distance visual impairment is estimated to be between \$3.8 and \$7.2 billion (6) for persons aged 12 years and older (based on an estimated annual direct cost per person of \$35 to \$56), and in a separate study of persons aged 40 years and older, \$5.5 billion (7). We used the 1999–2004 National Health and Nutrition Examination Survey (NHANES) data to estimate the population prevalence of refractive error and to describe the refractive characteristics of the U.S. population in greater detail.

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Methods

NHANES is an ongoing nationally representative survey of the U.S. civilian, non-institutionalized population conducted by the National Center for Health Statistics (NCHS), Centers for Disease Control and Prevention (8,9). Participants in the NHANES undergo a home interview and subsequent comprehensive physical examination and functional assessment in a Mobile Examination Center (MEC) (8). The 1999–2004 NHANES protocol was reviewed and approved by the NCHS Research Ethics Review Board. All participants (parent or guardian of minors) gave their written informed consent after receiving a description of the study and the potential risks of participation.

Demographic characteristics were collected at the household interview. Participants reported their ethnicity and race (10). NCHS later categorized these classifications into non-Hispanic black, non-Hispanic white, Mexican American, or “other” (including Asian (various countries), Pacific Islander, Native American, non-Mexican-American Hispanic, or multiracial).

The vision examination was conducted on participants aged 12 years and older. A NIDEK ARK-760 autorefractor (Nidek Co. Ltd., Tokyo, Japan) was used to measure the refractive error of each eye after corrective lenses had been removed. Three separate measurements of sphere, cylinder, and axis were acquired and averaged by the ARK-760. For myopia and hyperopia, we categorized participants based on the refractive error measurements from the eye with the larger absolute value of spherical equivalent (SphEq). If one eye had missing refractive error data, data from the non-missing eye were used. Refractions were recorded in plus cylinder notation and SphEq was computed as the sphere measurement plus half the cylinder measurement. Clinically important myopia was defined as myopic SphEq of at least -1.0 diopter; clinically important hyperopia was defined as hyperopic SphEq of $+3.0$ diopters or more. Severe myopia was defined as myopic SphEq of at least -5.0 diopters (11,12). We also present data with myopia defined as SphEq of at least -0.5 diopter. Astigmatism was defined as cylinder ≥ 1.0 diopter in the eye with the larger cylinder value.

Because of time constraints imposed by the comprehensive NHANES examination, it was not feasible to obtain cycloplegic refractions. Accommodation may therefore have affected the measurement of refractive error, particularly in younger participants, despite the auto fogging used by the autorefractor to minimize accommodation. Consequently, for persons aged 12–19 years, prevalence of myopia is likely to be overestimated and prevalence of hyperopia is likely to be underestimated by the autorefractor measurements. We therefore have not used refractive error data from NHANES 1999–2004 for estimating the prevalence of refractive error among persons aged 12–19 years.

Refractive error data obtained from eyes with a history of cataract surgery or refractive surgery, or in which contact lenses were worn during objective refraction, were treated as missing values. Participants excluded from analyses ($n=2203$) included those reporting a history of cataract surgery ($n=791$) or refractive surgery ($n=142$) in both eyes, or who wore contact lenses during objective refraction ($n=19$), or who were missing autorefractor data for both eyes ($n=1251$ due to lack of time, inability to cooperate with the protocol, or equipment malfunction). We included 615 participants with refractive error data for only one eye (the fellow eye had cataract extraction ($n=264$), refractive surgery ($n=21$), or missing autorefractor data ($n=330$)).

The NHANES utilizes a complex, multistage probability sample design with oversampling within selected demographic subgroups (13). Sampling weights derived by NCHS statisticians reflect the probability of selection into the sample and incorporate adjustments for differential non-response and poststratification (14,15), and their incorporation into analyses (using

SUDAAN (Software for the Statistical Analysis of Correlated Data, version 9.0.0, Research Triangle Institute, Research Triangle Park, NC 16) ensures that the weighted estimates reflect the U.S. population sizes for specified demographic categories and that standard errors are unbiased (17,18). We age-standardized prevalence estimates to the U.S. 2000 Census population (19).

Results

A total of 14,213 participants aged 20 years and older participated in the 1999–2004 NHANES MEC examination. Of these, 12,010 (84.5%) had complete refractive error data (Table 1). Participants with incomplete refractive error data were more likely to be older, female, report lower income, and have fewer years of formal education.

The distribution of SphEq refraction by age is shown in Figure 1. Participants aged 60 years and older were less likely to have myopic refractive error and more likely to have hyperopic refractive error than younger individuals.

