



Progress Shown in Death Rates From Four Leading Cancers ***Decline in Overall Mortality Has Slowed***

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Death rates from the four most common cancers - lung, breast, prostate, and colorectal - continued to decline in the late 1990s according to new data from the "Annual Report to the Nation on the Status of Cancer, 1975-2000." For all cancers combined, the death rate began to stabilize in the late 1990s, showing neither an increase nor a decrease, while the incidence rate (newly diagnosed cases) began to stabilize in the middle of the decade.

The report concludes that further reductions in cancer can be achieved but will require strong federal, state, local, and private partnerships to apply evidence-based cancer control measures - such as screening for colorectal cancer - that reach all segments of the population. Analyses of the findings, including new data from the states, also highlight the need for improved delivery of quality cancer care, as well as the development of more effective treatment and screening strategies.

Cancer incidence rates for all types of cancers combined increased from the mid-1970s through 1992, declined from 1992 to 1995, and then stabilized from 1995 to 2000 (there was a slight increase from 1995 to 2000, but it was not statistically significant*). In this most recent time period, an increase in breast cancer in women and prostate cancer in men was offset by a long-term decrease in lung cancer in men.

Overall death rates increased through 1990, stabilized through 1994, and declined from 1994 through 1998 before becoming stable from 1998 through 2000. There were continuing small declines in death rates for men, but death rates for women have been stable through the late 1990s.

"This report shows that we have made some progress in reducing the burden of cancer in the United States, but much still needs to be done to reach the *Healthy People 2010 goals* -- including wider application of what science has shown to be effective in preventing, screening, and treating cancer," said Centers for Disease Control and Prevention (CDC) Director Julie L. Gerberding, M.D. "The state-specific information featured in this year's report will help states understand and address the cancer burden in their communities."

The death rate from lung cancer, the leading cancer killer, continues to decrease among white and black men, while the rate of increase has slowed among women, reflecting reductions in tobacco smoking.

"The steep decline in lung cancer rates in men and the recent slowing of an increase in rates in women demonstrate that we can move the trend in the number one cancer killer in the right direction," said John R. Seffrin, Ph.D., chief executive officer of the American Cancer Society (ACS). "Further progress will require rigorous application of strategies that we know are effective in reducing tobacco use."

Death rates from breast cancer continue to fall despite a gradual, long-term increase in the rate of new diagnoses. Declining breast cancer death rates and rising breast cancer incidence rates during the 1990s have been attributed, in part, to increased use of mammography screening. This report notes that higher rates of late-stage disease in some population groups and geographic areas may reflect delayed access to care, often among women who lacked health insurance and among recent immigrants.

Prostate cancer death rates have been declining since 1994, while incidence rates have been rising since 1995, with a 3.0 percent per year increase in white men and a 2.3 percent per year increase in black men. Clarification of the risks and benefits of prostate specific antigen (PSA) screening, including potential impact on mortality, awaits the conclusion of two randomized clinical trials now in progress.

Colorectal cancer death rates have also been declining for both whites and blacks. Rates began declining in the 1970s, with steeper declines beginning in the mid-1980s. Meanwhile, colorectal cancer incidence rates stabilized beginning in 1996 for all men and women.

The authors of the report are encouraged by the recent continuing declines in death rates from the four leading cancers - lung, breast, prostate, and colorectal - declines that were observed nationally and in most states. "Biomedical research has dramatically enhanced our understanding of cancer and given us more effective strategies for cancer control," said Andrew C. von Eschenbach, M.D, Director of the National Cancer Institute (NCI), which is part of the National Institutes of Health. "These declines in death rates from four leading cancers are the dividends of those advances. During this period of unprecedented growth in cancer knowledge, technology, and resources, the NCI is committed to accelerating these trends, and extending them to other cancers, through the discovery, development and delivery of effective interventions."

The report examined recent patterns of cancer among whites, African Americans, Asian and Pacific Islanders, American Indians/Alaska Natives, and Hispanics. From 1992 through 2000, the most recent time period for which data are available, cancer rates among each of these groups differed considerably, but showed encouraging declines in some of the most prevalent cancers.

This year's report includes incidence data from 34 statewide cancer registries that cover 68 percent of the U.S. population. This marks an increase from previous years when data covered only 55 percent of the U.S. population. Holly L. Howe, Ph.D., executive director of National American Association of Central Cancer (NAACCR), noted, "The larger number of states in this year's report, with registries that are providing high quality data to produce meaningful incidence rates, is very encouraging. High quality at the state level is crucial because cancer control planning takes place first and foremost at the local and state levels."

