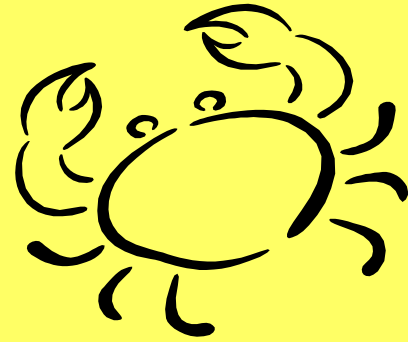


Cancer in Utah

1981-2000



Utah Cancer Registry
and
Utah Department of Health

Cancer In Utah

1981-2000

Cancer in Utah

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Acknowledgements

Cancer surveillance in Utah is made possible by the collaborative efforts of local health care providers, administrators, and cancer registrars. Special thanks go to those individuals and facilities listed in the table below. The Utah Cancer Registry also recognizes the support of our many colleagues in the Utah Comprehensive Cancer Control Initiative.

We want to take this opportunity to gratefully recognize the staff members of the Utah Cancer Registry, past and present, for their many contributions to the success of our organization. Thanks, as well, to our mentors, advisors, and colleagues at the University of Utah.

Finally, the Utah Cancer Registry is proud to be a member of the Surveillance, Epidemiology, and End Results Program. The Utah Cancer Registry is supported by National Cancer Institute Contract No. N01-PC-67000.

Cancer Registrars		
Alta View Hospital Lisa Orr, CTR	American Fork Community Hospital Lisa Orr, CTR	Dixie Medical Center Jodie Barden, CTR Karen Young, CTR
Cottonwood Hospital Medical Center Anne Bradley Vicki Schroeffer, CTR	LDS Hospital Heather Cheney Carol Koehler, CTR Gwen Shepherd, CTR	Logan Regional Medical Center Shirley Prescott
McKay-Dee Hospital Center Barbara Felt, CTR Jennifer McBride Kimberly Story	Ogden Regional Medical Center Alisa Cosper, RHIT, CTR	Primary Children's Medical Center Melissa Billingsley
St. Mark's Hospital Jacque Clarcken	University Health Sciences Center Heidi Clark, RHIT Jeanalda McCrom Sandra Reay, CTR Cher Smouse, CMA Jennifer Smith	Utah Valley Regional Medical Center Sandra Lynch, CTR Lynnel Rhodes, CTR
Veteran's Administration Medical Center Carrie Briscoe, CTR		
Health Care Facilities		
<ul style="list-style-type: none"> • 75th Medical Group (AFMC) • Allen Memorial Hospital • Alta View Hospital • American Fork Community Hospital • Ashley Valley Medical Center • Bear River Valley Hospital • Beaver Valley Hospital • Brigham City Community Hospital • Cache Valley Specialty Hospital • Castlevue Hospital • Central Valley Medical Center • Cottonwood Hospital Medical Center • Davis Hospital and Medical Center • Delta Community Medical Center • Dixie Medical Center 	<ul style="list-style-type: none"> • Fillmore Community Medical Center • Garfield Memorial Hospital • Gunnison Valley Hospital • Heber Valley Medical Center • Jordan Valley Hospital • Kane County Hospital • Lakeview Hospital • LDS Hospital • Logan Regional Medical Center • McKay-Dee Hospital Center • Milford Valley Memorial Hospital • Montezuma Creek Health Center • Mountain View Hospital • Ogden Regional Medical Center • Orem Community Hospital • Pioneer Valley Hospital 	<ul style="list-style-type: none"> • Primary Children's Medical Center • Salt Lake Regional Medical Center • San Juan County Hospital • Sanpete Valley Hospital • Sevier Valley Hospital • Shriner's Hospital • St. Mark's Hospital • Timpanogos Regional Hospital • Tooele Regional Medical Center • Uintah Basin Medical Center • University Health Sciences Center • Utah Valley Regional Medical Center • Valley View Medical Center • Veteran's Administration Medical Center