Hyperopia

The prevalence of hyperopia (SphEq ≥ 3.0 D) (Table 2) for ages 20–39, 40–59, and ≥ 60 years was 1.0% (95% confidence interval [CI], 0.6–1.4%), 2.4% (CI, 1.7–3.0%), and 10.0% (CI, 9.1–10.9%), respectively. In persons aged 60 years and older, hyperopia was more common in females (12.9%) than in males (6.6%; $p < 0.0001$).

Myopia

The overall pattern of myopia prevalence by age and gender was similar, regardless of the definition of myopia (≤ -1.0 D, ≤ -0.5 D, or ≤ -5.0 D): prevalence estimates were approximately equal for the 20–39 and 40–59-year age groups and markedly lower for those aged ≥ 60 years, and for those aged 20–39 years, females had higher prevalence than males. For myopia defined as SphEq ≤ -1.0 D (Table 3), prevalence estimates for ages 20–39, 40–59, and ≥ 60 years were 36.2% (CI, 34.2–38.3%), 37.6% (CI, 35.1–40.1%), and 20.5% (CI, 18.3–22.8%), respectively. Myopia ≤ -1.0 D was more prevalent in non-Hispanic whites (35.2%) than in non-Hispanic blacks (28.6%; $p < 0.0001$) or Mexican Americans (25.1%; $p < 0.0001$). For those aged 60 years and older, no differences in prevalence were observed among race-ethnicity categories or between males and females. For ages 20–39 and 40–59 years, prevalence of myopia ≤ -1.0 D was higher for non-Hispanic whites (38.7 and 40.6%, respectively) than for non-Hispanic blacks (32.0%, $p = 0.0004$; 32.1%, $p = 0.0003$) or Mexican Americans (27.1%, $p < 0.0001$; 26.4%, $p < 0.0001$). For those aged 20 to 39 years, females had a slightly higher prevalence of myopia ≤ -1.0 D (39.9%) than did males (32.6%; $p < 0.0001$).

Prevalence of myopia defined as SphEq ≤ -0.5 D (Table 4) for ages 20–39, 40–59, and ≥ 60 years was 50.2% (CI, 47.8–52.7%), 50.1% (CI, 47.8–52.4%), and 26.5% (CI, 24.0–29.0%), respectively. Myopia ≤ -0.5 D was most prevalent in those categorized as non-Hispanic white (46.0%), compared with those categorized as non-Hispanic black (41.5%; $p = 0.003$) or Mexican American (40.8%; $p = 0.0002$). The prevalence of myopia ≤ -0.5 D did not differ significantly between males and females except in those aged 20–39 years, where the prevalence in females (53.9%) was significantly higher than in males (46.6%; $p = 0.0002$).

Prevalence of severe myopia (SphEq ≤ -5.0 D) (Table 5) for ages 20–39, 40–59, and ≥ 60 years was 7.4% (CI, 6.5–8.3%), 7.8% (CI, 6.4–9.1%), and 3.1% (CI, 2.2–3.9%), respectively. Severe myopia was most prevalent in those categorized as non-Hispanic white (7.0%), compared with non-Hispanic blacks (4.7%; $p = 0.001$) and Mexican Americans (3.6%; $p < 0.0001$). The prevalence of severe myopia did not differ significantly between males and females except in

those aged 20–39 years, where the prevalence in females (9.2%) was significantly higher than in males (5.6%; $p<0.0001$).

Astigmatism

The prevalence of astigmatism (Table 6) increased with increasing age: for ages 20–39, 40–59, and ≥ 60 years, prevalence estimates were 23.1% (CI, 21.6–24.5%), 27.6% (CI, 25.8–29.3%), and 50.1% (CI, 48.2–52.0%), respectively. Prevalence of astigmatism varied little by race-ethnicity category. In those aged 60 years and older, astigmatism was more prevalent among males (54.9%) than among females (46.1%; $p<0.0001$).

Any clinically important refractive error

The prevalence of any clinically important refractive error (myopia, hyperopia, and/or astigmatism) (table available online only, at www.archophthalmol.com) increased with increasing age. Prevalence estimates for ages 20–39, 40–59, and ≥ 60 years were 46.3% (CI, 44.5–48.0%), 50.6% (CI, 48.1–53.0%), and 62.7% (CI, 60.3–65.1%), respectively. Prevalence of any clinically important refractive error was lower for Mexican Americans (44.4%) than for non-Hispanic whites (53.4%; $p<0.0001$) or non-Hispanic blacks (49.3%; $p=0.002$). For those aged 60 years and older, the prevalence of any clinically important refractive error was higher in males (66.8%) than in females (59.2%; $p=0.0003$).