The "Annual Report to the Nation on the Status of Cancer, 1975-2000, Featuring the Uses of Surveillance Data for Cancer Prevention and Control" is published in the Sept. 3, 2003 (Vol. 95, No. 17, pages 1276-1299), issue of the *Journal of the National Cancer Institute*** . The report is by the CDC, the ACS, the NCI, and the NAACCR.

Additional background on this report can be found at:

<http://www.cancer.gov/newscenter/pressreleases/2003ReportQandA> and <http://www.cancer.gov/newscenter/pressreleases/ReportFactSheet>.

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* For an explanation of how this non-significant increase was derived, please see question 17 in the Q&A on this report, which can be found at <http://newscenter.cancer.gov/pressreleases/2003ReportQandA>.

** The authors of this year's report are Hannah K. Weir, Ph.D. (CDC), Michael J. Thun, M.D. (ACS), Benjamin F. Hankey, Ph.D. (NCI), Lynn A.G. Ries, M.S. (NCI), Holly L. Howe, Ph.D. (NAACCR), Phyllis A. Wingo, Ph.D. (CDC), Ahmedin Jemal, Ph.D. (ACS), Elizabeth Ward, Ph.D.(ACS), Robert N. Anderson, Ph.D., (NCHS), and Brenda K. Edwards, Ph.D. (NCI).

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Questions and Answers: Annual Report to the Nation on the Status of Cancer 1975-2000, Featuring the Uses of Surveillance Data for Cancer Prevention and Control

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1. What is the purpose of this report and who created it?

This report provides an update of cancer death rates, incidence rates (new cases), and trends in the United States. It also includes information on surveillance data and describes how these data can be used to develop cancer control plans, target interventions and assess progress in reducing the burden of cancer in the United States. The Centers for Disease Control and Prevention (CDC), the American Cancer Society (ACS), the National Cancer Institute (NCI), which is part of the National Institutes of Health, and the North American Association of Central Cancer Registries (NAACCR) collaborated to create this report. These reports have been issued annually since 1998.

2. What are the sources of the data?

Cancer mortality information in the United States is based on causes of death reported by physicians on death certificates. The mortality information is processed and

consolidated into a national database by CDC through the National Vital Statistics System, which covers the entire United States.

Information on newly diagnosed cancer cases occurring in the United States is based on data collected by registries in CDC's National Program of Cancer Registries (NPCR) and NCI's Surveillance, Epidemiology, and End Results (SEER) Program. NAACCR evaluates and publishes data annually from registries in both programs.

Long-term incidence trends are reported by NCI SEER and cover 10 percent of the U.S. population. Trend data for the five major racial and ethnic groups or populations (white, black, Asian and Pacific Islander (API), American Indian/Alaska Native (AI/AN), and Hispanic) are also from SEER and cover 14 percent of the U.S. population. Recent five-year incidence rates, collected from NPCR and SEER and reported by NAACCR, cover 68 percent of the U.S. population.

Cancer screening and behavioral risk factor information for the special section on cancer control was obtained primarily from data collected through CDC's Behavioral Risk Factor Surveillance System (BRFSS) telephone surveys and then categorized according to *Healthy People 2010* objectives. These national health objectives were developed by the U.S. Department of Health and Human Services to identify the most significant preventable threats to the health of the U.S. population and to establish national goals to reduce these threats.

3. What reporting periods were chosen as a main focus of the report?

The period from 1996 through 2000 was chosen to represent the most recent cross-section of available data for the current cancer burden including the five major racial and ethnic groups. The period from 1975 through 2000 was chosen to represent the best perspective on long-term trends in cancer incidence and death rates.

Update On Incidence and Mortality Trends for All Cancer Sites Combined and the Four Major Cancers

4. What is happening with cancer death rates overall?

Overall, cancer death rates were stable from 1998 through 2000 - that is, the rates were neither increasing nor decreasing. Before this, death rates increased through 1990, stabilized through 1994, and declined from 1994 through 1998.