Cancer in Utah

Introduction

The Utah Cancer Registry is a population-based, central cancer registry that has served the State of Utah for 35 years. Cancer was first designated as a reportable disease in Utah in 1948. However, systematic cancer surveillance was not conducted in the state until 1966. That year, Charles Smart, M.D., a prominent surgeon from LDS Hospital in Salt Lake City, founded the Registry under the auspices of the Regional Medical Program. In 1973, the Utah Cancer Registry became one of the original members of the National Cancer Institute's Surveillance, Epidemiology, and End Results (SEER) Program. The Registry has continuously participated in the SEER program since that time.

Cancer is presently designated as a reportable disease in the State of Utah (Cancer Reporting Rule, R384-100). As such, all cases of cancer diagnosed or treated in the state must be reported to the Utah Department of Health. Through a letter of agreement between the Utah Department of Health and the University of Utah, the Utah Cancer Registry is designated as the official repository for such data.

Utah Cancer Registry staff members and cancer registrars at local health care facilities identify incident cases of cancer through routine and systematic review of pathology reports, medical records, radiation therapy records, hospital discharge lists, and vital records. Information regarding patient characteristics, cancer diagnosis, and treatment is ascertained primarily from specific statements in the medical record and other sources such as death certificates. Cancer surveillance in Utah is conducted in accordance with standards promulgated by the SEER Program [1, 2] and the North American Association of Central Cancer Registries [3].

This monograph provides a comprehensive review of cancer statistics for the State of Utah for the time period 1981-2000. Nationwide data are also presented for comparison purposes. Incidence rates, mortality rates, risk of developing cancer, survivorship, and stage of disease at diagnosis were calculated from both local and national data sources according to methods summarized in the following section. Additional information may be obtained from the Utah Cancer Registry's web site, <http://www.uuhsc.utah.edu/ucr> or by contacting the Registry at (801) 581-8407.

Cancer in Utah

Methods

Sources of data

Information on all incident cancer cases diagnosed among Utah residents during the period 1981-2000 was provided by the Utah Cancer Registry. This information was used to calculate incidence rates, estimate risk of developing specific types of cancer, calculate survival times, and construct tables according to stage of disease at diagnosis. Comparison data for the United States were obtained from the Surveillance, Epidemiology, and End Results (SEER) Program of the National Cancer Institute [1, 4]. SEER Program data were from nine geographic areas that, together, represented approximately 14 percent of the United States population. At the time of this writing, nationwide data were only available through calendar year 1999.

Information on cancer-related deaths for calculating mortality rates for Utah, 1981-2000, was provided by the Utah Department of Health's Office of Vital Records and Statistics. Comparison mortality data for the United States, 1981-1999, was provided by the National Center for Health Statistics.

Population estimates for calculating incidence and mortality rates in Utah were provided by the Governor's Office of Planning and Budget, State of Utah. Population estimates for nationwide rate calculations were provided by the United States Bureau of the Census.

Information on cancer-related screening behaviors (i.e., mammography, Pap tests, prostate specific antigen tests) and tobacco use were ascertained from the Utah Behavioral Risk Factor Surveillance System. This annual survey is conducted in Utah and other states with funds provided by the Centers for Disease Control and Prevention.

Cancer Primary Site/Type

For the purposes of this monograph, cancers were grouped into the site/type categories defined in Appendix 1. These categories were based on primary cancer site and/or histological type, and are consistent with standard reports of cancer as published by the National Cancer Institute [5].

Methods

Incidence and Mortality Rates

Age-adjusted incidence and mortality rates were calculated by the direct method [6], and were standardized to the age distribution of the 2000 United States population. Confidence intervals for age-adjusted rates were calculated according to the methods of Fay and Feuer [7]. Age-specific incidence and mortality rates were calculated for the following ten-year intervals (i.e., years of age at cancer diagnosis or death, respectively): 00-09, 10-19, 20-29, 30-39, 40-49, 50-59, 60-69, 70-79, 80+). Confidence intervals for age-specific rates were calculated by exact methods, as discussed in [8]. All incidence rates were calculated with the SEER*Stat software system [9] and are expressed per 100,000 person-years.

