

INTRODUCTION

This publication presents projected cancer incidence and mortality statistics for the Commonwealth of Pennsylvania. By utilizing the data collected by the Pennsylvania Cancer Registry, the Department of Health can develop programs to better address Pennsylvania's Cancer Program needs. Registry data are used to plan and evaluate cancer control measures in areas of risk assessment, prevention, early detection, patient care, public and professional education, and clinical research. Detailed incidence data for Pennsylvania are available to government agencies, as well as educational, planning and research organizations, and concerned private citizens.

A Technical Notes section appears at the beginning of this report to emphasize the importance of understanding and appropriately using the data shown. This section explains all steps used in the presentation of the data for this report. If you use any of the statistics presented in this report, we highly recommend that you read the Technical Notes section carefully and thoroughly. Please read all the qualifications listed and review as many of the cited references as possible before you proceed any further.

The Bureau of Health Statistics and Research specifically acknowledges the American Cancer Society (ACS). ACS granted permission to use their annual publication *Cancer Facts and Figures* as a direct reference in the development of this publication. We appreciate their cooperation.

The Bureau welcomes comments and suggestions on the content and format of this report. Staff members are available to answer questions regarding the report, including utilization and limitations of the data. Please address all comments, questions, requests for data, etc. to:

**Bureau of Health Statistics and Research
Pennsylvania Department of Health
555 Walnut Street, 6th Floor
Harrisburg, PA 17101-1914
Telephone: 717-783-2548
Fax: 717-772-3258**

This report and many other cancer and health statistics are on the Health Statistics page of the Department's website at www.health.state.pa.us/stats/

July 2004

The Pennsylvania Department of Health is an equal opportunity provider of grants, contracts, services, and employment.

HD0059P

CONTENTS

Average Day of Cancer Cases and Deaths	2	Pennsylvania and U.S. Mortality Rates.....	11
Basic Facts About Cancer in Pennsylvania	3	Trends for Top Four Cancer Sites	12
INCIDENCE TRENDS: All Cancers by Sex	4	2004 Projected Cancer Cases by Site and Sex	14
MORTALITY TRENDS: All Cancers by Sex	5	2004 Projected Cancer Deaths by Site and Sex	16
Stage of Disease: All Cancers by Sex	6	2004 Projected Cancer Cases by County	18
Incidence and Mortality Trends by Race.....	7	2004 Projected Cancer Deaths by County.....	19
Stage of Disease: All Cancers by Race	8	Guidelines for Early Detection.....	20
Behavioral Risk Factors.....	9	Cancer Prevention and Control Section Initiatives	21
Pennsylvania and U.S. Incidence Rates.....	10	References	22

TECHNICAL NOTES

Incidence Data:

Cancer abstracts collected by the Pennsylvania Cancer Registry (PCR) are the source for Pennsylvania cancer incidence data shown here. Data from PCR were used to project the expected number of cancer cases listed in this report. All 23 primary cancer sites follow the definitions used by the National Cancer Institute's SEER Program and are therefore comparable. Unless noted in situ cases other than urinary bladder cancer are not included in any calculation or projection contained in this report. Starting in 2001 cancer cases were coded using ICD-O-3 and staged using the *SEER Summary Staging Manual 2000*. Currently, 2001 is the latest year of available incidence data for the Commonwealth.

Mortality Data:

Pennsylvania's Certificate of Death is the source document for Pennsylvania cancer mortality data. The actual number of Pennsylvania cancer deaths reported were used to forecast the expected number of cancer deaths listed in this report. Currently, 2002 is the latest year of available mortality data for the Commonwealth.

Incidence and Mortality Projections:

The projections of new cancer cases in this report were obtained by producing a regression line using the method of least squares. This approach utilized the actual number of cases reported to the PCR with a diagnosis year of 1997 through 2001. This method constructed the regression line that minimizes the sum of the squared residuals. A residual is the difference between each data point (actual or observed event) and the regression line (predicted event). Once a regression line has been computed, then an estimate of the population standard error of the estimate is computed. This estimate measures the variability of the line. Also computed is the estimate of the population standard deviation of the dependent variable (year of diagnosis). This is a measure of the variability of projected cancer cases based on the arithmetic mean of cancer cases for the five years of 1997 through 2001. The estimate of the population standard error of the estimates was then compared to the estimate of the population standard deviation of the mean to identify which method had less variability. If the population standard deviation was lower, then the arithmetic mean for the five-year period was used as the projected number of cancer cases. This same method was applied to projecting the number of cancer deaths. However, since the cancer mortality file is more current, the five-year period of 1998 through 2002 was used to project the number of cancer deaths.

Precision of Projections:

The projected number of new cancer cases and new cancer deaths have been rounded to the nearest whole five. The projected figures should be used cautiously. Considerable variation may occur, particularly with estimates of small numbers.

Age-Adjusted Rates (Direct Method):

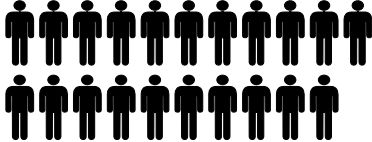







Age-specific rates for a selected population are applied to a standard population (in this report the 2000 U.S. standard million population) in order to calculate what rate would be expected if the selected population had the same age distribution as the standard. The total of these expected events divided by the total of the standard population and multiplied by 100,000 yields the age-adjusted rate per 100,000. It is important to use the same standard population in the computation of each age-adjusted rate to allow comparability. Age-adjusted rates should never be compared with any other type of rate or be used as absolute measurements of vital events. All state population figures used for calculating rates are estimates produced jointly by the U.S. Census Bureau and the State Data Center of Penn State at Harrisburg.

Data Use and Limitations:









It is highly recommended that any user of the data presented in this report read the information provided in this Technical Notes section carefully and thoroughly and review as many of the cited references as possible. Of primary concern when using forecasted values is the high probability of chance variation due to unknown (or uncontrollable) factors. This includes the concern of chance variation associated with the small number of events that can occur when using county statistics.

An Average Day of Projected Cancer Cases and Deaths For Major Primary Sites by Sex, Pennsylvania, 2004

MALES

	<u>Projected Cases</u>	<u>Projected Deaths</u>
All Sites	 105	 41
Prostate	 32	 4
Bronchus and Lung	 16	 12
Colon and Rectum	 12	 4

FEMALES

	<u>Projected Cases</u>	<u>Projected Deaths</u>
All Sites	 101	 40
Female Breast	 28	 6
Bronchus and Lung	 13	 10
Colon and Rectum	 12	 4



BASIC FACTS ABOUT CANCER IN PENNSYLVANIA

What is Cancer?

- Group of diseases related to the uncontrolled growth and spread of abnormal cells.
- Death can occur if growth of abnormal cells spreads.
- If detected early and treated promptly, many cancers can be cured.

What Causes Cancer?

- Environmental factors include chemicals, radiation (ultra violet, x-rays, gamma rays), viruses, and lifestyle (tobacco use, diet, alcohol consumption).
- Internal factors include hormones, immune status, and inherited conditions.

How is Cancer Prevented?

- Primary prevention includes avoiding oncogenic exposures (tobacco, sun exposure, excess dietary fat).
- Secondary prevention includes early detection and treatment of benign precursor lesions.

How is Cancer Treated?

- Surgery, radiation, chemotherapy, hormones, and immunotherapy.

Who Gets Cancer?

- Cancer strikes all segments of the state's population.
- Occurrence of cancer rises with age and exposure to risk factors.

What Are the Most Common Cancers?

- Female Breast
- Bronchus and Lung
- Prostate
- Colon and Rectum
- Urinary Bladder

How Many New Cancer Cases and Deaths Will There Be This Year?

- About 75,380** Pennsylvanians are projected to be diagnosed with invasive cancer in 2004.
- 72,645** Pennsylvania residents were diagnosed with invasive cancer in 2001.
- About 29,830 Pennsylvanians are projected to die from cancer in 2004.
- 29,460 Pennsylvania residents died as a result of cancer in 2002.

** includes *in situ* stage for urinary bladder cancer

Why Are the Number of Cancer Cases Increasing in Pennsylvania?

- Larger percentage of early stage detection.
- Aging population.
- Better awareness of symptoms/signs.

Are Cancer Death Rates Declining in Pennsylvania?

- Although, total cancer deaths have averaged 30,000 per year since 1990, the age-adjusted rates have been declining since 1990.
- Similarly, cancer deaths among men and women have remained steady, while corresponding rates have declined.

What Is a Cancer Cluster?

- Larger than expected number of cancer cases during a limited time period in a specific geographic area.

How Are Cancer Clusters Investigated?

- By examining data from cancer registries.
- By comparing the observed number of cancers in a specific geographic area to the expected number.

Where Can Additional Information on Cancer Be Obtained?

- National statistics and information
 - National Cancer Institute Cancer Information Service (800) 4-CANCER (422-6237)
 - American Cancer Society (800) 227-2345
 - Cancer Care, Inc. (800) 813-HOPE (813-4673)
 - Y-ME National Organization for Breast Cancer Information Support Program (800) 221-2141
 - Prostate Cancer:
 - US TOO International (800) 808-7866
 - CaPCURE (800) 757-2873
 - National Prostate Cancer Coalition (813) 253-0541
 - Skin Cancer:
 - American Academy of Dermatology (708) 330-0230
 - Skin Cancer Foundation (800) SKIN-490 (754-6490)
 - National Ovarian Cancer Coalition (888) 682-7426
- State and local statistics and information
 - Pennsylvania Department of Health:
 - Health Statistics (717) 783-2548
 - or www.health.state.pa.us/stats
 - Cancer Prevention/Control Section (717) 787-5251
 - Your local American Cancer Society
 - Your local Department of Health
 - Your local American Lung Association

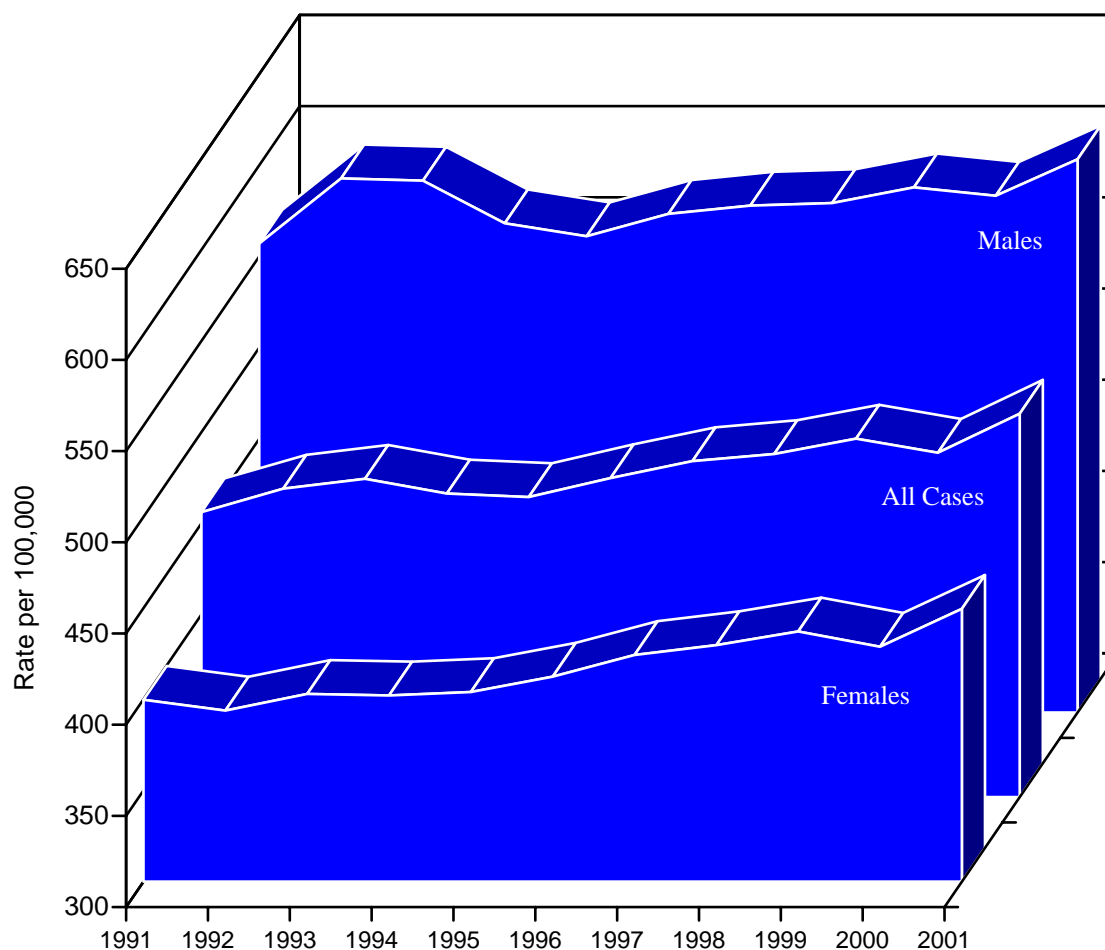
INCIDENCE TRENDS: All Cancers By Sex

All Cancer Cases - Pennsylvania's age-adjusted cancer incidence rate for all cancers has been on the increase between 1991 and 2001. The 2001 rate of 510.2 per 100,000 was 11.8 percent higher than the 1991 rate of 456.2.