5. Why are cancer death rates stabilizing after having declined in recent years?

Trends in cancer death rates for women stabilized, whereas death rates for men continued to decline, resulting in an overall stabilization of the death rates from 1998 through 2000. One factor contributing to the overall stabilization of death rates is the introduction of the *International Classification of Diseases, 10th revision* (ICD-10), beginning with 1999 mortality data, which affected recent mortality trends included in this report. The ICD-10 replaced ICD-9, which was used from 1979 through 1998. Changes in rules for selecting underlying causes of death with ICD-10 resulted in a larger net allocation (0.7 percent) of deaths due to cancer for 1999 and 2000. The

change in classification rules contributed, in part, to the leveling off of death rates for all cancers combined in the interval from 1998 through 2000. And finally, new population data based on the 2000 U.S. Census changed the rates slightly.

6. What is happening with cancer incidence rates overall?

Cancer incidence rates for all cancer sites combined increased from the mid-1970s through 1992, but declined from 1992 through 1995, and then stabilized from 1995 through 2000. Upon using a statistical method to adjust for delays in reporting, the most recent trend showed an increase of borderline statistical significance ($p=.05$). The increase in the delay-adjusted trend will require monitoring with additional years of data. (See question #17)

7. Why are cancer incidence rates stabilizing after having declined in recent years?

Overall cancer incidence rates remained essentially stable from 1995 through 2000. Recent increases in incidence rates in breast cancer among women and prostate cancer among men - specifically white men - offset long-term decreases in lung cancer in men.

8. What is happening with incidence and death rates for lung, breast, prostate and colorectal cancers?

These top four cancers represent more than half of all new cancer cases or deaths. Men and women of different racial and ethnic groups showed considerably different trends for each cancer site, such as:

- Lung cancer death rates among white and black men declined throughout the 1990s and the rate of increase in mortality among women slowed, demonstrating the impact of smoking cessation efforts in the past decade.
- Breast cancer incidence rates continued to increase among black and white women although the rate of increase has slowed since 1986. Death rates from breast cancer decreased beginning in the early 1990s, with steeper declines reported among white women than among black women. Declining breast cancer death rates and rising breast cancer incidence rates during the 1990s have been attributed, in part, to increased mammography screening and the dissemination of improved therapies.
- Prostate cancer death rates have been declining since 1994, while incidence rates have been rising since 1995 in both white and black men. The reason for the recent increase in incidence rates among men is not clear. Prostate cancer incidence rates increased throughout the 1970s and early 1980s. The introduction of the prostate specific antigen (PSA) test is thought to have contributed to the very steep increase in prostate cancer incidence rates in the late 1980s. With the PSA test, prostate cancers were diagnosed several years earlier than they would have been diagnosed without the PSA test. And in some cases, men may have been diagnosed with cancers that would otherwise never have been diagnosed nor progressed throughout the course of their life. As might be expected, incidence rates increased dramatically following the

introduction of the PSA test and then decreased immediately following. The observed decrease in the incidence rates of late-stage prostate cancer after 1992 is also consistent with the effects of introducing testing into a population with little or no testing history. The recent increase in prostate cancer incidence rates among men is similar to the increase noted prior to the introduction of the PSA test.

- Colorectal cancer death rates have been on the decline for both whites and blacks for the time period covered in this report. Rates began declining in the 1970s, with steeper declines beginning in the mid-1980s. Larger decreases in death rates were observed among white men and white women than among black men and black women. Colorectal incidence rates stabilized beginning in 1996 for all men and women.

9. What is the cancer burden among racial and ethnic groups or populations?

In this report, cancer incidence and death rates are described for white, black, Asian and Pacific Islander (API), American Indian/Alaska Native (AI/AN), and Hispanic persons (Hispanic persons are not mutually exclusive from persons who are white, black, API, and AI/AN.) While overall cancer incidence rates declined among API, AI/AN, and Hispanic men, there were no consistent trends in incidence rates among API, AI/AN, and Hispanic women. Cancer death rates among API men and women declined; however, trends in death rates were stable for AI/AN and Hispanic men and women.

Data on the cancer burden for these populations are covered and monitored by two federal programs: CDC's National Program of Cancer Registries (NPCR) and NCI's Surveillance, Epidemiology, and End Results (SEER) Program.

10. Why are breast and colorectal cancer death rates decreasing more steeply in whites compared to blacks?

An examination of black and white populations revealed growing differences for colorectal and breast cancer death rates. By 2000, death rates for white populations were substantially lower than those for black populations, an indication that black men and black women may not have experienced the same benefits from screening and/or treatment as white men and white women. These patterns in death rates indicate that disparities in deaths from some cancers are increasing and that new methods are needed to disseminate advances in prevention, screening and treatment to all segments of the population.

