

**Cancer Is the New Leading Cause of Death in Minnesota as Deaths From Heart Disease Decrease**

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For the first time in 2000 and again in 2001, more Minnesotans died of cancer than of heart disease, making cancer the leading cause of death in Minnesota. Cancer accounted for 24 percent of all deaths in Minnesota in 2001, compared to the 23 percent of deaths attributed to heart disease. Nationally, heart disease remained the leading cause of death, accounting for 29 percent of all deaths in 2001 (Table 1).

Table 1: Heart Disease and Cancer Mortality, 2001

	Minnesota			United States		
	Deaths	Percent	Rate <sup>1</sup>	Deaths	Percent	Rate
Heart Disease	8,760	23.2%	175.7	700,142	29.0%	247.8
Cancer	8,967	23.8%	183.1	553,768	22.9%	196.0
All Deaths	37,735	100%	744.9	2,416,425	100%	854.5

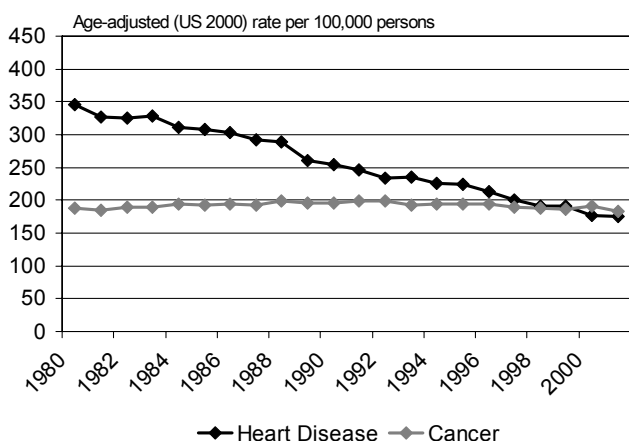
Source: National Vital Statistics Report (NVSS), Vol. 52, No. 3, September 18, 2003. Deaths: Final Data for 2001.

<sup>1</sup> Rates are per 100,000 persons and are age-adjusted to the 2000 US population.

Heart disease is defined as deaths with ICD-10 codes (I00-I09,I11,I13,I20-I51) as the underlying cause of death. Cancer is defined as ICD-10 codes C00-C97. Heart Disease does not include deaths due to hypertension, stroke, and other diseases of the circulatory system. All cardiovascular diseases combined accounted for about 34 percent of deaths in Minnesota.

Cancer has become the leading cause of death in Minnesota primarily because the heart disease mortality rate decreased by 40 percent from 1988 to 2000, while cancer mortality decreased by only 4 percent (Figure 1). Cancer is likely to remain the leading cause of death in Minnesota, as preliminary mortality data indicate that cancer surpassed heart disease by an even larger margin in Minnesota in 2002.

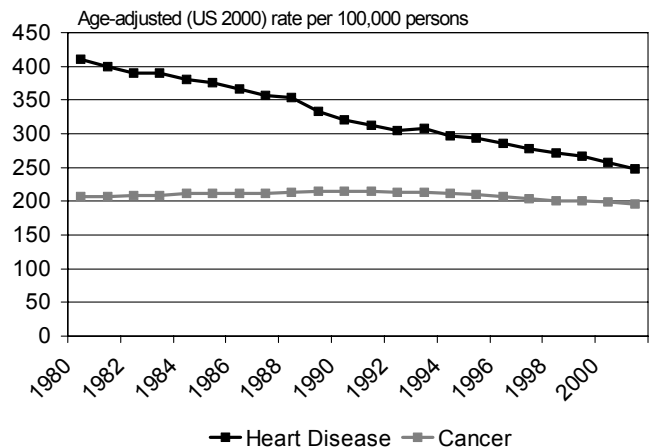
Figure 1: Heart Disease and Cancer Mortality, Minnesota, 1980-2001



Source: NCHS public use all cause mortality databases with state as provided to the SEER program. Data for 2001 are from NVSS Vol. 52(3), September 18, 2003.