Males - Increases have also been seen in the age-adjusted incidence rates for male residents since 1991. The 2001 rate was 603.3, compared to 557.1 in 1991 - a 8.3 percent difference for males. A large portion of the increase for males can be attributed to the higher numbers of prostate cancers being diagnosed more easily with use of the Prostate Specific Antigen (PSA) blood test. During the eleven year period of 1991-2001, the highest rate occurred in 2001 while the lowest rate occurred in 1991. Male rates have also consistently been much higher than the rates for female residents of the state. For example, the age-adjusted incidence rate for males in 2001 was 603.3, compared to 449.6 for females.

Females - Among female residents, the age-adjusted incidence rate has also been on the increase. The 2001 rate (449.6) was 12.5 percent higher than the 1991 rate (399.7). During the eleven year period, the highest rate occurred in 2001 while the lowest rate occurred in 1992 (393.8). The female incidence rate has been consistently lower than the male incidence rate. This difference between the sexes has remained steady. In both 1991 and 2001, the male rate was approximately 34-39 percent greater than the female rate.

Age-Adjusted Invasive Cancer Incidence Rates by Sex, 1991-2001



NOTE: Age-adjusted rates are computed by the direct method using 2000 U.S. standard million population.

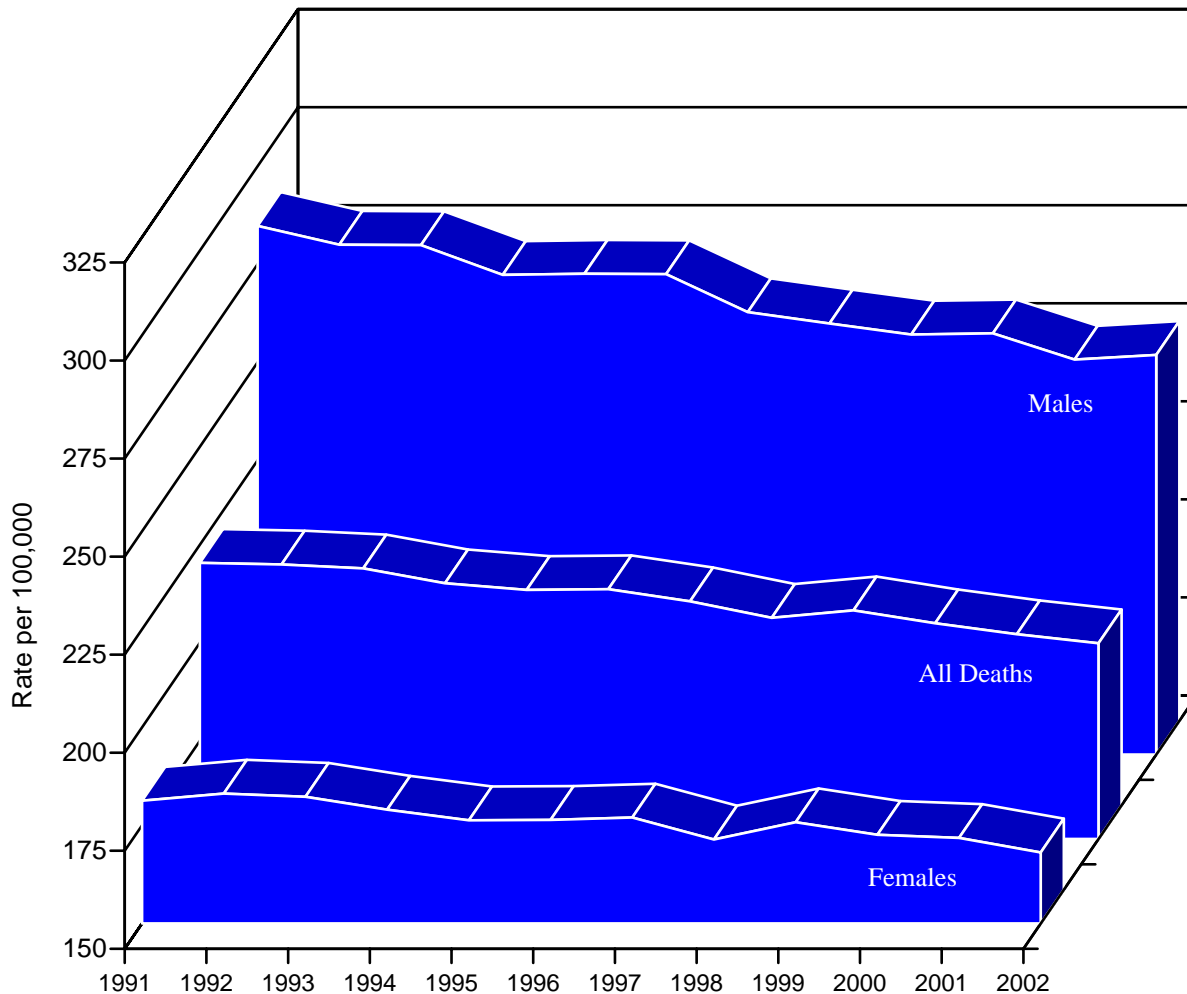
MORTALITY TRENDS: All Cancers By Sex

All Cancer Deaths - Pennsylvania's age-adjusted cancer mortality rate for all cancers has declined between 1991 and 2002. The 2002 rate of 199.9 per 100,000 was 9.3 percent lower than the 1991 rate of 220.4. The decline has been rather consistent over the twelve-year period. The highest rate occurred in 1991 at 220.4 while the lowest rate occurred in 2002.

Males - In 1991, the age-adjusted mortality rate for all male cancers was 284.8. By 2002, the rate had declined to 251.9 which is nearly 12 percent lower. During the twelve year period, the highest rate occurred in 1991 at 284.8 while the lowest rate occurred in 2002. However, mortality rates for male residents have remained nearly 50 percent higher than for female residents.

Females - Among female residents, the age-adjusted mortality rate has also declined between 1991 and 2002 but not as much as it has for males residents. The 2002 rate (168.1) was 7.3 percent lower than the 1991 rate of 181.3. During the twelve year period, the highest rate occurred in 1992 at 183.1 and the lowest rate occurred in 2002 at 168.1. Cancer mortality rates among women in Pennsylvania have been dramatically lower than male rates.

Age-Adjusted Cancer Mortality Rates by Sex, 1991-2002



NOTE: Age-adjusted rates are computed by the direct method using 2000 U.S. standard million population.

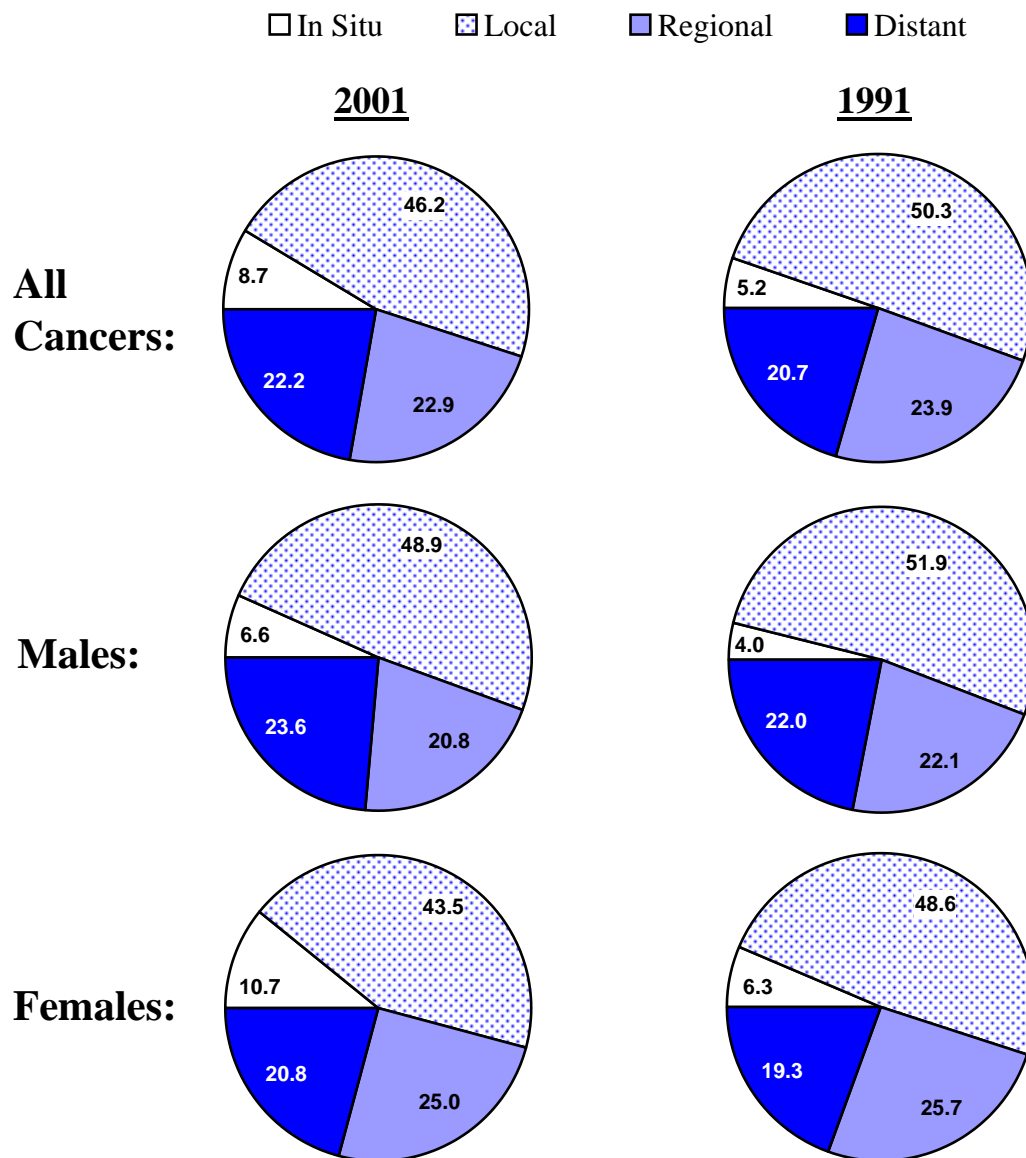
Percent of Cancer Cases by Stage of Disease at Diagnosis All Cancers by Sex, Pennsylvania Residents, 1991 and 2001

All Cancer Cases – When cancers are diagnosed during an early (in situ or local) stage, treatment can be effective and survival rates are higher than for cancers diagnosed during a late (regional or distant) stage. Among Pennsylvania residents, early stage diagnoses have remained in the 55-56 percent range for the years 1991 and 2001. While in situ diagnoses have increased from 5.2 to 8.7 percent, local stage diagnoses declined from 50.3 to 46.2 percent. Regional stage diagnoses declined slightly from 23.9 to 22.9 percent. However, distant stage diagnoses increased slightly from 20.7 to 22.2 percent.

Males - Among males, approximately 56 percent of cancers were diagnosed at early stages in 1991 and 2001.

In situ diagnoses increased from 4.0 to 6.6 percent; however, local stage diagnoses declined. Late stage diagnoses remained at 44 percent in 1991 and 2001, with a slight increase in distant stage diagnoses but a slight decline for regional stage.

Females – Early stage diagnoses remained in the 54-55 percent range in 1991 and 2001. However, the percentage of in situ diagnoses increased from 6.3 to 10.7 while the local stage percentages declined from 48.6 to 43.5. Late stage diagnoses accounted for 45-46 percent in both 1991 and 2001. Females had higher percentages of in situ and regional diagnoses than males but lower percentages for local and distant stages.



