



# *Minnesota Cancer Surveillance System NOTES*



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## **Cancer in Minnesota, 2003**

*Carin Perkins, Ph.D., MCSS Epidemiologist*

Minnesota cancer data for 2003 was submitted to the North American Association of Central Cancer Registries in December 2005 and met the highest quality standards (a gold certification) for completeness, timeliness, and accuracy. We are extremely grateful for the hard work of cancer registrars throughout the state and bordering areas that makes this achievement possible.

A total of 23,286 invasive cancers and in situ bladder cancers were diagnosed among Minnesota residents in 2003. The table (next page) shows data on the ten most commonly diagnosed cancers by gender. Information on less frequently diagnosed cancers and cancer mortality data for 2003 can be found on the MCSS website

<http://www.health.state.mn.us/divs/hpcd/cdee/mcss/index.html> in Minnesota Cancer Facts and Figures 2006, produced through a collaboration of the MCSS, the American Cancer Society Midwest Division, and the Minnesota Cancer Alliance. The Alliance is a broad-based coalition of public, private, and non-profit organizations dedicated to implementing the statewide comprehensive cancer control plan, Cancer Plan Minnesota. To find out more about this ongoing effort, visit <http://www.cancerplanmn.org>. The presentation "Minnesota's Cancer Burden: Are We Making Progress?" and other presentations and information from the 2006 Cancer Summit can be found at the Alliance web site under Summit 2006.

A few words about the APC: The average annual percent change in cancer rates, or APC, is a commonly used measure to summarize cancer trends. Statistically significant APCs are shown in the right-hand column of the table. The APC is the average percent change each year in the age-adjusted rate over the specified time period. If it is a negative number, the rate is decreasing; if it is a positive number, the rate is increasing. For example, the APC of +1.0% for non-Hodgkin lymphoma (NHL) in males means that the rate increased, on average, by about one percent each year from 1988 to 2003. If the APC is statistically significant and the change has been roughly constant from year to year, the APC is a good summary of the direction and magnitude of the trend.

Another statistical technique, JoinPoint regression, tests whether the change has been constant over time. For prostate and kidney cancers among males, breast cancer among females, and all cancer sites combined among both men and women, JoinPoint regression indicated that there was at least one significant change in the trend during the 16-year period. For these sites, only the APC during the most recent time period following the last change in trend is shown, and the time period is given in the table footnote.

Cancer trends in Minnesota: For the first time since MCSS was implemented, it appears that the overall cancer incidence rate may be stabilizing among both men and women. For men, the trend has not  
*(continued on next pg)*

**(Cancer in Minnesota, 2003: Continued from page 1)**

increased or decreased significantly since 1995, largely due to decreases in lung cancer and stabilization of prostate cancer incidence. For women, overall incidence was increasing by 1.2% each year from 1995 to 2001, but then stabilized, largely due to decreases in breast cancer incidence since 2001. Continued surveillance will indicate whether these changes are a temporary or a watershed in cancer incidence.

Three cancers are increasing significantly among both men and women: thyroid (APC +3.6% for both sexes combined), melanoma of the skin (+3.2%), and non-Hodgkin lymphoma (+1.1%). Colorectal cancer is decreasing significantly among both men and women (APC -1.2% for both sexes combined). Lung cancer is decreasing among males by 0.5% per year but is still increasing among women by 2.3% per year. Similar trends are seen nationally.

**Cancer disparities in Minnesota:** Over the five-year period 1999-2003, the overall incidence rate for American Indian men was slightly higher than among African American men, but the difference was not statistically significant, and both were significantly higher than other race/ethnic groups in the state. More detail on race/ethnic differences in cancer incidence and mortality can be found in *Minnesota Cancer Facts and Figures 2006*.