Discussion

We found that refractive error was common in the U.S. population aged 20 years and older: the prevalence of myopia was 33%; of severe myopia, 6.5%, of hyperopia, 3.6%; and of astigmatism, 36%. Our estimated prevalence of myopia was higher than the 25% reported in previous U.S. studies (20,11; discussed further below) and similar (in persons aged 40 years and older) to that of ethnic Chinese persons in Singapore (12). General overall statements regarding the distribution of myopia among demographic subgroups cannot be made, since we found statistically significant interactions between age and gender ($p=.0003$) and between age and race/ethnicity ($p=.0002$), as well as a borderline statistically significant interaction between gender and race/ethnicity ($p=.07$). Overall, it appears that the pattern of myopia prevalence by age is similar, regardless of the definition of myopia, with nearly identical prevalence estimates within the 20–39 and 40–59-year age groups and a markedly lower prevalence for the 60+ age group (approximately half that for the younger ages). Gender differences in myopia prevalence were observed within the 20–39-year age group, where myopia ($\text{SphEq} \leq -1.0\text{D}$) was more prevalent in females (40%) than in males (33%; $p<0.0001$); the same pattern was observed for myopia defined as $\text{SphEq} \leq -0.5\text{D}$ ($p=0.0002$) and for myopia defined as $\text{SphEq} \leq -5.0\text{D}$ ($p<0.0001$). The prevalence of myopia $\leq -0.5\text{D}$ was similar to that found in studies of Asian populations (12). Gender differences in refractive error prevalence were also observed within the 60+ age group, where hyperopia was more common (13% versus 7%; $p<0.0001$), and astigmatism less common (46% versus 66%; $p<0.0001$) among females than among males. Prevalence of refractive error varied by age, with those aged 60 years and older being less likely to have myopia ($p<0.0001$ for all myopia definitions) and more likely to have hyperopia ($p<0.0001$) and/or astigmatism ($p<0.0001$) than younger persons. Although hyperopia and astigmatism prevalence did not vary among race-ethnicity categories, myopia prevalence was higher in non-Hispanic whites than in non-Hispanic blacks (38.7% versus 28.6%; $p<0.0001$) or Mexican Americans (38.7% versus 25.1%; $p<0.0001$) (although this race-ethnicity difference was not apparent in those aged 60 years and older).

Most previous epidemiologic studies providing prevalence estimates for refractive error were limited to a specific geographic location or age group. The 1971–1972 NHANES study provided the first U.S.-wide population-based prevalence estimates for many eye conditions,

including refractive error. Sperduto and colleagues (20) found that the prevalence of myopia in the U.S. in persons aged 12–54 years was approximately 25% (right eye, based on lensometry (for those with visual acuity 20/40 or better) or on retinoscopy (for those with worse visual acuity)), compared with 33.1% in the current study (in persons aged 20 years and older). The prevalence estimates for myopia are substantially higher for both non-Hispanic black and non-Hispanic white participants in 1999–2004 (28.6% and 35.2%, respectively) than in 1971–72 (13.0% and 26.3%, respectively). It is possible that myopia prevalence in the U.S. has increased over the 30-year period between the two NHANES studies. A previous study documented an increased prevalence of myopia over a 12-year period in young Israeli adults (21) and attributed it to a possible cohort effect. However, because of considerable differences in the methodology used to define myopia in the two NHANES studies, additional research would be required to conclude that prevalence of myopia had increased, and, if so, to explore possible reasons for such an increase.

Recently, the Eye Disease Prevalence Research Group (EDPRG) performed a meta-analysis of existing population-based studies in persons 40 years or older (conducted from 1985 – 2000) to derive robust population estimates for the prevalence of refractive error in the U.S. and in other countries (11). Definitions of hyperopia, myopia, and severe myopia were the same as in our study. Our NHANES-based estimate of prevalence of myopia in the U.S. for persons aged 40 years and older was 31.0% (CI, 29.1–32.9%), substantially higher than the EDPRG estimate for the U.S. (25.4%; CI, 24.5–26.4%). Prevalence of myopia was higher in the recent NHANES study than in the EDPRG for both non-Hispanic blacks and non-Hispanic whites.