Minnesota was the first state in which cancer became the leading cause of death, although other states recently have reported similar trends. The crossover between cancer and heart disease mortality occurred earlier in Minnesota than in other states because the age-adjusted heart disease mortality rate is approximately 30 percent lower in Minnesota than in the United States overall, whereas the cancer mortality rate is only 7 percent lower in Minnesota. Minnesota had the lowest heart disease mortality rate in the U.S. in 2000 and 2001. The three states with the next lowest age-adjusted heart disease mortality rates in 2001 (Hawaii, 179.5 deaths per 100,000 population; Colorado, 181.0; Utah, 185.2) had considerably lower cancer mortality rates (Hawaii, 155.9 deaths per 100,000 population; Colorado, 181.0; Utah, 143.4) than Minnesota. Given that mortality rates for heart disease are decreasing at a faster rate than those for cancer in most of the United States, it is likely that cancer eventually will become the leading cause of death nationally (Figure 2).

Figure 2: Heart Disease and Cancer Mortality, United States, 1980-2001



Source: NCHS public use all cause mortality databases with state as provided to the SEER program. Data for 2001 are from NVSS Vol. 52(3), September 18, 2003.

**COLLECTION OF RACE DATA**

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A major focus of the Minnesota Department of Health is to eliminate disparities in health status. Cancer is one area where marked differences in incidence and mortality by race exist. Accurate race data are needed to identify disparities and to measure progress in reducing them; data for “other” and “unknown” races do not contribute to this effort.

Several years ago, the collection of data on patients’ race was discouraged because of concerns that biases on the part of health care providers could lead to substandard care. In recent years, these concerns have been replaced with a desire to have complete and accurate surveillance data for control of many diseases, including cancer. Organizations (continued on back side)

## MCSS NOTES

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. Available electronically at:

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

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### COLLECTION OF RACE DATA (continued)

representing American Indians and people of color in Minnesota have endorsed the MCSS's (Minnesota Cancer Surveillance System) efforts to provide cancer rates by race. We cannot provide these data if health care providers do not collect race data and report them to us.

Ideally, race should be collected in the same manner as the denominator used for calculating cancer incidence and mortality rates, i.e. census data. It is important that race(s) be self-identified rather than determined by staff at the facility. Cancer records have room for up to five race codes. The suggested method for collecting these data is to ask, "What race(s) do you consider yourself?" and to provide five lines or multiple check boxes for the patient's reply. A brief explanation of the need for accurate data and the facility's nondiscrimination policy are also recommended.

We urge registrars, physicians, and administrators to implement policies in patient registration areas to collect complete and accurate race data, and to report these data to the Minnesota Department of Health for all reportable diseases, including cancer.

### MINNESOTA CANCER SUMMIT

On Tuesday, November 16<sup>th</sup>, Cancer Plan Minnesota will hold its 2<sup>nd</sup> Minnesota Cancer Summit at the Radisson Riverfront in Saint Paul. This day-long event will be an opportunity to engage in the discussion about our state's efforts to reduce the burden of cancer for all Minnesotans.

Over the past decade, the significant growth of cancer prevention and control programs within health agencies has made it clear that improved integration

and coordination of cancer control activities is essential to maximize resources and achieve desired cancer control outcomes. As a result, the U.S. Centers for Disease Control provided funding for the creation of state-based comprehensive cancer control programs. The goal is to create effective frameworks for collective efforts aimed at reducing the burden of cancer throughout our country.

In Minnesota, a 32 member Steering Committee, chaired by Dr. Brian Rank, has guided the initiative over the past year and a half and overseen the activity of the initiative's five work groups: Prevention, Detection, Treatment, Survivorship and Palliation. In addition, cross-cutting committees have examined cancer disparities, genomics and data issues. The draft objectives and strategies proposed by these groups will be presented at the Summit, and participants will have an opportunity to provide comments and feedback that will be used to complete the final draft of Minnesota's cancer plan.

The keynote address will be delivered by Dr. Dileep Bal, Chief of the Cancer Control Branch at the California Department of Health and former National President of the American Cancer Society. His remarks will focus on the California experience and how the lessons learned may be applicable to other states. Additional information on the Summit can be obtained from [matt.flory@cancer.org](mailto:matt.flory@cancer.org).

### CANCER REGISTRIES

All cases diagnosed in 2003 should have been submitted to the MCSS. If your registry still has outstanding cases, please work with your software vendor to facilitate the transmission of these cases as soon as possible.