**Table: Ten Most Commonly Diagnosed Cancers by Gender, Minnesota, 2003**

	Cancer Incidence 2003†		Rate	APC‡
	No. of Cases	% of Cases		
<b>Males</b>				
Prostate	3,884	31.8	175.0	~
Lung and Bronchus	1,566	12.8	71.8	- 0.5%
Colon and Rectum	1,303	10.7	59.2	- 1.6%
Urinary Bladder	824	6.7	38.2	~
Non-Hodgkin Lymphoma	586	4.8	26.0	+ 1.0%
Kidney and Renal Pelvis	464	3.8	20.1	+ 5.1%
Melanoma of the Skin	464	3.8	20.0	+ 3.3%
Leukemia	427	3.5	19.2	~
Oral Cavity and Pharynx	330	2.5	14.1	- 2.3%
Pancreas	251	2.1	11.5	~
All Sites Combined	12,210	100.0	546.9	~
<b>Females</b>				
Breast	3,398	30.7	125.3	~
Lung and Bronchus	1,357	12.3	50.7	+ 2.3%
Colon and Rectum	1,220	11.0	42.7	- 0.9%
Uterus§	662	6.0	24.6	~
Non-Hodgkin Lymphoma	483	4.4	17.3	+ 1.2%
Melanoma of the Skin	438	4.0	16.5	+ 3.3%
Ovary	360	3.3	13.2	- 1.5%
Thyroid	314	2.8	12.0	+ 4.2%
Urinary Bladder	314	2.8	11.3	~
Leukemia	304	2.7	11.1	~
All Sites Combined	11,076	100.0	406.2	~

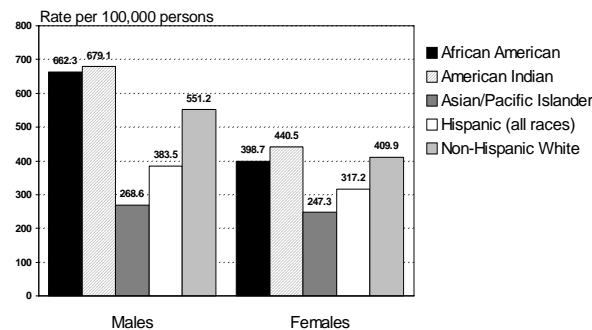
† *In situ* cancers except *in situ* bladder cancer were excluded. Cases were either microscopically confirmed or Death Certificate Only. Also excluded are histologies that were borderline malignant under ICD-O-2 but invasive under ICD-O-3, and those that were uncertain behavior under ICD-O-FT and ICD-O-3 but invasive under ICD-O-2. The incidence rate is per 100,000 persons, age-adjusted to the 2000 US population standard.

‡ APC is the average annual percent change in the age-adjusted rate during the period 1988-2003. Because of significant changes in trend, the APCs for prostate cancer and all cancer sites combined for males are for the period 1995-2003; the APC for kidney cancer among males is for the period 1998-2003; and the APCs for breast cancer and all cancer sites combined for females are for the period 2001-2003.

~ APC is not statistically significant ( $p \geq 0.05$ ).

§ Uterus includes Uterus, not otherwise specified.

**Cancer Incidence by Race/Ethnicity and Gender, Minnesota, 1999-2003**



Source: MCSS. Rates are age-adjusted to the 2000 U.S. population.

**MINNESOTA CANCER RESOURCES  
Web Site Launched**

The Minnesota Cancer Alliance recently launched [Minnesota Cancer Resources](#), the state's first Web site connecting cancer patients with local resources and services, no matter where they live in the state.

The Web site provides cancer patients, their caregivers and health care professionals with links to support groups, in-home and hospice services, as well as resources for transportation, symptom management and physical appearance. It also links to reputable sites that provide additional information about treatment options, pain management, clinical trials, childhood cancer and screening guidelines.