The prevalence of myopia $\leq -0.5D$ in the current study was 41.0% for persons aged 40 years and older. Wong et al found a similar prevalence of myopia (38.7%) in ethnic Chinese persons living in Singapore (12). However, the prevalence of severe myopia in the current study was lower (6.0%) than that found by Wong et al (9.1%), possibly attributable to differences in the age structure of the two populations, since the U.S. may have a higher proportion of older individuals (who have a relatively lower prevalence of myopia) than Singapore. Our estimated prevalence of myopia $\leq -0.5D$ for persons aged 60 years and older was 26.5%, greater than the 19.5% estimated from the Rotterdam study (ages 55 and older (22)). The prevalence of myopia in the Blue Mountains Eye Study was 15% (23), strikingly lower than the prevalence of myopia $\leq -0.5D$ found in the current NHANES and that reported from the Beaver Dam Eye Study (24). The Blue Mountains and Rotterdam populations may have a different distribution of underlying risk factors for myopia that could explain their lower prevalence estimates, but we are unable to address this issue within the scope of the current study.

Our myopia prevalence estimates for non-Hispanic black participants aged 40–59 years (32.1%; CI, 28.1–36.1%) were also higher than those reported by the Barbados Eye Study (25, conducted from 1987– 1992) for participants aged 40–59 years (9%). Our prevalence estimates for myopia in those aged 60 years and older appear comparable to those reported from the Barbados study.

The EDPRG results for Hispanic individuals were based on a single study (4) in a Mexican-American population (Proyecto Ver (Nogales, Arizona)). Recently, the Los Angeles Latino Eye Study (LALES) (26) reported prevalence estimates of myopia for Hispanic persons aged 40 years and older (over 90% of whom reported Mexican ancestry (27)). For those aged 40–59 years, the prevalence of myopia among NHANES Mexican American participants was higher than their LALES and EDPRG counterparts. For those aged 60 years and older, NHANES and LALES prevalences were similar and higher than those from the EDPRG.

It is not possible for us to compare results for “other” race-ethnicity with previous studies, because this category includes participants with a wide range of ancestries and NHANES does

not provide data to allow further differentiation within this subgroup. However, since the NHANES sample as a whole is designed to represent the entire U.S. population, it is important to include the “other” subgroup in calculating estimates for the entire U.S. population.

We found that the prevalence of myopia was lowest in participants aged 60 years and older, consistent with other population-based studies (28,29). Although it is possible that the lower prevalence of myopia in those aged 60 years and older is due to a cohort effect, as reported in other, younger populations (21,30), this observation may also be due to intrinsic, age-related changes in the refractive components of the eye (31,32).

The observed lower prevalence of myopia in persons aged 60 years and older may also be due in part to an association of cataract surgery (a criterion for exclusion) with myopic refractive status (33). Because we have no information on the refractive status of participants prior to cataract surgery, we are unable to explore this hypothesis.

Our study has several important limitations. Because of time constraints and potential for participant fatigue, we could not perform a full ophthalmic exam on all participants in the MEC. Our study protocol therefore included the use of an autorefractor, operated according to a standard protocol by trained operators. Our non-cycloplegic refraction values were based on the mean of three measurements by the autorefractor and did not include subjective refinement. This may have resulted in over-estimates of the true number with myopia (34), especially among younger participants, who have a higher amplitude of accommodation. Because of this concern we did not use the NHANES 1999–2004 data to provide prevalence estimates of refractive error for those aged 12–19 years.

As in the EDPRG, we categorized participants based on the refractive characteristics of the eye with greater absolute value SphEq, resulting in an estimated myopia prevalence of 32.99% (CI, 31.47–34.52%, based on 5709 individuals). If we had considered an individual as myopic if either eye was myopic (35), we would have classified an additional 15 participants as myopic, resulting in a prevalence of 33.05 % (CI, 31.52–34.58%).

Although the NHANES sampling weights correct for non-response within population subgroups, it is possible that NHANES participants who had vision data had different refractive characteristics than those who did not. Response rates to the home interview and MEC examination were lower in older individuals (36). Participants who reported for the MEC examination may have had missing vision data due to equipment malfunction or inability to cooperate with the examination.

Because refractive error’s impact on visual acuity can be mitigated relatively easily, it has sometimes been overlooked as an important cause of visual impairment (37,38). Many previous epidemiologic studies based definitions of visual impairment on best-corrected, rather than presenting (i.e., with habitual correction) visual acuity (39). However, newer research has focused attention on the benefits of correcting refractive error (40,41). A recent analysis found that a substantial proportion of the economic burden posed by vision disorders is due to refractive error, concluding: “... interventions to diagnose and treat uncorrected refractive error have the potential to be highly cost-effective based on the improvements in patient quality of life they generate” (7).

In summary, the NHANES 1999–2004 data show that half of the U.S. population aged 20 years and older has some type of clinically important refractive error. Refractive error is therefore the most common condition affecting the ocular health of the U.S. population, involving young adults, middle-aged persons, and older adults of all ethnicities. In our previous study (6) we estimated the annual direct cost of providing refractive correction to the 100 million people who need it to achieve good vision as exceeding \$3.5 billion (not including the costs of

identifying those who need refractive correction). Others estimated the economic burden (including indirect costs) of refractive error in those aged 40 years and older to be \$5.5 billion (7). Accurate, current estimates of the prevalence of refractive error are essential for projecting vision care needs and planning for delivery of vision care services to the large number of people affected.