Cancer Control

11. How is progress against cancer measured in this report?

Progress is measured using cancer incidence and death rates and information on screening and risk factors, all of which are available at the national and state levels. Cancer control planners can use this data to assess the current cancer burden, target evidence-based interventions, and monitor progress related to cancer prevention and screening. Somewhat different measures of progress were chosen for each of the four most common cancers - lung, breast, prostate, colorectal - depending on the extent of

scientific evidence regarding causation, the ability to modify the underlying risk factors, the evidence that screening tests are effective in reducing incidence or mortality, and the ability to interpret incidence and/or death rates in measuring changes in the burden of disease.

12. How did you group and rank the states for cancer control planning purposes?

This report examined screening and behavioral risk factor surveillance data that are currently available at the state level to plan, implement and monitor cancer prevention and control programs for the four most common cancers - lung, breast, prostate, and colorectal. States were grouped and ranked on the basis of variables selected from *Healthy People 2010* objectives. States were then divided into three groups and were sorted alphabetically within groups. The first group includes states farthest from meeting *Healthy People 2010* objectives according to the selected cancer control parameters.

13. What were the findings among states?

Analysis of state data for the leading cancers revealed mixed progress in achieving national objectives for improving cancer screening, risk factor reduction, and decreases in mortality.

- Lung cancer: No state has yet met the *Healthy People 2010* objective of reducing adult smoking to 12 percent of the population. Tobacco consumption is declining in most states. However, in states where high rates of tobacco consumption continue, there are also high rates of lung cancer deaths. The authors recommend that tobacco control measures be strengthened in all states, especially those where tobacco consumption rates remain high or are increasing.
- Breast cancer: Mammography screening has been shown by a number of studies to reduce deaths from breast cancer. Breast cancer death rates are declining in most states, and many of these states have met the *Healthy People 2010* objective for at least 70 percent of women, aged 40 years or older, having undergone mammography within the past two years. Despite the availability of screening programs for underserved women, the rate of mammography among uninsured women in most states is well below the overall rate of mammography among all women in the state.
- Prostate cancer: Most states have yet to meet the *Healthy People 2010* objective of reducing prostate cancer death rates to below 29 deaths per 100,000 men. However, prostate cancer death rates appear to be declining for both black and white men in many of these states. More research is needed to assess the contribution that prostate specific antigen (PSA) testing has had upon the decline in the rate of prostate cancer deaths. Given the current discussion around the risks and benefits of PSA testing, the U.S. Preventive Services Task Force (USPSTF) concludes that there is insufficient evidence to recommend that the PSA test be part of routine cancer screening in the general population. (USPSTF is an advisory group to the U.S. Department of Health and Human Services).

- **Colorectal cancer:** Colorectal death cancer rates continue a long-term decline among both black and white men and black and white women in most states. Still many states are not close to meeting the *Healthy People 2010* objective for at least 50 percent of their population, aged 50 years or older, to have flexible sigmoidoscopy, colonoscopy or home-administered fecal occult blood test to detect colorectal cancer.

Further reduction in the burden of cancer is possible if increased dissemination of evidence-based cancer control programs reaches all segments of the population.

14. What tools are available for comprehensive cancer control planning?

A number of strategies for implementing evidence-based cancer control programs are now available to planners at the state and local levels via new Web-based resources. One such resource, Cancer Control PLANET (<http://cancercontrolplanet.cancer.gov/>), includes multiple tools that enable cancer control planners to use national, state and local surveillance data to develop comprehensive cancer control programs that address the challenges facing their communities. PLANET is a joint public and private effort involving NCI, CDC, ACS and the Substance Abuse and Mental Health Services Administration.

How to Read This Report

15. How are cancer incidence and death rates presented?

Cancer incidence rates and cancer death rates are measured as the number of cases or deaths per 100,000 people and are age-adjusted to the 2000 U.S. standard population. When a cancer affects only one gender - for example, prostate cancer - then the number is per 100,000 persons of that gender.

16. What is an annual percent change or APC?

The annual percent change (APC) is the average rate of change in a cancer rate per year in a given time frame (i.e., how fast or slowly a cancer rate has increased or decreased each year over a period of years). Annual percent change was calculated for both incidence and death rates. The number is given as a percent, such as the approximate one percent per year decrease.

A negative APC describes a decreasing trend, and a positive APC describes an increasing trend. The rates are age-adjusted, which allows for comparison of different populations over various age groups and times.