Please take a moment to visit the site and pass the link along to others who may be interested in this valuable resource. In addition, organizations can order free promotional materials, including brochures, magnets and table tents, by calling 507-266-9087. To receive PDF files of the promotional materials, contact:

[Elizabeth.Moe@health.state.mn.us](mailto:Elizabeth.Moe@health.state.mn.us)

# ONLINE RESOURCES

## **NATIONAL CANCER INSTITUTE (NCI)** [www.cancer.gov/](http://www.cancer.gov/)

A component of the National Institutes of Health (NIH), one of eight agencies that compose the Public Health Service (PHS) in the Department of Health and Human Services (DHHS). The NCI, established under the National Cancer Act of 1937, is the Federal Government's principal agency for cancer research and training.

### **Surveillance Research** <http://surveillance.cancer.gov/>

Provides numerous links to information about surveillance research and cancer statistics and much more.

### **SEER: Surveillance Epidemiology and End Results** <http://seer.cancer.gov/>

Provides information on cancer statistics to help reduce the burden of cancer on the U.S. population.

## **CENTERS FOR DISEASE CONTROL AND PREVENTION (CDC)** [www.cdc.gov/](http://www.cdc.gov/)

The Centers for Disease Control and Prevention (CDC) is a leader in nationwide efforts to ease the burden of cancer.

### **Cancer Prevention and Control** <http://www.cdc.gov/cancer/>

Through the Division of Cancer Prevention and Control, CDC works with national cancer organizations, state health agencies, and other key groups to develop, implement, and promote effective strategies for preventing and controlling cancer.

### **National Program of Cancer Registries** <http://www.cdc.gov/cancer/npcr/>

Data collected by state cancer registries enable public health professionals to understand and address the cancer burden more effectively. CDC provides support for states to maintain registries that provide high-quality data.

## **AMERICAN COLLEGE OF SURGEONS (ACS)** [www.facs.org/](http://www.facs.org/)

The American College of Surgeons is a scientific and educational association of surgeons that was founded in 1913 to improve the quality of care for the surgical patient by setting high standards for surgical education and practice.

### **Commission on Cancer (CoC)** <http://www.facs.org/cancer/index.html>

The Commission on Cancer is a consortium of professional organizations dedicated to improving survival and quality of life for cancer patients through standard setting, prevention, research, education, and the monitoring of comprehensive quality care.

### **Inquiry and Response System** <http://web.facs.org/coc/default.htm>

The Inquiry and Response System (I & R) is a resource available to all cancer care professionals. It is a repository of thousands of questions and answers related to data and cancer program standards developed by the American College of Surgeons Commission on Cancer (CoC) and the American Joint Committee on Cancer (AJCC).

## **NATIONAL COMPREHENSIVE CANCER NETWORK (NCCN)** <http://www.nccn.org/>

The National Comprehensive Cancer Network (NCCN), a not-for-profit alliance of 20 of the world's leading cancer centers, is dedicated to improving the quality and effectiveness of care provided to patients with cancer. The primary goal of all NCCN initiatives is to improve the quality, effectiveness, and efficiency of oncology practice so patients can live better lives.

### **Cancer Resource Links on the Web** [http://www.nccn.org/professionals/reference\\_links.asp](http://www.nccn.org/professionals/reference_links.asp)

Includes Cancer Library, Clinical Trials, Complementary & Alternative Medicine, Financial Assistance, General Cancer Information/Support Organizations, Government Agencies, Hospice Care, International/Cultural Support Groups, Travel Assistance, Cancer Support Organizations by Site, and Professional Organizations.

## **MINNESOTA CANCER ALLIANCE** [http://www.cancerplanmn.org/The\\_Minnesota\\_Cancer\\_Alliance.html](http://www.cancerplanmn.org/The_Minnesota_Cancer_Alliance.html)

The Minnesota Cancer Alliance is a coalition of health care organizations, community-based groups and volunteers that evolved from collaborative efforts to create Cancer Plan Minnesota. Founded in 2005, the Alliance was formed to support and implement the plan.

### **Cancer Plan MN** <http://www.cancerplanmn.org/draft.html>

A comprehensive cancer control plan created to reduce the cancer burden among all Minnesotans.