Supplementary Material

Refer to Web version on PubMed Central for supplementary material.

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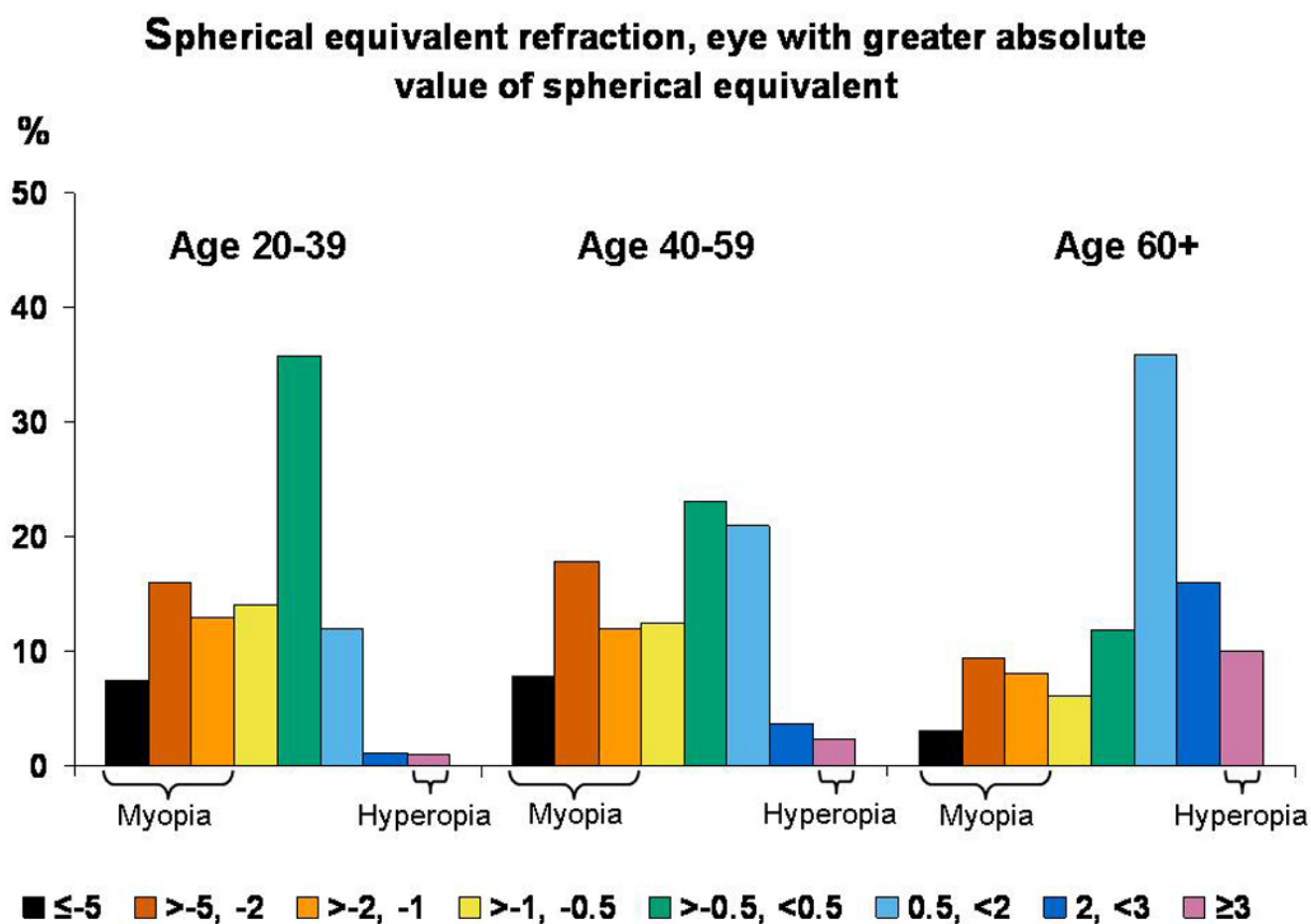


Figure 1.
Distribution of spherical equivalent, by age. Data for those aged 12–19 years are not shown because of the possible effects of accommodation on non-cycloplegic refractions.

Table 1

Characteristics of participants aged 20 years and older reporting to the Mobile Examination Center, NHANES 1999–2004.