INCIDENCE AND MORTALITY TRENDS By Race

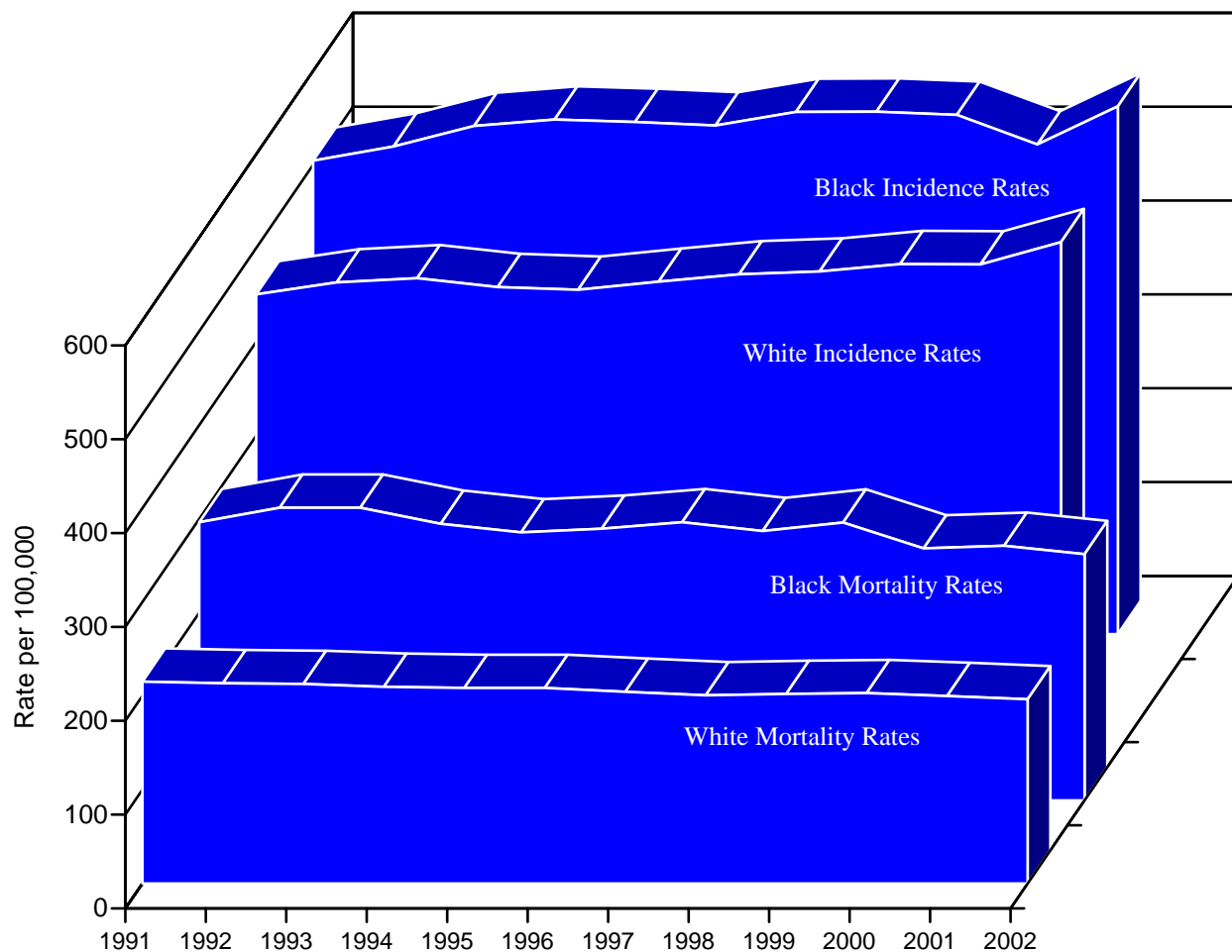
White Incidence Rates - Among white residents, the age-adjusted incidence rate has been on the increase between 1991 and 2001. The 2001 rate (506.3 per 100,000) was 12.4 percent higher than the 1991 rate (450.6). The 2001 increase was affected by ICD-O changes and improved record reporting.

Black Incidence Rates - The age-adjusted incidence rate for blacks has also been on the increase. The 2001 rate (562.4) was 11.5 percent higher than the 1991 rate (504.5). Incidence rates among black residents were consistently higher than rates for white residents during the eleven-year period of 1991-2001. The 2001 increase for blacks was also affected by ICD-O changes and improved record reporting.

White Mortality Rates - The age-adjusted cancer mortality rates for white residents have generally been on the decline since 1991. The 2002 rate of 196.3 was 8.7 percent lower than the 1991 rate of 215.1. During the twelve-year period, the highest rate occurred in 1991 and the lowest rate occurred in 2002.

Black Mortality Rates - Among black residents, the age-adjusted cancer mortality rates between 1991 and 2001 showed an overall decline, with a high of 311.9 in 1992 and 1993 and a low of 262.4 in 2002. However, in 2002, the cancer death rate for black residents was nearly 34 percent higher than the rate for white residents.

TRENDS: Cancer Incidence and Mortality Age-Adjusted Rates by Race, Pennsylvania Residents



NOTES: Age-adjusted rates are computed by the direct method using the 2000 U.S. standard million population. Incidence rates are based on invasive (and in situ urinary bladder) cancers.

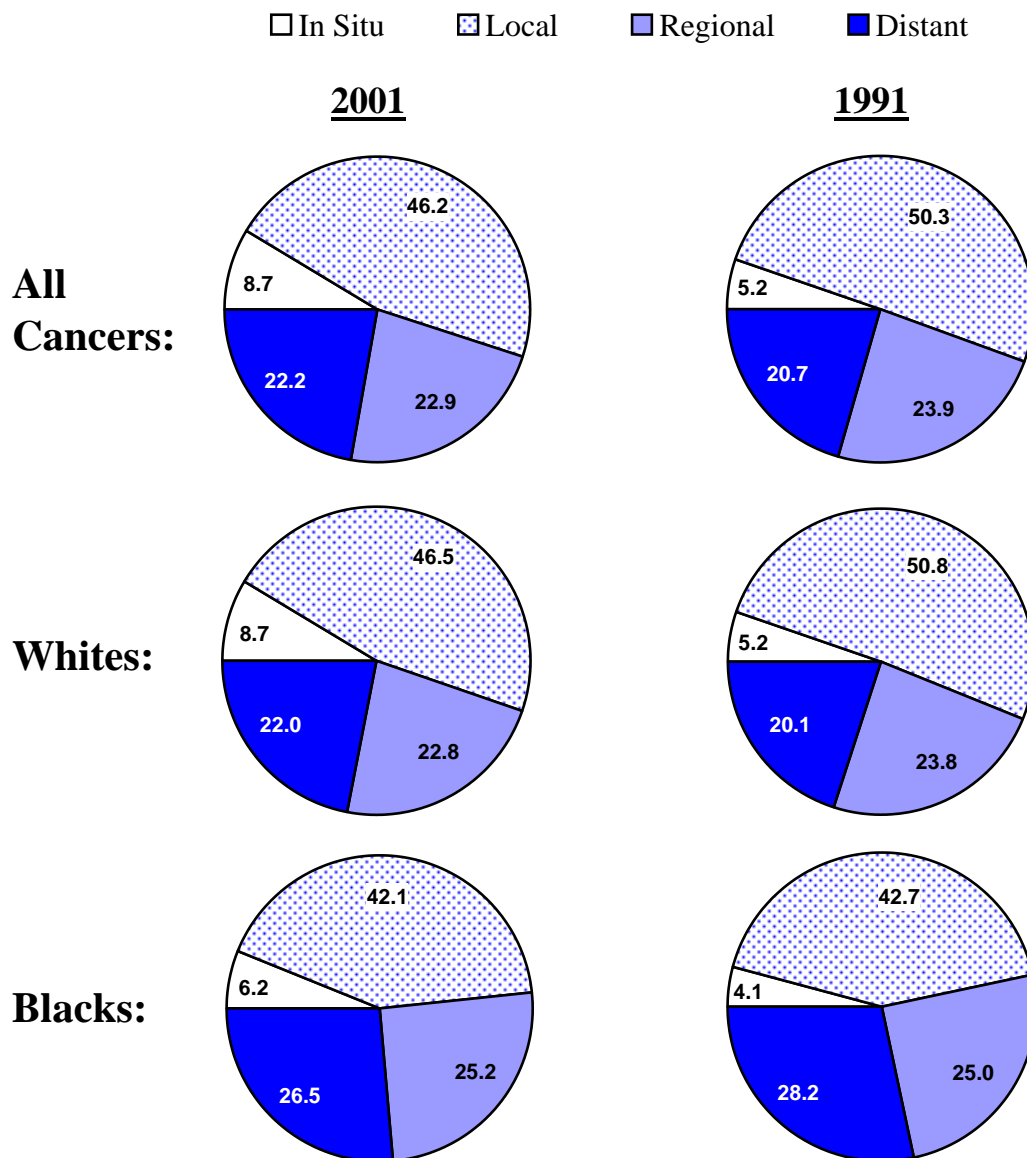
Percent of Cancer Cases by Stage of Disease at Diagnosis All Cancers by Race, Pennsylvania Residents, 1991 and 2001

Stage of Disease - In 1991, the differences in the percentages of staged diagnoses by race was dramatic. During that year, 56 percent of cancer diagnoses among whites were made at the early (in situ or local) stage while comparable diagnoses among blacks only represented 46.8 percent. By 2001, these dramatic differences had declined somewhat, but blacks still had fewer early stage diagnoses than whites. Identifying these differences is important since treatment, mortalities, and survival rates are directly affected by stage at time of diagnosis.

Whites - Among whites, approximately 56 percent of cancers were diagnosed at early stages in 1991 and 2001.

In situ diagnoses increased from 5.2 to 8.7 percent while local stage diagnoses decreased from 50.8 to 46.5 percent. Late stage diagnoses remained at 44 percent in 1991 and 2001, with a slight decline in regional stage diagnoses but with a slight increase in distant stage diagnoses.

Blacks - Among blacks residents, early stage cancer diagnoses increased from 46.8 percent in 1991 to 48.3 percent in 2001. However, the percentages of early stage diagnoses remained dramatically lower than for whites. Late stage diagnoses declined among black residents, with distant stage diagnoses decreasing from 28.2 percent in 1991 to 26.5 percent in 2001.



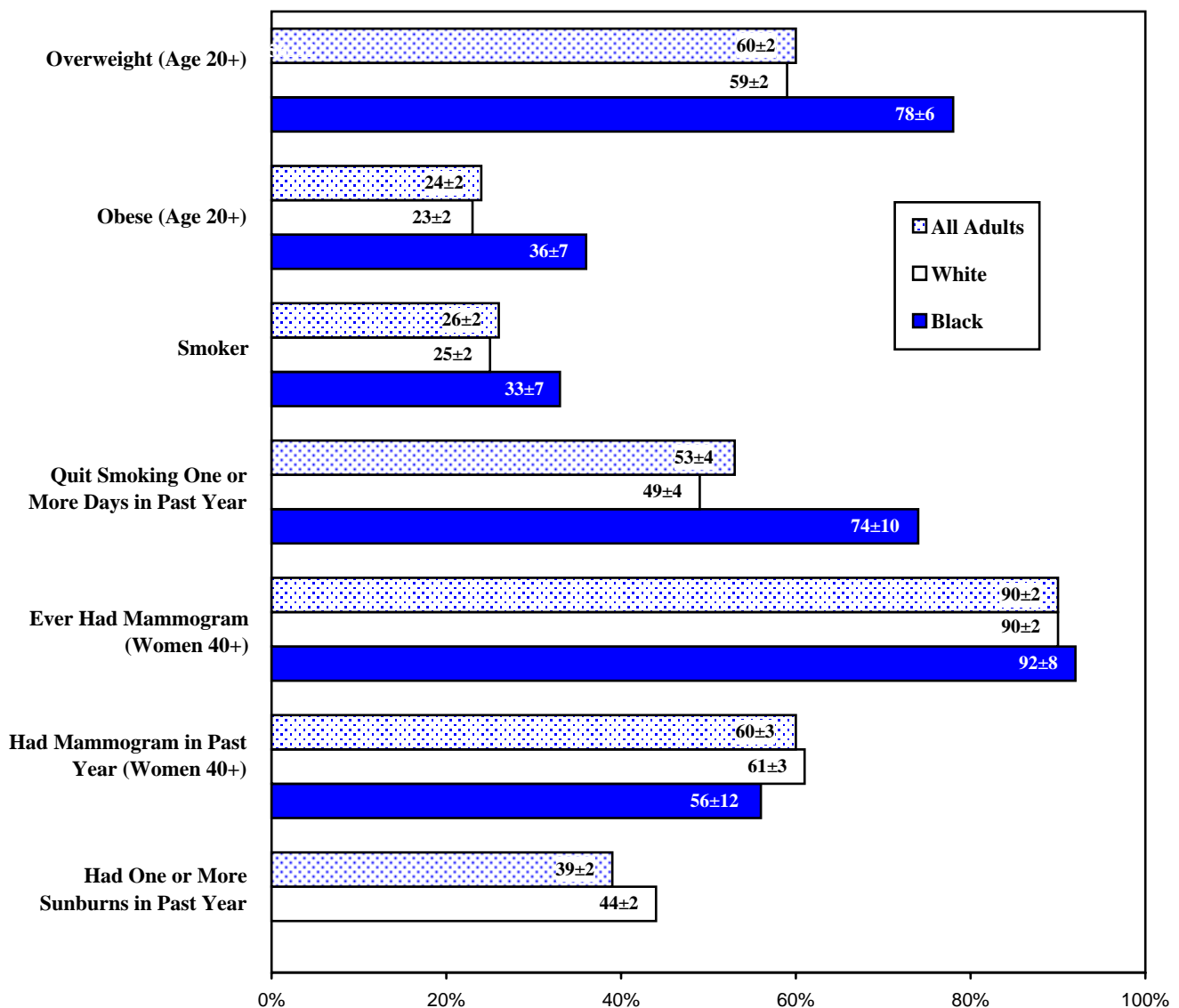
Behavioral Risk Factors

The Pennsylvania Department of Health conducts an annual telephone sample survey of adult residents as part of its Behavioral Risk Factor Surveillance System. Results from the 2003 survey for selected risk factors that impact on cancer incidence are shown below for all adults, whites (non-Hispanic), and blacks (non-Hispanic). For more information, please read the additional notes at the bottom of this page.