**The Minnesota Cancer Surveillance System (MCSS)** is the state's cancer registry. It is an ongoing program within the Section of Chronic Disease and Environmental Epidemiology at the Minnesota Department of Health (MDH).

**STAFFING UPDATE**

The MCSS has continued to experience staffing changes during the past several months.

\*\*Kristi Randall, MCSS Notes editor, resigned in April to accept a position closer to her home. This was the reason no June issue of the MCSS Notes was published.

\*\*Jane E. Braun, M.S., C.T.R., MCSS Assistant Director for Operations for 12 1/2 years, resigned in May to become the Deputy Director of the MDH Office of Emergency Preparedness. We were not happy to see Jane leave us but are confident that MDH will now be better prepared for emergencies.

\*\*Patty Jaclyn-Doty, RHIT, began work with the MCSS on May 10 as a Medical Records Technician. Welcome, Patty!

\*\*Cheryl Korpela, RHIT, MCSS Medical Records Technician for 4 1/2 years, resigned at the end of May to work in a hospital cancer registry. We are comforted in our loss by the fact that the registry has hired such a competent person.

\*\*Lynell Hage began work on July 6 as temporary "MCSS Administrative Everything" (not her official title), which includes editing the MCSS Notes. We are very glad to have her expert help until we can fill the position permanently.

\*\*Pat Thoreson, RHIT, began work with the MCSS on August 21 as a Medical Records Technician. Welcome, Pat!

\*\*Brenda Holden begins work on September 12 as MCSS Assistant Director for Operations. Brenda comes to us from the Cancer Control Section of the MDH; before that she was the Executive Director of the MDH Health Technology Advisory Committee. We are thrilled to have Brenda join us. When you meet her, please welcome her, too.

\*\*Both of our final candidates for the MCSS Assistant Director for Information Management accepted other positions, so we re-opened the position and are again interviewing candidates.

**MCSS Notes**

*MCSS Notes* is published quarterly by the Minnesota Department of Health, Minnesota Cancer Surveillance System (MCSS), in cooperation with the Minnesota Society of Pathologists (MSP). Upon request, this information will be made available in alternate format, such as large print, Braille, or cassette.

Dianne Mandernach,  
Commissioner of Health

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- Sept 28, 2006**, 6-8 pm
  - Sept 30, 2006**, 9-11am
  - Oct 12, 2006**, 6-8pm
  - Nov 2, 2006**, 6-8pm
  - Nov 4, 2006**, 9-11 am
- University of MN  
Minneapolis, MN

**Cancer U: Ask the Experts Series**

Offered to provide cancer patients, survivors, caregivers, and others interested in learning more about cancer an opportunity to get accurate information about cancer from University cancer researchers and physicians.

*Prostate Cancer: Advances in Research and Treatment (Sept)*

*Women & Cancer: Advances in Research and Treatment (Oct)*

*Lung Cancer: Advances in Research and Treatment (Nov)*

Please check the web site for locations and more information:

<http://www.cancer.umn.edu/outreach/canceru/index.html>

- Oct 12, 2006**
- Dec 14, 2006**
- Jan 11, 2007**
- Feb 8, 2007**
- March 8, 2007**
- May 10, 2007**
- June 14, 2007**
- Sep 13, 2007**

**»»»»»»»»»»NAACCR Webinar Series««««««««««**

The Minnesota Cancer Surveillance System will be sponsoring a series of 8 webinars for Hospital Registrars and Cancer Reporters beginning in Oct, 2006. Each webinar will address cancer data collection for a specific site and will include information on anatomy, multiple primary and histology coding rules, collaborative staging, and treatment data items as required by the American College of Surgeons Commission on Cancer. These will be offered in 3 locations simultaneously to minimize travel distances.

For locations, time and more details visit:

<http://www.health.state.mn.us/divs/hpcd/cdee/mcss/webinars.html>

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