Characteristic	N	Complete refractive error data (n=12,010) %	95% CI*	N	Incomplete refractive error data (n=2,203) %	95% CI
Age						
20–39	4653	41.6	39.9–43.3	415	24.6	21.6–27.5
40–59	3776	39.4	38.0–40.8	385	27.6	25.2–30.1
60+	3581	19.0	17.8–20.2	1403	47.8	44.4–51.2
Gender						
Female	6220	51.2	50.5–52.0	1258	58.8	55.4–62.2
Male	5790	48.8	48.0–49.5	945	41.2	37.8–44.6
Race-ethnicity						
Non-Hispanic black	2343	10.6	8.6–12.6	404	13.2	10.3–16.0
Mexican American	2728	7.1	5.4–8.7	479	9.6	7.2–12.1
Non-Hispanic white	5841	71.8	68.5–75.1	1160	68.0	64.0–72.0
Other [†]	998	10.4	7.9–13.0	160	9.2	6.2–12.1
Education						
Less than High School	3682	19.9	18.6–21.2	968	26.6	23.9–29.3
High School	2899	26.5	24.9–28.0	472	24.8	21.7–27.9
Some college	5413	53.6	51.6–55.7	747	48.6	44.8–52.3
Income						
Below poverty level	1985	13.3	11.9–14.7	445	17.5	14.6–20.4
At or near poverty level	2810	20.8	19.1–22.4	619	23.2	20.9–25.5
Above (2x) poverty level	6212	65.9	63.4–68.4	882	59.2	55.2–63.3
Health insurance, < 65 yrs						
Uninsured	2411	19.8	18.2–21.5	249	18.6	15.7–21.5
Private (± other coverage)	5818	70.7	68.6–72.8	523	65.8	61.7–70.0
Medicaid (no private coverage)	634	4.6	3.8–5.4	101	9.3	6.8–11.7
Medicare/other federal	403	4.9	4.0–5.7	60	6.3	4.3–8.3
Health insurance, ≥ 65 yrs						
Uninsured	62	1.0	0.5–1.4	21	1.0	0.4–1.6
Private only	224	8.4	6.4–10.5	80	6.0	3.8–8.3
Private + Medicare	986	46.0	42.6–49.3	452	42.8	38.9–46.7
Medicare ± other federal	1148	42.5	39.3–45.8	630	47.4	43.5–51.2
Medicaid and/or other federal	98	2.1	1.4–2.8	45	2.8	1.3–4.3

* CI: Confidence interval.

[†]“Other”: persons reporting their race-ethnicity as Chinese, Japanese, Korean, Southeast Asian, Native American, Pacific Islander, non-Mexican-American Hispanic, or multiracial.

Table 2

Prevalence of hyperopia (≥ 3 diopter spherical equivalent) by race-ethnicity, gender, and age, NHANES 1999–2004.

	Prevalence and 95% CI* for ages:		
	20–39 years	40–59 years	60 years and older
Total	1.0 0.6–1.4	2.4 1.7–3.0	3.6 3.2–4.0
Males	1.3 0.7–1.8	2.2 1.4–2.9	2.8 2.4–3.2
Females	0.8 0.3–1.3	2.7 1.7–3.6	4.2 3.7–4.8
Non-Hispanic black	0.8 0.2–1.5	2.2 1.0–3.4	2.5 1.6–3.2
Males	1.6 0.3–2.9	1.7 0.3–3.0	1.7 1.0–2.4
Females	0.3 0.0–0.6	2.7 0.9–4.4	3.0 1.8–4.1
Non-Hispanic white	1.1 0.6–1.7	2.5 1.7–3.3	3.7 3.3–4.2
Males	1.2 0.4–2.0	2.3 1.5–3.2	3.0 2.5–3.4
Females	1.0 0.3–1.7	2.7 1.5–4.0	4.4 3.7–5.1
Mexican American	0.4 0.0–0.7	1.5 0.7–2.2	2.7 2.0–3.4
Males	0.2 0.0–0.5	0.7 0.0–1.6	1.6 0.8–2.4
Females	0.6 0.0–1.2	2.3 1.1–3.4	3.8 2.8–4.7
Other	1.3 0.2–2.4	2.3 0.8–3.8	4.4 2.7–6.0
Males	2.1 0.2–4.0	2.2 0.0–4.6	3.4 1.7–5.2
Females	0.5 0.0–1.5	2.4 0.1–4.8	4.9 2.9–6.9

* CI: Confidence interval.

Table 3

Prevalence of myopia (≤ -1 diopter spherical equivalent) by race-ethnicity, gender, and age, NHANES 1999–2004.