Sixty percent of all adults (age 20+) surveyed were considered to be overweight and 24 percent were obese. Twenty-six percent of the respondents smoked cigarettes regularly in 2003. Fifty-three percent of all smokers surveyed quit smoking for at least one day in the past year. The percentage of women who had ever had a mammogram (age 40+) was relatively high (90). However, a significantly lower percentage was reported for women age 40 and older who had had a mammogram in the past year (60).

Behavioral risk factors highlighted some significant differences between the races. Significantly more blacks were overweight (78 vs. 59 percent), obese (36 vs. 23 percent), and quit smoking at least one day (74 vs. 49 percent) compared to whites in 2003. Thirty-nine percent of all adults surveyed in 2003 had one or more sunburns within in the past year. Sunburn was nearly non-existent among blacks. Skin cancer is predominant among whites.

Selected Behavioral Risk Factors by Race, Pennsylvania Adults, 2003



NOTES: The estimated percent prevalences were calculated using weighted data (i.e., the age, sex and race distribution of the estimated state population) and were age-adjusted to the 2000 U.S. standard million population in order to match the Healthy People 2010 data. Data include 95% confidence intervals (±). Hispanics are excluded from the white and black categories.

PENNSYLVANIA and UNITED STATES: Comparison of Selected Age-Adjusted Invasive Cancer Incidence Rates

All Cancers* - The annual age-adjusted incidence rates in PA for all cancers had been lower than comparable U.S. rates between 1991 and 1996. However, more recent annual rates (1998-2001) for cancer incidence in PA have been higher and PA rates have been on the increase.

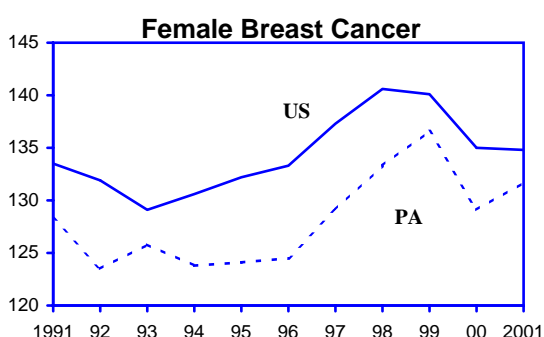
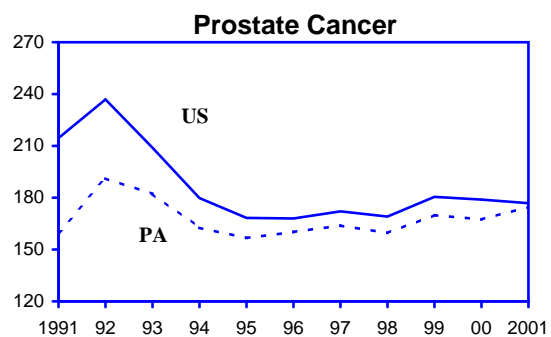
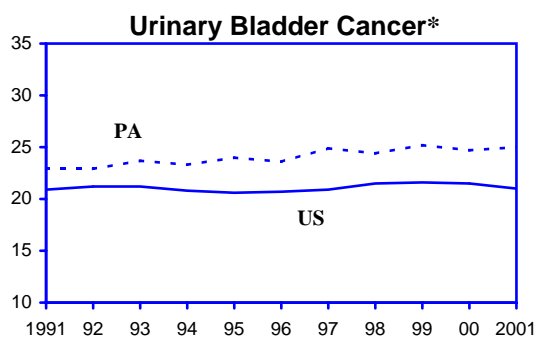
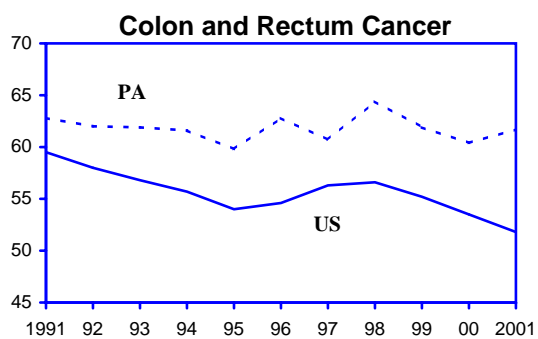
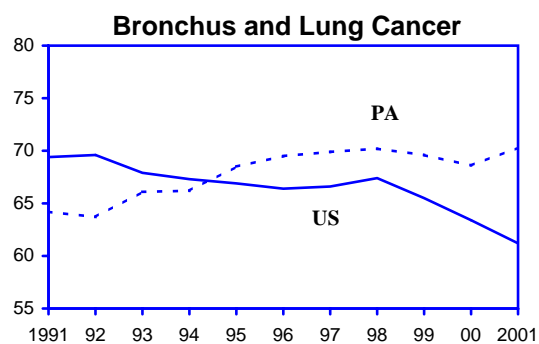
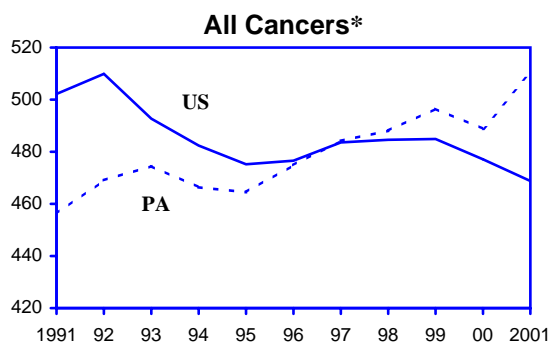
Bronchus and Lung Cancer - Between 1991 and 1994, the annual age-adjusted incidence rates for lung and bronchus cancer among PA residents were lower than comparable rates for the U.S. However, since 1995 the incidence rates among PA residents have been higher than the U.S. The rates in PA have generally increased since 1991 while U.S. rates have generally declined.

Colon and Rectum Cancer - Age-adjusted incidence rates for colon and rectum cancer among PA residents were much higher than U.S. rates between 1991 and 2001. PA rates have not changed much but US rates have declined.

Urinary Bladder Cancer* - Age-adjusted incidence rates for urinary bladder cancer in PA were slightly higher than the U.S. throughout the period of 1991-2001. Incidence rates for urinary bladder cancer have not changed much since 1991 for both the U.S and PA.

Prostate Cancer - During the period of 1991-2001, PA age-adjusted incidence rates for prostate cancer were lower than comparable U.S. rates. However, the difference between the two has narrowed in recent years. The highest incidence rates for both the U.S. and PA occurred in 1992, probably as a result of the new Prostate Specific Antigen (PSA) blood test.

Female Breast Cancer - Between 1991 and 2001, the annual age-adjusted incidence rates for female breast cancer in PA were consistently lower than comparable rates for the U.S. The highest rate in PA occurred in 1999.



NOTES: Age-adjusted rates 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). * Includes in situ urinary bladder cancers.

PENNSYLVANIA and UNITED STATES: Comparison of Selected Age-Adjusted Cancer Mortality Rates

All Cancers - Between 1991 and 2001, the annual age-adjusted cancer mortality rates in Pennsylvania and the U.S. have generally declined but Pennsylvania's rates were consistently higher than comparable U.S. mortality rates.

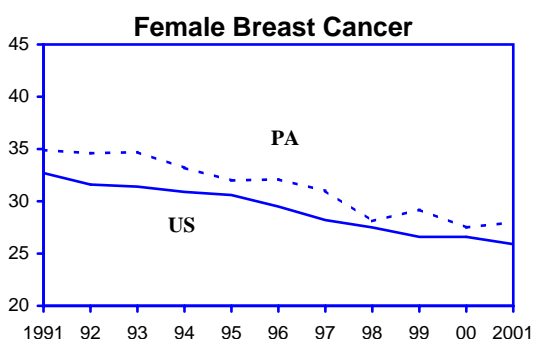
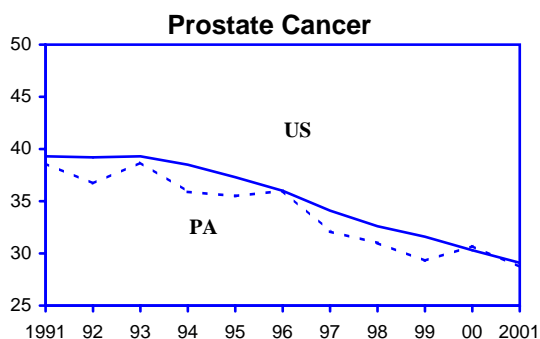
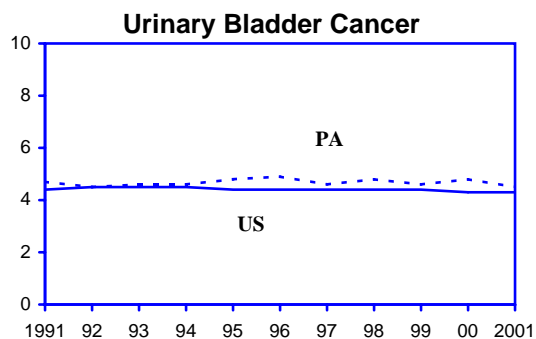
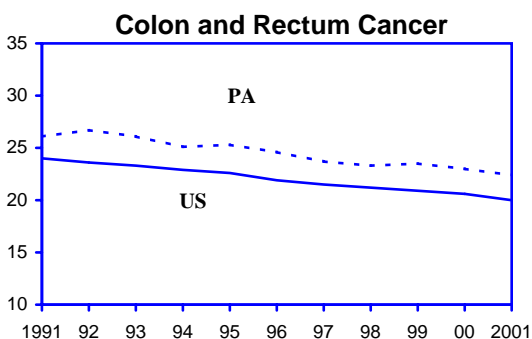
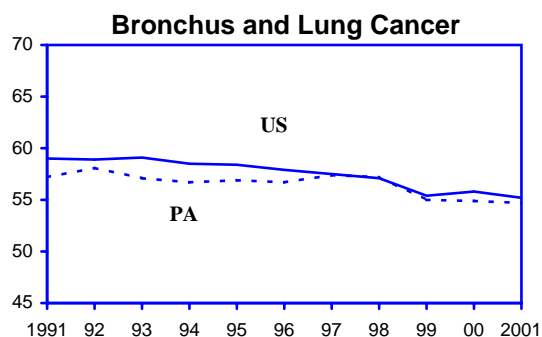
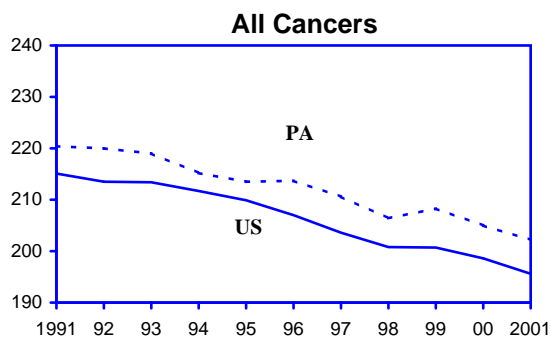
Bronchus and Lung Cancer - Annual age-adjusted mortality rates were slightly lower among Pennsylvania residents compared to U.S. rates during the period of 1991-2001. The mortality rates for both the U.S. and PA have decreased slightly during the eleven-year period.

Colon and Rectum Cancer - Age-adjusted mortality rates for colon and rectum cancer in both Pennsylvania and the U.S. have declined since 1991. However, Pennsylvania's rates were consistently higher than the U.S. rates between 1991 and 2001.

Urinary Bladder Cancer - Mortality rates for urinary bladder cancer have not changed much over the years. Between 1991 and 2001, mortality rates were slightly higher for residents of Pennsylvania than for the U.S.

Prostate Cancer - The annual age-adjusted mortality rates for prostate cancer have been on the decline since 1991 for both the U.S. and Pennsylvania. Between 1991 and 2001, mortality rates in Pennsylvania were slightly lower or similar to comparable U.S. rates.