New in This Report

17. Why were rates adjusted for delays in reporting incidence data to SEER?

This report is the first to present analyses of long-term trends in cancer incidence rates with and without adjustment for reporting delays. Adjusting for these delays provides the basis for a potentially more accurate assessment of incidence rates and trends in the most recent years for which data are available. Cancer registries routinely take two to

three years to compile their current cancer statistics. An additional one to two years may be required to revise the incidence data on certain cancers, such as melanoma and prostate and breast cancers, particularly when they are diagnosed in out-patient settings. Cancer registries continue to update incidence rates to include these cases. Consequently, the initial data reported for certain cancer incidence rates may be an underestimate. Long-term reporting patterns in SEER registries have been analyzed, and it is now possible to adjust site-specific and all cancers combined incidence rates to correct for expected reporting delays.

18. How did the new U.S. Census data impact this report?

Population estimates for 1990 through 2000 were recently revised by using 1990 and 2000 decennial census data. For the first time, in the 2000 Census, respondents were able to identify themselves as multiracial. To report long-term trends in disease rates for single-race groups, CDC developed a method to bridge the multiracial populations into single-race categories. This method was used by the U.S. Bureau of the Census, with funding from NCI, to produce single-race census (2000) and intercensal (1990-2000) estimates for white, black, Asian/Pacific Islander, American Indian/Alaska Native and Hispanic populations. For more information, go to www.seer.cancer.gov/popdata/methods.pdf.

19. Where is this report published?

The report is published in the Sept. 3, 2003, issue of *Journal of the National Cancer Institute* (Vol. 95 No. 17, 1276-1299). The authors of this year's report are Hannah K. Weir, Ph.D. (CDC), Michael J. Thun, M.D. (ACS), Benjamin F. Hankey, Sc.D. (NCI), Lynn A.G. Ries, M.S. (NCI), Holly L. Howe, Ph.D. (NAACCR), Phyllis A. Wingo, Ph.D. (CDC), Ahmedin Jemal, Ph.D. (ACS), Elizabeth Ward, Ph.D. (ACS), Robert N. Anderson, Ph.D. (CDC), and Brenda K. Edwards, Ph.D. (NCI).

20. Where can I find out more about the report?

For more information, visit the following Web sites:

ACS: <http://www.cancer.org>

CDC (Division of Cancer Prevention and Control): <http://www.cdc.gov/cancer>

CDC (National Center for Health Statistics' mortality report): <http://www.cdc.gov/nchs/about/major/dvs/mortdata.htm>

NAACCR: <http://www.naacr.org/>

NCI: <http://www.cancer.gov> and the SEER Homepage: <http://www.seer.cancer.gov>. This site contains all data points for graphs in the manuscript, as well as supplementary data and charts. Click on the icon "1975-2000 Report to the Nation."

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Quick Facts: Annual Report to the Nation on the Status of Cancer 1975-2000, Featuring the Uses of Surveillance Data for Cancer Prevention and Control

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The Purpose of This Report

The "Annual Report to the Nation on the Status of Cancer, 1975-2000" provides an update on cancer mortality (death rates), incidence rates (new cases), and trends in the United States. It also includes data that can be used to develop cancer control plans and programs at the state and local levels. The report is issued annually by the Centers for Disease Control and Prevention (CDC), the American Cancer Society (ACS), the National Cancer Institute (NCI), which is part of the National Institutes of Health, and the North American Association of Central Cancer Registries (NAACCR).

Report highlights

- Overall, cancer death rates (for men and women combined) were stable from 1998 through 2000 - that is, rates neither increased nor decreased. Before this, death rates increased through 1990, stabilized through 1994, and declined from 1994 through 1998. Throughout the late 1990s, trends for women stabilized, while death rates for men continued to decline.
- Cancer incidence rates for all cancer types combined increased from the mid-1970s through 1992, but declined from 1992 through 1995, and then stabilized (a non-significant increase) from 1995 through 2000. Increases in incidence rates in breast cancer and prostate cancer offset long-term decreases in lung cancer in men.
- The report notes a growing difference in death rates between white and black populations for colorectal and breast cancers. By 2000, death rates for these cancers in whites were substantially lower than those in blacks, an indication that black men and women may not have experienced the same benefits from screening and/or treatment as white men and women. These patterns signal that disparities in deaths from some cancers are increasing and that new methods are needed to disseminate advances in prevention, screening and treatment services to all segments of the population.