	Prevalence and 95% CI* for ages:		
	20–39 years	40–59 years	60 years and older
Total	36.2 34.2–38.3	37.6 35.1–40.1	33.1 31.5–34.7
Males	32.6 29.9–35.2	36.9 33.9–40.0	31.9 30.1–33.8
Females	39.9 37.1–42.8	38.2 35.1–42.1	34.4 32.3–36.4
Non-Hispanic black	32.0 29.0–35.0	32.1 28.1–36.1	28.6 26.2–31.1
Males	32.0 29.0–35.0	32.1 28.1–36.1	26.2 23.0–29.4
Females	38.2 33.7–42.7	31.3 26.1–36.5	30.6 27.5–33.8
Non-Hispanic white	38.7 36.0–41.4	40.6 37.7–43.5	35.2 33.2–37.3
Males	35.1 31.8–38.5	39.0 35.3–42.6	33.8 31.6–36.0
Females	42.3 38.4–46.3	42.3 38.6–46.0	36.8 34.2–39.5
Mexican American	27.1 23.4–30.7	26.4 23.4–29.4	25.1 23.0–27.2
Males	23.9 19.5–28.3	22.0 18.2–25.9	22.8 19.9–25.7
Females	30.9 26.8–35.0	31.1 25.9–36.3	27.8 25.0–30.6
Other	35.6 30.4–40.8	26.8 19.4–34.3	29.4 25.3–33.6
Males	34.6 26.4–42.8	33.6 22.7–44.4	31.6 26.1–37.2
Females	36.7 30.0–43.4	22.0 14.7–29.4	28.0 23.2–32.8

* CI: Confidence interval.

Table 4

Prevalence of myopia (≤ -0.5 diopter spherical equivalent) by race-ethnicity, gender, and age, NHANES 1999–2004.

	20–39 years	40–59 years	Prevalence and 95% CI* for ages: 60 years and older		20 years and older	40 years and older
Total	50.2 47.8–52.7	50.1 47.8–52.4	26.5 24.0–29.0	44.7 43.0–46.4	41.0 39.2–42.9	
	46.6 43.6–49.7	50.2 47.7–52.7	29.5 26.4–32.7	44.0 42.1–45.9	42.3 40.1–44.5	
	53.9 51.2–56.6	50.0 47.1–52.9	23.9 20.3–27.4	45.5 43.6–47.4	40.0 37.7–42.3	
Non-Hispanic black	49.0 45.6–52.4	44.3 39.4–49.2	23.9 20.3–27.6	41.5 38.7–44.2	36.5 32.8–40.2	
	43.2 37.5–48.8	44.6 38.8–50.3	26.6 22.1–31.0	39.8 36.2–43.5	37.6 33.3–42.0	
	53.8 49.1–58.4	44.2 37.5–50.8	22.1 16.4–27.7	42.9 39.2–46.5	35.7 30.6–40.7	
Non-Hispanic white	51.3 48.6–54.0	52.6 49.8–55.4	26.4 23.5–29.3	46.0 44.0–48.0	42.6 40.2–44.9	
	47.6 43.8–51.3	51.8 48.5–55.0	29.4 25.7–33.0	44.9 42.5–47.3	43.2 40.4–46.0	
	55.1 51.7–58.5	53.5 50.0–57.1	23.8 19.8–27.7	47.3 44.8–49.8	42.1 39.2–45.1	
Mexican American	47.4 43.8–51.0	41.8 38.6–44.9	27.8 24.1–31.4	40.8 38.5–43.0	36.4 33.7–39.1	
	47.0 42.1–52.0	38.8 34.8–42.8	32.0 26.7–37.4	40.5 37.3–43.6	36.2 32.5–39.8	
	47.8 44.0–51.8	45.0 40.1–49.8	23.9 18.9–28.9	41.2 38.4–44.1	36.9 33.3–40.4	
Other	48.8 42.0–55.5	42.0 33.8–50.1	30.2 23.5–36.9	41.9 37.6–46.3	37.4 31.6–43.2	
	44.8 35.2–54.3	50.4 39.5–61.2	34.1 21.6–46.5	44.4 38.6–50.2	44.1 35.7–52.5	
	53.0 45.6–60.3	36.0 27.3–44.6	27.5 18.1–36.9	40.7 35.7–45.8	32.7 26.7–38.8	

* CI: Confidence interval.

Table 5

Prevalence of severe myopia (≤ -5 diopter spherical equivalent) by race-ethnicity, gender, and age, NHANES 1999–2004.