Female Breast Cancer - Between 1991 and 2001, the annual age-adjusted mortality rates for female breast cancer decreased in Pennsylvania but remained somewhat higher than U.S. rates.



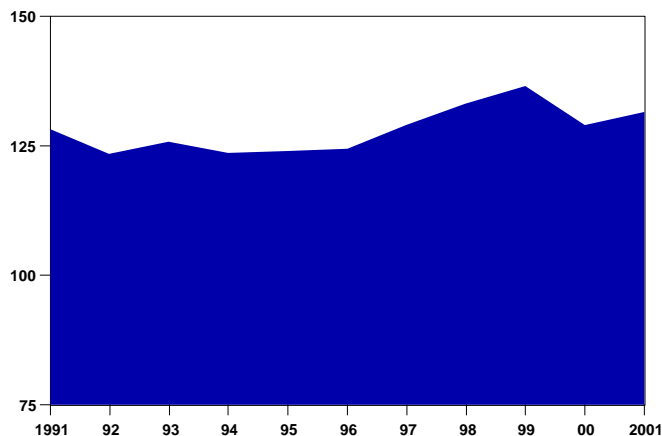
NOTES: Age-adjusted rates are computed by the direct method using the 2000 U.S. standard million population. U.S. age-adjusted rates were calculated from the National Cancer Institute's SEER program.

BREAST CANCER

Trends:

The age-adjusted incidence rate for invasive breast cancer among Pennsylvania women has been slightly higher in recent years. Staging data show more diagnoses at earlier stages in recent years. It is projected that there will be about 10,315 new cases diagnosed in 2004, compared to 10,060 in 2001. The number of deaths in 2004 due to this disease is estimated to be about 2,295, similar to the number (2,288) reported for 2002.

Age-Adjusted Incidence Rate, 1991-2001



Signs and Symptoms:

Earliest sign is an abnormality appearing on a mammogram before it can be felt by touch. Symptoms that are physically detectable may include a lump, thickening, swelling, distortion or tenderness; skin irritation or dimpling; and nipple pain, scaliness, ulceration, retraction or spontaneous discharge. Breast pain is not usually a first symptom of breast cancer.

Risk Factors:

Risk increases with age and for family history of breast cancer, long menstrual history, increased breast density, obesity after menopause, recent use of oral contraceptives or postmenopausal estrogens and progestins, never having children or having first child after age 30, and alcohol intake.

Early Detection:

See page 20.

Treatment:

Lumpectomy or mastectomy and removal of lymph nodes under the arm, radiation therapy, chemotherapy or hormone therapy. Two or more methods are often used in combination. All options for best management should be considered.

Survival:

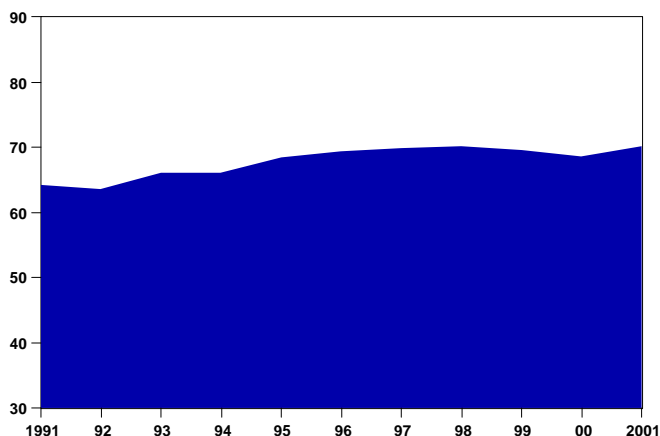
The five-year relative survival rate for localized breast cancer is 97%. However, it decreases to 79% for regional stages of the disease and to 23% for distant metastases. Longer term survival is stage dependent, with best survival for early stage diagnoses.

LUNG/BRONCHUS CANCER

Trends:

The chart below shows that the age-adjusted incidence rate for invasive cancer of the lung and bronchus among Pennsylvania residents has been on the increase between 1991 and 2001. Over 71 percent of these cancers were diagnosed at late (regional and distant) stages of the disease in 2001. There were 10,185 cases reported in 2001 and about 10,255 are expected in 2004. Deaths are projected to remain at about 8,000 in 2004.

Age-Adjusted Incidence Rate, 1991-2001



Signs and Symptoms:

Persistent cough, sputum streaked with blood, chest pain, and recurring pneumonia or bronchitis.

Risk Factors:

Cigarette smoking is by far the most important risk factor in the development of lung cancer. Other factors include certain occupational or environmental exposure to substances, such as arsenic; some organic chemicals and radon and asbestos, particularly for smokers; radiation exposure from occupational, medical and environmental sources; air pollution; tuberculosis; and environmental (second-hand) tobacco smoke for nonsmokers.

Early Detection:

See page 20.

Treatment:

Options include surgery, radiation therapy, and chemotherapy determined by type and stage of the disease. For later stage diagnoses, radiation therapy and chemotherapy are often used in combination with surgery. Chemotherapy alone or combined with radiation has been effective for small cell lung cancer.

Survival:

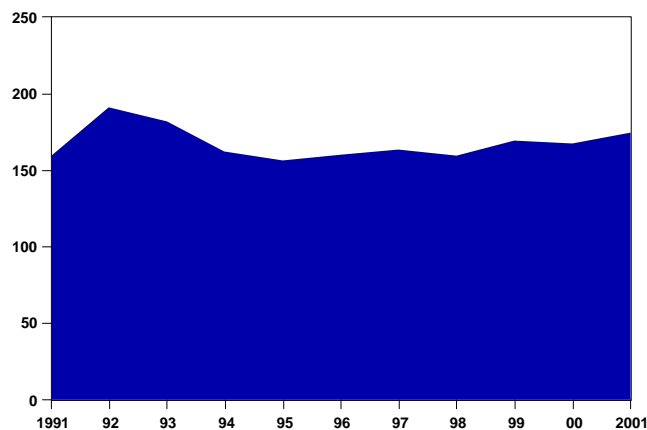
The one-year survival rate has increased from 37% in 1975 to 42% in 1999, largely due to improvements in surgical techniques. Five-year survival is only 15%. The survival rate for localized cases is 49%, but only 16% of lung cancers are discovered that early.

PROSTATE CANCER

Trends:

The state's annual age-adjusted incidence rate between 1991 and 2001 for invasive prostate cancer was highest in 1992 (see graph below). This was mainly due to more widespread use of a simple blood test (PSA) to detect this disease at its early stages. Rates have declined and have not changed much since then. Projections for 2004 indicate that 11,525 new cases may be reported, somewhat higher than in 2001. About 1,535 deaths are projected for 2004, almost 6% less than in 2002.

Age-Adjusted Incidence Rate, 1991-2001



Signs and Symptoms:

Weak/interrupted urine flow; inability to urinate or difficulty starting or stopping flow; need to urinate frequently, especially at night; blood in urine; pain or burning on urination; chronic pain in lower back, pelvis or upper thighs. Most of these symptoms can also be caused by other benign conditions.

Risk Factors:

Over 70% of all prostate cancers are diagnosed in men over age 65. Blacks have the highest incidence rates in the world. There may be some familial tendency. Dietary fat may also be a risk factor.

Early Detection:

See page 20.

Treatment:

Surgery or radiation, depending on patient's age and stage of the cancer. Hormones, chemotherapy or radiation may be used for metastatic disease. Hormone treatment can also help reduce pain and other symptoms. "Watchful waiting" may be appropriate, especially for older persons and/or early stage diagnoses.

Survival:

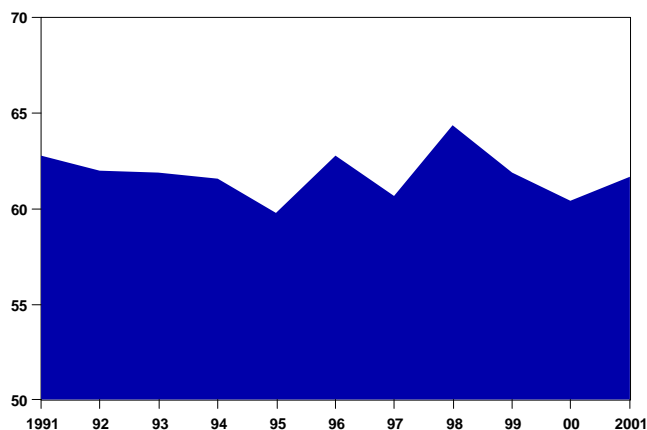
Almost 96% of the prostate cancers diagnosed among Pennsylvania residents in 2001 were at the local or regional stage. The five-year survival rate for these patients is 100%. The survival rate for all stages is 98%. Recent data show that 84% of men with prostate cancer survive 10 years and 56% survive 15 years.

COLON/RECTUM CANCER

Trends:

The age-adjusted incidence rate for Pennsylvanians diagnosed with invasive colon and rectum cancer has not shown any definite trends between 1991 and 2001 (see graph below). The number of new cases projected for 2004 is 8,950 which is just slightly lower than the 9,085 reported for 2001. The number of resident deaths for 2004 is also expected to be slightly lower – 3,140 compared to 3,197 in 2002.

Age-Adjusted Incidence Rate, 1991-2001



Signs and Symptoms:

Rectal bleeding, blood in the stool, a change in bowel habits, stomach cramps in lower abdomen.

Risk Factors:

Over age 50 and/or familial history of colon cancer or polyps and inflammatory bowel disease have been associated with increased risk. Other risk factors include smoking, physical inactivity, high-fat and/or low-fiber diet, alcohol intake, as well as inadequate consumption of fruits and vegetables.

Early Detection:

See page 20.

Treatment:

Surgery is the most common form of treatment and frequently results in a cure for cancers that have not spread. Chemotherapy or chemotherapy with radiation before or after surgery is recommended for patients whose cancer has significantly perforated the bowel wall or spread to the lymph nodes. Colostomy (creation of an abdominal opening for elimination of body wastes) is seldom needed for colon cancer patients.

Survival:

One-year and five-year survival rates are 83% and 62%, respectively. For early, localized stages, the five-year survival rate is 90%; however, only 38% are discovered then. Five-year survival for regional stages is 66% but drops to 9% for those diagnosed with distant metastases.

2004 PROJECTED CANCER CASES By SITE and SEX

All Cases - The number of invasive cancer cases among Pennsylvania residents is projected to increase by 3.8 percent between 2001 and 2004, from 72,645 to 75,375. Five cancer sites - female breast, prostate, skin melanoma, thyroid, and kidney/renal pelvis - are projected to have the largest increases. The largest declines are expected to occur for cancers of the stomach, larynx, colon/rectum, and cervix uteri. Fourteen of the twenty-three primary cancer sites are expected to have higher incidence figures in 2004 compared to 2001.

Males - Among males, the number of invasive cancer cases is projected to increase by 3.9 percent between 2001 and 2004, from 36,984 to 38,440. The largest increases are expected for prostate (667 more cases), kidney/renal pelvis (128 more

cases), melanoma of skin (141 more cases), and liver/intrahepatic bile duct (104 more cases). The largest declines are expected for larynx cancers (86 less cases) and stomach cancers (68 less cases) between 2001 and 2004.

Females - Among females, invasive cancer cases are expected to increase by 3.6 percent between 2001 and 2004, from 35,660 to 36,935. Sites with the largest expected numerical increases include breast cancer (255 more cases), thyroid (343 more cases), bronchus/lung (153 more cases) and melanoma of the skin (156 more cases). The largest decreases are expected to occur for colon/rectum cancer (119 less cases) and cervix uteri cancers (61 less cases).