Rates for the Four Leading Types of Cancer

The following top four cancers represent more than half of all cancer cases:

- **Lung Cancer** – death rates among white and black men declined throughout the 1990s, while the rate of increase in deaths among women slowed during the same period, reflecting reductions in tobacco smoking. Lung cancer is the leading cause of cancer death in men and women in the United States.

- **Colorectal Cancer** – death rates have been declining for both white and black men and women beginning in the 1970s, with steeper declines beginning in the mid-1980s. However, larger decreases in death rates were observed among white men and women than among black men and women, an indication that black men and women may not have experienced the same benefits from screening and treatment as white men and women. Meanwhile, incidence rates stabilized beginning in 1996 for all men and women.
- **Breast Cancer** – death rates continue to fall despite a gradual, long-term increase in incidence rates. Decreasing breast cancer death rates and increasing incidence rates during the 1990s have been attributed, in part, to increased use of mammography screening and the availability of improved therapies. However, death rates for white women are substantially lower than those for black women, an indication that black women may not have experienced the same benefits from screening and treatment as white women.
- **Prostate Cancer** – death rates have been declining since 1994, while incidence rates have been rising since 1995, with a 3.0 percent per year increase in incidence in white men and a 2.3 percent per year increase in black men. The reason for the recent increase is not clear. Prostate cancer incidence rates increased throughout the 1970s and early 1980s. Clarification of the risks and benefits of prostate specific antigen (PSA) screening, including potential impact on mortality, awaits the conclusion of two randomized clinical trials now in progress.

Sources of Data Used in This Report

- CDC's National Program of Cancer Registries (NPCR)
- NCI's Surveillance, Epidemiology, and End Results (SEER) Program
- CDC's Behavioral Risk Factor Surveillance System (BRFSS)
- CDC's National Vital Statistics System
- NAACCR's evaluation and publication of registry data

Years of Data Included in This Report

The report covers cancer incidence and mortality data over two time periods:

- Data considered current for this report are from 1996 through 2000, and
- Data from 1975 through 2000 were chosen to represent the best perspective on long-term trends in cancer incidence and death rates.

Data Analysis Process

Cancer registries routinely take two to three years to compile their current cancer statistics. An additional one to two years may be required to revise the incidence data on certain cancers - such as melanoma and prostate and breast cancers - particularly when they are diagnosed in out-patient settings. Cancer registries continue to update

incidence rates to include these cases. Using a statistical method to adjust for delays in reporting, this report is the first to present analyses of long-term trends in cancer incidence rates with and without adjustment for such reporting delays. These delay-adjusted incidence rates provide the basis for a potentially more accurate assessment of rates and trends, especially for the most recent years. It is now possible to adjust site-specific and all cancers-combined incidence rates to correct for expected reporting delays.

Where to Find the Report

The report is published in the Sept. 3, 2003, issue of the Journal of the National Cancer Institute (Vol. 95 No. 17, pages 1276-1299). The authors of this year's report are Hannah K. Weir, Ph.D. (CDC), Michael J. Thun, M.D. (ACS), Benjamin F. Hankey, Sc.D. (NCI), Lynn A.G. Ries, M.S. (NCI), Holly L. Howe, Ph.D. (NAACCR), Phyllis A. Wingo, Ph.D. (CDC), Ahmedin Jemal, Ph.D. (ACS), Elizabeth Ward, Ph.D. (ACS), Robert N. Anderson, Ph.D. (CDC), and Brenda K. Edwards, Ph.D. (NCI).

Where to Find Additional Information

Additional background on this report can be found at:

<http://www.cancer.gov/newscenter/pressreleases/2003ReportRelease>

<http://www.cancer.gov/newscenter/pressreleases/2003ReportQandA>

Resources

For more information, visit the following Web sites:

ACS: <http://www.cancer.org>

Cancer Control PLANET: <http://cancercontrolplanet.cancer.gov>

CDC (Division of Cancer Prevention and Control): <http://www.cdc.gov/cancer>

CDC (National Center for Health Statistics' mortality report):

<http://www.cdc.gov/cancer>

NAACCR: <http://www.naaccr.org>

NCI: <http://www.cancer.gov> and the SEER Homepage: <http://www.seer.cancer.gov>. This site contains all data points for graphs in the manuscript, as well as supplementary data and charts. Click on the icon "1975-2000 Report to the Nation."

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