	Prevalence and 95% CI* for ages:			
	20–39 years	40–59 years	60 years and older	20 years and older
Total	7.4 6.5–8.3	7.8 6.4–9.1	3.1 2.2–3.9	6.5 5.0–6.9
Males	5.6 4.4–6.8	6.8 4.9–8.6	3.2 2.0–4.4	5.5 4.1–6.7
Females	9.2 7.8–10.5	8.8 7.3–10.3	2.9 1.8–4.1	7.6 6.8–8.4
Non-Hispanic black	5.5 3.5–7.4	5.7 4.0–7.4	2.0 0.9–3.0	4.7 3.7–5.8
Males	3.0 1.0–4.9	3.6 1.7–5.6	2.5 0.6–4.4	3.1 2.1–4.1
Females	7.5 4.5–10.6	7.4 4.5–10.4	1.6 0.1–3.1	6.1 4.5–7.7
Non-Hispanic white	7.9 6.5–9.3	8.5 6.7–10.4	3.0 2.1–4.0	7.0 6.0–8.0
Males	6.5 4.8–8.2	7.4 5.0–9.8	3.5 2.1–4.9	6.1 5.0–7.3
Females	9.4 7.2–11.5	9.7 7.7–11.6	2.7 1.4–3.9	7.9 6.7–9.2
Mexican American	4.2 2.5–5.8	3.6 2.5–4.8	2.7 1.5–3.8	3.6 2.8–4.5
Males	2.8 1.6–4.0	1.4 0.6–2.2	2.9 0.7–5.2	2.3 1.6–3.0
Females	5.9 2.9–8.9	6.0 3.6–8.5	2.5 0.9–4.0	5.1 3.5–6.8
Other	9.1 6.6–11.6	6.7 2.9–10.6	4.6 1.1–8.2	7.2 5.1–9.2
Males	6.0 3.2–8.9	8.2 1.9–14.5	0.5 0.0–1.5	5.5 3.0–8.1
Females	12.3 8.4–16.3	5.7 1.8–9.6	7.5 1.6–13.4	8.8 6.1–11.4

* CI: Confidence interval.

Table 6

Prevalence of astigmatism (≥ 1 diopter cylinder) by race-ethnicity, gender, and age, NHANES 1999–2004.

	20–39 years	40–59 years	Prevalence and 95% CI* for ages:		
			60 years and older	20 years and older	40 years and older
Total	23.1 21.6–24.5	27.6 25.8–29.3	50.1 48.2–52.0	36.2 34.9–37.5	31.0 30.1–32.0
Males	24.1 22.2–26.0	28.4 26.0–30.8	54.9 52.3–57.4	38.6 36.8–40.3	32.8 31.7–33.9
Females	22.1 20.1–24.0	26.8 24.6–29.0	46.1 43.1–49.2	34.2 32.3–36.1	29.48 28.0–30.8
Non-Hispanic black	24.5 21.2–27.9	29.7 27.2–32.3	49.8 44.9–54.7	37.4 34.8–40.1	32.3 30.2–34.5
Males	24.8 20.7–29.0	30.3 25.1–35.5	54.5 47.5–61.4	39.6 35.6–43.5	33.7 30.4–37.0
Females	24.3 19.9–28.7	29.3 24.6–33.9	46.5 40.6–52.4	35.9 32.1–39.6	31.3 28.8–33.8
Non-Hispanic white	22.8 20.5–25.0	27.9 25.8–29.9	50.4 48.2–52.6	36.5 35.0–38.0	31.1 29.8–32.3
Males	24.3 21.5–27.2	28.4 25.4–31.4	55.5 52.8–58.2	38.8 36.6–40.9	33.1 31.6–34.6
Females	21.2 18.4–23.9	27.4 24.8–30.0	45.9 42.4–49.4	34.5 32.2–36.7	29.2 27.4–31.0
Mexican American	21.5 18.8–24.2	27.1 24.6–29.5	51.3 49.0–53.6	36.4 34.7–38.0	30.5 28.7–32.3
Males	20.3 16.9–23.6	26.5 22.6–30.4	59.2 54.5–63.7	39.0 35.9–42.1	31.6 29.0–34.2
Females	23.1 18.9–27.3	27.7 23.7–31.8	44.2 40.4–48.0	34.0 31.5–36.6	29.7 27.2–32.2
Other	24.5 19.0–30.0	23.2 17.5–29.0	47.1 37.1–57.0	32.4 27.4–37.4	29.2 25.1–33.4
Males	25.6 19.2–32.0	27.4 17.9–36.9	44.2 31.6–56.7	33.8 26.7–41.0	30.6 25.5–35.6
Females	23.3 16.4–30.2	20.2 13.3–27.1	49.2 37.4–60.8	31.3 24.8–37.8	28.2 23.4–32.9

* CI: Confidence interval.