2004 Projected and 2001 Invasive Cancer Cases, Pennsylvania Residents Percent Change 2001 to 2004, All Cancers and 23 Selected Sites by Sex

Cancer Site	ALL CASES			MALES			FEMALES		
	2004 Projected	2001 Observed	Percent Change	2004 Projected	2001 Observed	Percent Change	2004 Projected	2001 Observed	Percent Change
All Cancers **	75,375	72,645	3.8	38,440	36,984	3.9	36,935	35,660	3.6
Brain and Other Nervous System	870 *	881	-1.2	465 *	476	-2.3	405 *	405	0.0
Bronchus and Lung	10,255	10,185	0.7	5,700 *	5,718	-0.3	4,620	4,467	3.4
Buccal Cavity/Pharynx	1,345 *	1,373	-2.0	955	926	3.1	440 *	447	-1.6
Cervix Uteri	500	561	-10.9	-	-	-	500	561	-10.9
Colon and Rectum	8,950 *	9,085	-1.5	4,440 *	4,451	-0.2	4,515 *	4,634	-2.6
Corpus/Uterus, NOS	2,530	2,417	4.7	-	-	-	2,530	2,417	4.7
Esophagus	850	798	6.5	640	602	6.3	210	196	7.1
Female Breast	10,315	10,060	2.5	-	-	-	10,315	10,060	2.5
Hodgkin Lymphomas	455	415	9.6	225 *	224	0.4	215	191	12.6
Kidney/Renal Pelvis	2,175	1,974	10.2	1,335	1,207	10.6	840	767	9.5
Larynx	530	622	-14.8	415	501	-17.2	110	121	-9.1
Leukemias	1,815	1,713	6.0	1,025	945	8.5	790	768	2.9
Liver/ Intrahepatic Bile Duct	755	632	19.5	525	421	24.7	230	211	9.0
Melanoma of Skin	2,435	2,133	14.2	1,300	1,159	12.2	1,130	974	16.0
Multiple Myeloma	750 *	771	-2.7	380 *	411	-7.5	365 *	360	1.4
Non-Hodgkin Lymphomas	2,940	2,863	2.7	1,525	1,466	4.0	1,420	1,397	1.6
Ovary	1,140	1,146	-0.5	-	-	-	1,140	1,146	-0.5
Pancreas	1,780	1,646	8.1	855	768	11.3	920	878	4.8
Prostate	11,525	10,858	6.1	11,525	10,858	6.1	-	-	-
Stomach	990	1,081	-8.4	575	643	-10.6	435 *	438	-0.7
Testis	345 *	363	-5.0	345 *	363	-5.0	-	-	-
Thyroid	1,895	1,455	30.2	415	323	28.5	1,475	1,132	30.3
Urinary Bladder **	3,770	3,671	2.7	2,665	2,645	0.8	1,110	1,026	8.2

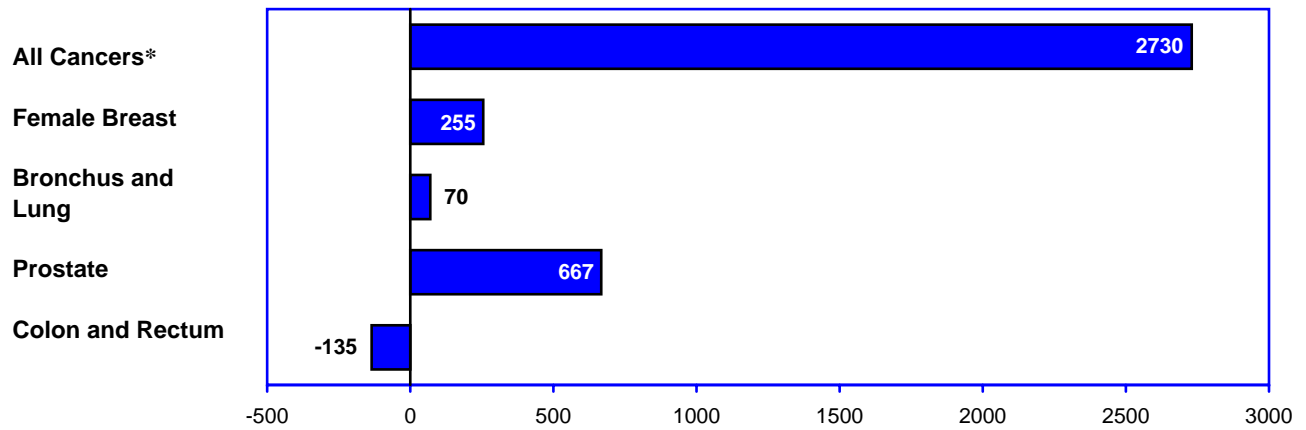
NOTES: Males and females may not sum to the total due to independent analysis by sex and by total. Projections were rounded to the nearest whole five. Pennsylvania cancer primary site groupings match the primary site definitions used by the National Cancer Institute's SEER program.

* The arithmetic mean for the five-year period of 1997-2001 was used to estimate the number of cases. See Technical Notes for additional information.

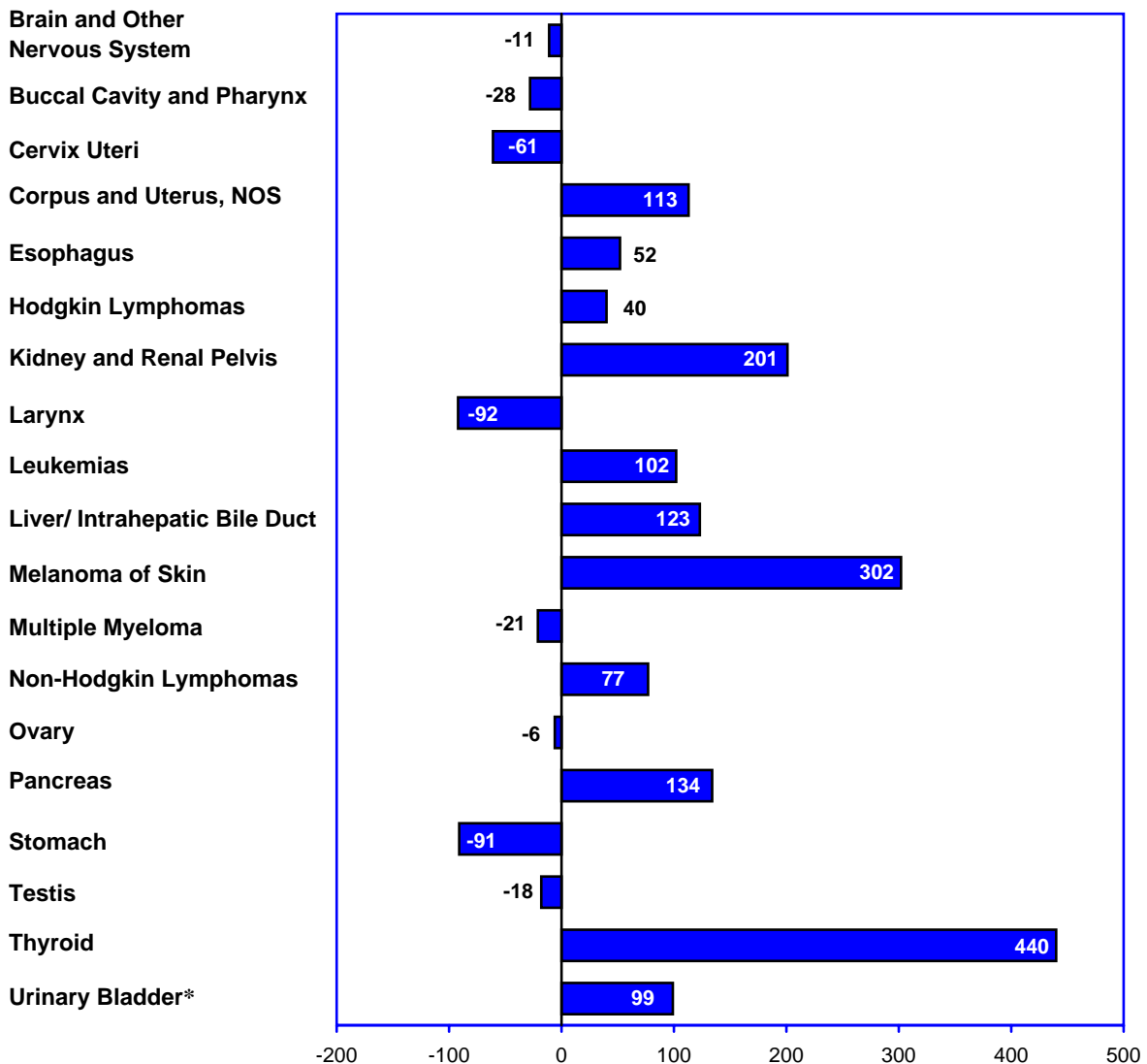
** Includes in situ for urinary bladder cancers.

Expected Change in Number of Invasive Cancer Cases, 2001 to 2004

All Cancers and Top 4 Sites



19 Other Selected Sites



NOTE: Pennsylvania cancer primary site groupings match the primary site definitions used by the National Cancer Institute's SEER program.

* Includes in situ urinary bladder cancers.

2004 PROJECTED CANCER DEATHS By SITE and SEX

All Deaths - The expected number of cancer deaths among residents in 2004 is projected to be about 29,830, almost the same number that occurred in 2002 (29,460). Among the 23 major sites, twelve are expected to have fewer deaths in 2004. The largest increases in the number of deaths are expected for cancers of the pancreas and the ovary. The largest declines in the number of resident deaths between 2002 and 2004 are projected for cancers of the prostate, stomach, and colon/rectum.

Males - The number of male cancer deaths is projected to decrease slightly, from 14,928 in 2002 to 14,785 in 2004. Among the 23 sites, the largest declines in cancer deaths

among males between 2002 and 2004 are projected for bronchus/lung, prostate, and stomach cancers. The largest increases in cancer deaths among males could be recorded for pancreatic cancers.

Females - The number of female cancer deaths in Pennsylvania is projected to be 14,700 in 2004, a slight decline from the number that occurred in 2002 (14,532). Among the 23 sites, the two largest declines in cancer deaths among women are projected to occur for colon/rectum cancer and non-Hodgkin lymphomas while ovary, pancreatic, and corpus uterus cancers are projected to have the largest increases in the number of female cancer deaths between 2002 and 2004.

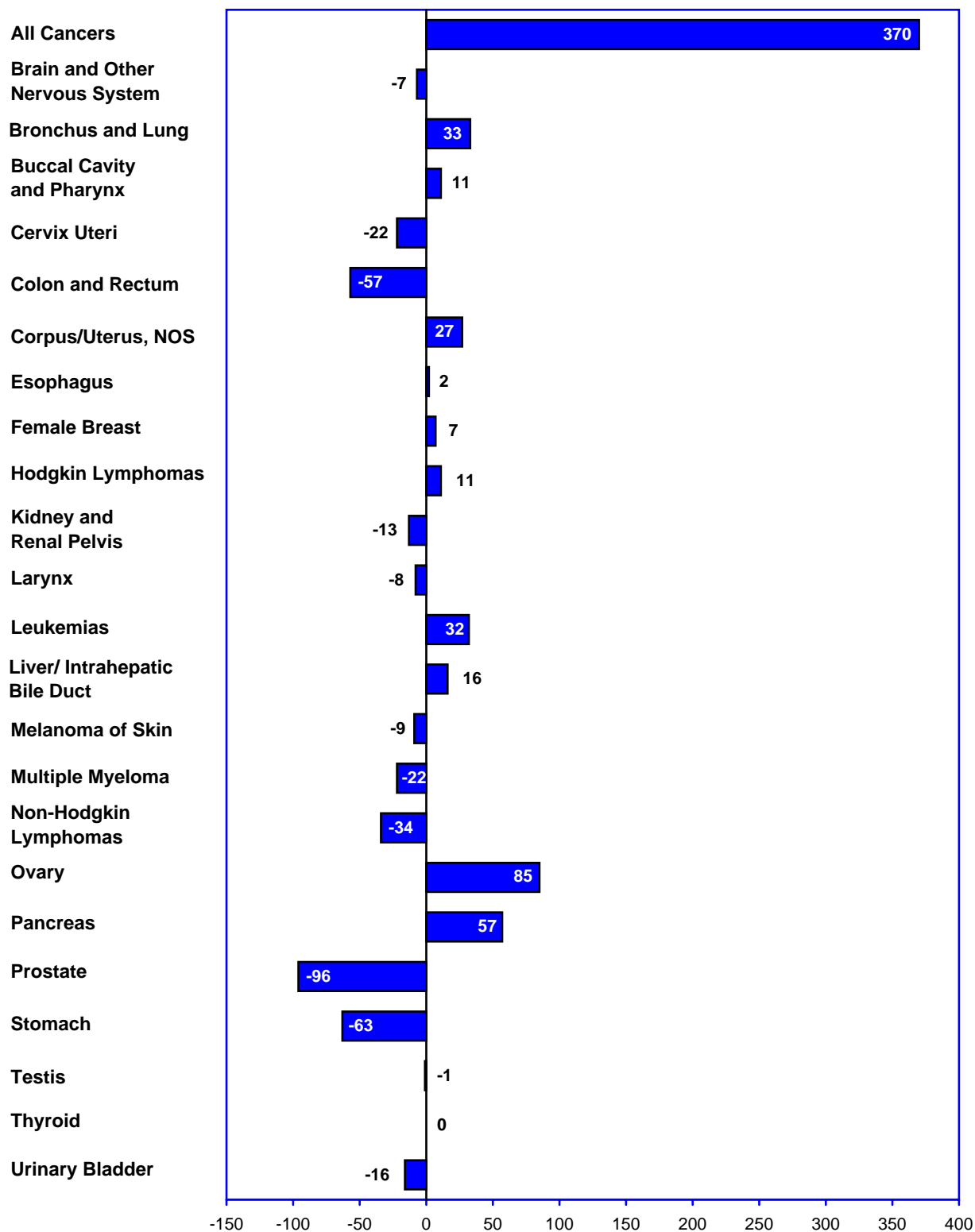
2004 Projected and 2002 Observed Cancer Deaths, Pennsylvania Residents Percent Change 2002 to 2004, All Cancers and 23 Selected Sites by Sex

Cancer Site	ALL DEATHS			MALES			FEMALES		
	2004 Projected	2002 Observed	Percent Change	2004 Projected	2002 Observed	Percent Change	2004 Projected	2002 Observed	Percent Change
All Cancers	29,830 *	29,460	1.3	14,785	14,928	-1.0	14,700 *	14,532	1.2
Brain and Other Nervous System	550	557	-1.3	290	297	-2.4	275 *	260	5.8
Bronchus and Lung	8,020 *	7,987	0.4	4,415	4,486	-1.6	3,495	3,501	-0.2
Buccal Cavity/Pharynx	345 *	334	3.3	230 *	227	1.3	100	107	-6.5
Cervix Uteri	160	182	-12.1	-	-	-	160	182	-12.1
Colon and Rectum	3,140	3,197	-1.8	1,565	1,588	-1.4	1,580	1,609	-1.8
Corpus/Uterus, NOS	440	413	6.5	-	-	-	440	413	6.5
Esophagus	740	738	0.3	565	580	-2.6	165 *	158	4.4
Female Breast	2,295 *	2,288	0.3	-	-	-	2,295 *	2,288	0.3
Hodgkin Lymphomas	75 *	64	17.2	40 *	35	14.3	35 *	29	20.7
Kidney/Renal Pelvis	610 *	623	-2.1	365 *	359	1.7	265	264	0.4
Larynx	205 *	213	-3.8	160 *	169	-5.3	45 *	44	2.3
Leukemias	1,105 *	1,073	3.0	600 *	597	0.5	465	476	-2.3
Liver/ Intrahepatic Bile Duct	640	624	2.6	410	401	2.2	225 *	223	0.9
Melanoma of Skin	380 *	389	-2.3	230 *	224	2.7	175	165	6.1
Multiple Myeloma	520	542	-4.1	240	260	-7.7	290 *	282	2.8
Non-Hodgkin Lymphomas	1,145	1,179	-2.9	615	624	-1.4	530	555	-4.5
Ovary	860	775	11.0	-	-	-	860	775	11.0
Pancreas	1,640	1,583	3.6	785	763	2.9	860	820	4.9
Prostate	1,535	1,631	-5.9	1,535	1,631	-5.9	-	-	-
Stomach	530	593	-10.6	295	344	-14.2	235	249	-5.6
Testis	10	11	-9.1	10	11	-9.1	-	-	-
Thyroid	65 *	65	0.0	25 *	21	19.0	45 *	44	2.3
Urinary Bladder	710 *	726	-2.2	455	470	-3.2	265	256	3.5

NOTES: Males and females may not sum to the total due to independent analysis by sex and by total. Projections were rounded to the nearest whole five. Pennsylvania cancer primary site groupings match the primary site definitions used by the National Cancer Institute's SEER program.

* The arithmetic mean for the five-year period of 1998-2002 was used to estimate the number of cases. See Technical Notes for additional information.

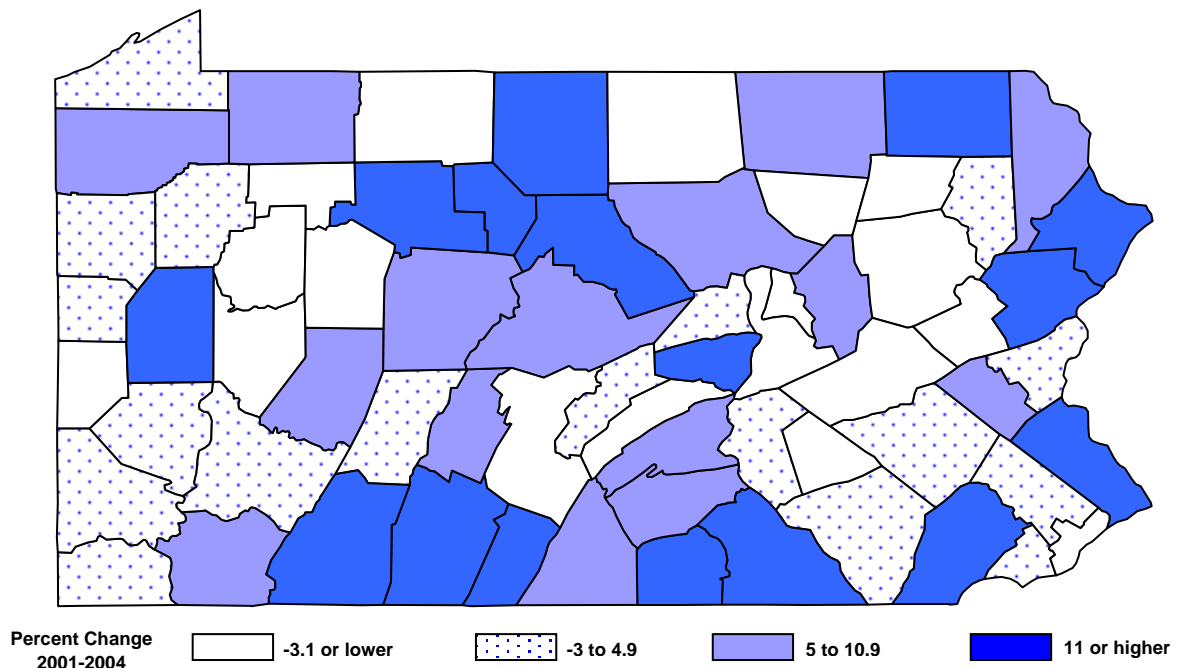
Expected Change in Number of Cancer Deaths, 2002 to 2004 All Cancers and 23 Selected Sites



NOTE: Pennsylvania cancer primary site groupings match the primary site definitions used by the National Cancer Institute's SEER program.

2004 Projected and 2001 Observed Invasive Cancer Cases ** Percent Change 2001 to 2004 by Pennsylvania County of Residence

County	2004 Projected	2001 Observed	Percent Change	County	2004 Projected	2001 Observed	Percent Change
ALL COUNTIES	75,375	72,645	3.8	JUNIATA	115 *	119	-3.4
ADAMS	555	465	19.4	LACKAWANNA	1,400 *	1,433	-2.3
ALLEGHENY	8,615	8,453	1.9	LANCASTER	2,505	2,420	3.5
ARMSTRONG	360	396	-9.1	LAWRENCE	585 *	574	1.9
BEAVER	1,125 *	1,187	-5.2	LEBANON	665 *	691	-3.8
BEDFORD	375	312	20.2	LEHIGH	1,900	1,788	6.3
BERKS	2,230	2,138	4.3	LUZERNE	2,030	2,107	-3.7
BLAIR	880	810	8.6	LYCOMING	795	727	9.4
BRADFORD	395	365	8.2	MCKEAN	220	237	-7.2
BUCKS	3,590	3,212	11.8	MERCER	860	822	4.6
BUTLER	1,125	1,004	12.1	MIFFLIN	320	306	4.6
CAMBRIA	1,065 *	1,088	-2.1	MONROE	880	773	13.8
CAMERON	45 *	39	15.4	MONTGOMERY	4,545	4,351	4.5
CARBON	385 *	400	-3.8	MONTOUR	110 *	115	-4.3
CENTRE	630	572	10.1	NORTHAMPTON	1,690	1,651	2.4
CHESTER	2,535	2,255	12.4	NORTHUMBERLAND	610 *	636	-4.1
CLARION	175	206	-15.0	PERRY	235	215	9.3
CLEARFIELD	565	515	9.7	PHILADELPHIA	8,330	8,642	-3.6
CLINTON	275	231	19.0	PIKE	320	246	30.1
COLUMBIA	400	368	8.7	POTTER	120	106	13.2
CRAWFORD	595	563	5.7	SCHUYLKILL	965	1,017	-5.1
CUMBERLAND	1,120	1,058	5.9	SNYDER	230	191	20.4
DAUPHIN	1,355	1,354	0.1	SOMERSET	575	477	20.5
DELAWARE	3,440	3,389	1.5	SULLIVAN	35	42	-16.7
ELK	270	235	14.9	SUSQUEHANNA	305	260	17.3
ERIE	1,620	1,567	3.4	TIOGA	235 *	253	-7.1
FAYETTE	1,120	1,023	9.5	UNION	195 *	186	4.8
FOREST	35	38	-7.9	VENANGO	310 *	311	-0.3
FRANKLIN	885	811	9.1	WARREN	280	259	8.1
FULTON	105	70	50.0	WASHINGTON	1,510	1,449	4.2
GREENE	225 *	221	1.8	WAYNE	395	374	5.6
HUNTINGDON	155	185	-16.2	WESTMORELAND	2,375	2,304	3.1
INDIANA	555	503	10.3	WYOMING	45	105	-57.1
JEFFERSON	285 *	299	-4.7	YORK	2,360	2,126	11.0



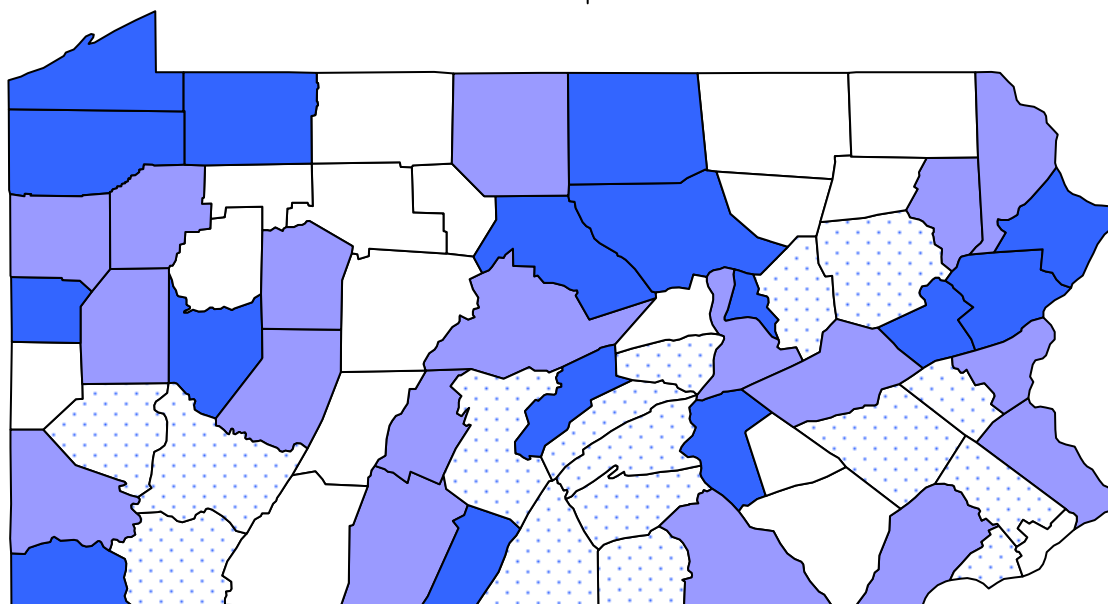
NOTE: Projections were rounded to the nearest whole five.

*The arithmetic mean for the five-year period of 1997-2001 was used to estimate the number of cases. See Technical Notes for additional information.

**All cancer cases staged as in situ, except for urinary bladder cancers, are excluded.

2004 Projected and 2002 Observed Cancer Deaths Percent Change 2002 to 2004 by Pennsylvania County of Residence

County	2004 Projected	2002 Observed	Percent Change	County	2004 Projected	2002 Observed	Percent Change
ALL COUNTIES	29,830 *	29,460	1.3	JUNIATA	55 *	56	-1.8
ADAMS	185 *	188	-1.6	LACKAWANNA	675	659	2.4
ALLEGHENY	3,470	3,472	-0.1	LANCASTER	965 *	1,008	-4.3
ARMSTRONG	205	182	12.6	LAWRENCE	255 *	241	5.8
BEAVER	460	491	-6.3	LEBANON	255	275	-7.3
BEDFORD	115 *	112	2.7	LEHIGH	725 *	729	-0.5
BERKS	870	874	-0.5	LUZERNE	825	846	-2.5
BLAIR	365	365	0.0	LYCOMING	270 *	240	12.5
BRADFORD	140 *	146	-4.1	MCKEAN	100	114	-12.3
BUCKS	1,210 *	1,194	1.3	MERCER	320 *	310	3.2
BUTLER	415	411	1.0	MIFFLIN	130	109	19.3
CAMBRIA	385	431	-10.7	MONROE	365	315	15.9
CAMERON	10	17	-41.2	MONTGOMERY	1,695 *	1,739	-2.5
CARBON	205	192	6.8	MONTOUR	45 *	35	28.6
CENTRE	205	201	2.0	NORTHAMPTON	600 *	589	1.9
CHESTER	890	856	4.0	NORTHUMBERLAND	265 *	256	3.5
CLARION	90 *	105	-14.3	PERRY	85 *	86	-1.2
CLEARFIELD	175	181	-3.3	PHILADELPHIA	3,595	3,788	-5.1
CLINTON	115	107	7.5	PIKE	100	89	12.4
COLUMBIA	135 *	136	-0.7	POTTER	55	53	3.8
CRAWFORD	220 *	211	4.3	SCHUYLKILL	430	429	0.2
CUMBERLAND	455 *	465	-2.2	SNYDER	75 *	77	-2.6
DAUPHIN	585	562	4.1	SOMERSET	190 *	196	-3.1
DELAWARE	1,285	1,290	-0.4	SULLIVAN	10	14	-28.6
ELK	70	82	-14.6	SUSQUEHANNA	90	95	-5.3
ERIE	695	652	6.6	TIOGA	100 *	87	14.9
FAYETTE	405 *	407	-0.5	UNION	60 *	62	-3.2
FOREST	10	12	-16.7	VENANGO	145 *	145	0.0
FRANKLIN	300	304	-1.3	WARREN	110 *	103	6.8
FULTON	25 *	17	47.1	WASHINGTON	580 *	558	3.9
GREENE	100 *	92	8.7	WAYNE	155	150	3.3
HUNTINGDON	100	101	-1.0	WESTMORELAND	975 *	977	-0.2
INDIANA	195 *	195	0.0	WYOMING	45	58	-22.4
JEFFERSON	115 *	115	0.0	YORK	825	806	2.4



Percent Change 2002-2004

-2.7 or lower	-2.6 to -0.1	0 to 4	4.1 or higher
---------------	--------------	--------	---------------

NOTE: Projections were rounded to the nearest whole five.

*The arithmetic mean for the five-year period of 1998-2002 was used to estimate the number of deaths. See Technical Notes for additional information.

American Cancer Society (ACS) Guidelines for Early Detection of Cancer in Asymptomatic People

CANCER SITE	RECOMMENDATION
General Cancer-Related Checkup	<p>It is important to have periodic general health examinations that include a specific cancer-related checkup. These checkups should include health counseling and, depending on a person's age, might include examinations for cancers of the thyroid, oral cavity, skin, lymph nodes, testes, and ovaries, as well as for some nonmalignant diseases. (The Pennsylvania Department of Health highly recommends a complete clinical skin examination every year.)</p>
Breast	<ul style="list-style-type: none">• Annual mammograms starting at age 40 and continuing as long as in good health• Clinical breast exam every 3 years for women ages 20-39; every year starting at age 40• Report breast changes promptly to health care provider; start breast self-exams in 20s• Women at increased risk (e.g., family history, genetic tendency, past breast cancer) should talk with their doctors about the benefits and limitations of starting mammography screening earlier, having additional tests or having more frequent exams.
Colon and Rectum	<p>Beginning at age 50, men and women should follow <i>one</i> of the exam schedules below:</p> <ol style="list-style-type: none">1. Fecal occult blood test (FOBT) every year2. Flexible sigmoidoscopy (FSIG) every 5 years3. Annual FOBT and flexible sigmoidoscopy every 5 years*4. Double-contrast barium enema every 5 years5. Colonoscopy every 10 years <p>* Combined testing is preferred over either annual FOBT or FSIG every 5 years. People at moderate or high risk for colorectal cancer should talk with a doctor about a different testing schedule.</p>
Prostate	<p>The ACS recommends that both the Prostate-Specific Antigen (PSA) blood test and the digital rectal exam be offered annually, beginning at age 50, to men who have a life expectancy of at least 10 years. Men at high risk (blacks and men who have a first-degree relative who was diagnosed with prostate cancer at an early age) should begin testing at age 45. Patients should be given information about the benefits and limitations of early detection and treatment so they can make an informed decision.</p> <p>(The Pennsylvania Department of Health is neither for nor against prostate cancer screening but encourages men to discuss the issue with their physician.)</p>
Uterus	<p>Cervix: All women who are or have been sexually active for approximately three years or who are 21 and older should have an annual regular Pap test or a liquid-based test every two years. At or after age 30, those who have three normal tests in a row can be screened every 2-3 years but doctors may screen more often if certain risk factors exist. Women aged 70+ with three or more normal Pap tests in a row in last 10 years may choose to stop screening. Screening is not necessary after total hysterectomy unless surgery was for cervical cancer treatment.</p> <p>Endometrium: All women should report any unexpected bleeding or spotting to their physician. Beginning at age 35, women with or at risk for hereditary non-polyposis colon cancer should have an annual endometrial biopsy.</p>

Cancer Prevention and Control Section Initiatives of the Pennsylvania Department of Health

The Pennsylvania Department of Health's Cancer Prevention and Control Section and the Breast and Cervical Cancer Section support and fund many special cancer awareness, screening, and research initiatives. In addition, the Department's Cancer Prevention Consultants, located in District Offices throughout the state, provide public education programs on skin and colorectal cancer at the community level. Below are some highlights about specific initiatives undertaken by the Cancer Prevention Sections. If you want more information about these initiatives, call the Department's toll-free hotline at 1-877-PA-HEALTH.

Breast and Cervical Cancer Section

HealthyWoman Program: The Centers for Disease Control and Prevention (CDC), through the National Breast and Cervical Cancer Early Detection Program (NBCCEDP), provides federal funds to the Department for a statewide, comprehensive breast and cervical cancer screening program for women who are medically underserved. Through a system of healthcare providers, the HealthyWoman Program offers breast and cervical cancer screening to women with low to moderate income (at or below 250% of the federal poverty level), no insurance or limited insurance, and age 50-64. It also provides services to 40-49 year old women who have a problem that may be symptomatic of breast or cervical cancer. All HealthyWoman services are provided at no charge to eligible women. Services include: clinical breast examinations, education on breast self-examinations, mammograms, pelvic examinations, Pap tests, and follow-up diagnostics for abnormal results. The HealthyWoman Program also provides public and professional education, quality assurance, surveillance, monitoring, and evaluation activities. Now in its tenth year of funding, the HealthyWoman Program screens between 5,000-6,000 women each year, and more than 700 women have been diagnosed with cancer or a precancerous condition of the breast or cervix.

Breast and Cervical Cancer Prevention and Treatment Program: Pennsylvania's Breast and Cervical Cancer Prevention and Treatment (BCCPT) Program is a coordinated effort between the Departments of Public Welfare and Health. The Breast and Cervical Cancer Prevention and Treatment Program allows the Department of Public Welfare to provide full Medical Assistance treatment benefits to HealthyWoman Program-eligible women diagnosed with breast or cervical cancer or a precancerous condition. As a conduit to the Breast and Cervical Cancer Prevention and Treatment Program, the HealthyWoman Program determines eligibility and facilitates enrollment into treatment programs. To receive healthcare coverage through the Breast and Cervical Treatment Program, the client must be:

- Under the age of 65
- Diagnosed with breast or cervical cancer or a pre-cancerous condition of the breast or cervix
- Eligible and enrolled in the HealthyWoman Program
- United States citizen or eligible alien; and
- Resident of Pennsylvania with a Social Security number

When a woman is eligible for the BCCPT Program, coverage by medical assistance begins on the date of the diagnosis with breast or cervical cancer, or a precancerous condition of the breast or cervix. The coverage continues as long as the healthcare provider verifies the need for treatment of this condition.

Breast and Cervical Cancer Research Fund: In 1997, Act 7 was signed, which enabled individuals to contribute to breast and cervical cancer research by either donating a portion of their state income tax refund or contributing directly to the Department of Health. Since the beginning of the program, the Department has received over \$1,400,000 and has provided funding to thirty-seven Pennsylvania researchers at nine institutions for peer-reviewed studies to address breast and cervical cancer issues.

Colorectal Cancer: The Cancer Prevention and Control Section continues to provide funding to several Pennsylvania county and municipal health departments to implement colorectal cancer educational programs in the communities that they serve. Colorectal educational programs are targeting individuals aged 65 and older who have colorectal cancer screening provided through Medicare.

67 Women/67 Counties: Facing Breast Cancer in Pennsylvania: This educational display is the result of the partnership between the Department of Health and the Pennsylvania Breast Cancer Coalition (PBCC) designed to increase awareness of breast cancer and its impact on individuals and families and promote the need for early detection and treatment. The walk-through educational display depicts the stories of women from every county in Pennsylvania diagnosed with breast cancer. "67 Women/67 Counties" is displayed regularly in communities throughout the state.

Cancer Prevention and Control Section

With the Department of Health serving as catalyst, stakeholders from across the state came together to develop a new strategic plan for cancer prevention and control. The Pennsylvania Comprehensive Cancer Control Plan, created by the Pennsylvania Cancer Control Consortium (PAC3), was ratified in October 2003, and demonstrates the evolution from a cancer control plan for the Department to a five-year statewide cancer plan that is data driven and built upon public-private partnerships.

Continued on back page.....

Cancer Prevention and Control Section Initiatives (continued)

Colorectal Cancer: The Cancer Prevention and Control Section provides funding to six of the ten Pennsylvania county and municipal health departments to implement colorectal cancer educational programs in the communities that they serve. Colorectal educational programs are targeting individuals aged 65 and older who have colorectal cancer screening provided through Medicare.

Skin Cancer: The Cancer Prevention and Control Section continues to support skin cancer education to children and adults. The primary focus is on educating day care staff and families of children enrolled in day care. The Departments of Health and Public Welfare, Bureau of Child Day Care Services, have joined together to educate day care staff on sun safety practices. The Department's six Cancer Prevention Consultants conduct skin cancer education presentations in the communities that they serve. Cancer Prevention Consultants are available for on-site educational programs to day care staff, parents, and children, to work with the day care directors to develop sun safety policies, and to assist in measuring the effectiveness of the day care center interventions. Seven of the ten Pennsylvania county and municipal health departments also provide skin cancer education focusing on these same populations.

Prostate Cancer: A Joint Request for Applications (RFA) was issued by the Department's Heart Disease and Stroke Program and the Cancer Prevention and Control Section, to target Black males, age 35 and older, in specific selected counties to reduce stroke and prostate cancer. Applicants were encouraged

to be innovative and creative in their approach and focus efforts on community-based prevention. Critical to the RFA were the removal of barriers to patient education with regard to stroke and prostate cancer prevention, the fostering of compliance utilization of effective strategies to improve patient compliance, and effective evaluation measures to determine what works and why. Two new interventions that were selected through this competitive bid process will begin in January 2005.

Public Education and Awareness: During 2004, the Cancer Prevention and Control Section will continue to:

- Recruit new members for PAC3;
- Seek funding to support comprehensive cancer control activities in the implementation phase;
- Develop and build community-based partnerships via regional forums to promote regional cancer control;
- Establish a PAC3 Coordinating Office to be housed at the University of Pittsburgh Cancer Institute;
- Publish second edition of the book, "Helping People Cope: A Guide For Families Facing Cancer";
- Increase breast cancer awareness activities to reach older, low-income Pennsylvania women with no insurance or limited insurance;
- Conduct skin cancer/sun safety campaigns directed to parents of young children, to teenagers, and to outdoor workers; and
- Increase Pennsylvania's awareness of colorectal and prostate cancers.

REFERENCES

American Cancer Society. *Cancer Prevention & Early Detection Facts & Figures 2004*, Atlanta, GA: 2004.

Pennsylvania Department of Health. *An Analysis of Cancer Incidence in Pennsylvania Counties 1996-2000*, Harrisburg, PA: August 2003.

Pennsylvania Department of Health. *Cancer Facts and Figures Pennsylvania, 2003*, Harrisburg, PA: July 2003.

Pennsylvania Department of Health. *Pennsylvania Cancer Incidence and Mortality 2001*, Harrisburg, PA: July 2004.

Samuel B. Richmond. *Statistical Analysis*, Second Edition. Graduate School of Business, Columbia University: John Wiley and Sons, 1964.

World Health Organization. *ICD-O International Classification of Diseases for Oncology Second Edition*, Geneva. ISBN 92 4 1544147: 1990.

World Health Organization. *ICD-O International Classification of Diseases for Oncology Third Edition*, Geneva, Switzerland: 2000.

World Health Organization. *Manual of the International Statistical Classification of Diseases, Injuries, and Causes of Death*. Geneva: Ninth Revision. ISBN 92 4 154005 2: 1977.

World Health Organization, *International Statistical Classification of Diseases and Related Health Problems: Tenth Revision*. Geneva 1992.