Risk of Developing a Specific Type of Cancer

As utilized for the purposes of this monograph, “cumulative incidence” provides an estimate of the risk of developing a specified cancer from birth until 79 years of age [10]. For example, if the age-specific, colorectal cancer incidence rates observed during the period 1996-2000 are applied to a hypothetical cohort of newborn boys in Utah, we would expect that one in 21 would develop colorectal cancer by the time they reach 79 years of age (see Summary section on page 25 of this monograph).

A number of limitations should be considered when interpreting the cumulative incidence as a measure of risk. First, it is unlikely that the present incidence rates will remain unchanged over the entire lifetime of a person born today. Second, the cumulative incidence does not account for variation in risk factors among individuals. For example, the risk of lung cancer would be much higher for a person who smokes three packages of cigarettes per day than for a non-smoker, yet the cumulative incidence assumes that everyone in the hypothetical population is at equal risk. Finally, the risk estimates presented in this monograph were not adjusted for competing causes of death and may, therefore, overestimate the true risk of developing a specific type of cancer. Nonetheless, the cumulative incidence provides a measure of disease burden that is readily interpretable for health professionals and the lay public. We urge caution in interpreting these figures.

Methods

Nationwide Number of Incident Cancer Cases and Cancer-Related Deaths

At present, there is no nationwide system of cancer surveillance to enumerate incident cases of cancer diagnosed in the United States. For this reason, we applied age-specific incidence rates from the SEER Program for the period 1996-1999 to estimates of the United States resident population for the same period to calculate the average annual number of incident cancer cases that were diagnosed nationwide during that period.

In contrast, the National Center for Health Statistics oversees a program of death certification that provides reasonably accurate estimates of the number of cancer-related deaths nationwide. The average annual number of deaths reported herein was based on cancer-related deaths reported to the National Center for Health Statistics during the period 1996-99.

Stage of Disease at Diagnosis

The summary stage of disease at diagnosis was coded according to guidelines of the National Cancer Institute's SEER Program. For most cancers, the stage of disease at diagnosis may be roughly summarized as follows:

- LOCAL A tumor that is invasive but is still restricted to the site of origin;
- REGIONAL A tumor that has spread by direct extension to immediately adjacent organs or tissues and/or metastasized to regional lymph nodes and appears to have spread no further;
- DISTANT A tumor that has spread by direct extension beyond the immediately adjacent organs or tissues, and/or metastasized to distant lymph nodes or other distant tissues;
- UNKNOWN Insufficient information was available to determine the stage of disease at diagnosis.

With the exception of cancers of the urinary bladder, all cancer sites/types presented in this monograph were restricted to cases with local, regional, distant, or unknown stages at diagnosis (i.e., in situ cases were excluded). In accordance with prevailing conventions for cancer reporting, both in situ and localized tumors of the urinary bladder were combined and reported as "localized" tumors for the purposes of this monograph.

Methods

Relative Survival

Relative survival provides an estimate of the proportion of patients surviving at annual intervals following their initial diagnosis of cancer, after adjusting for competing causes of death [11]. In this monograph, one-year intervals of survival are plotted in graphs while five-year survival figures are reported in tables.

Readers are cautioned that the relative survival figures presented in this monograph are somewhat crude measures of survival. An individual's survival from cancer is determined by many factors including age, treatment, and other characteristics that are not accounted for in this analysis. Therefore, these figures should not be interpreted as the probability of survival from cancer for a single individual.

Cancer in Utah

Methods

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Cancer in Utah

Oral Cavity & Pharynx

<i>Summary</i>	Male		Female	
	Utah 1996-2000	US 1996-99	Utah 1996-2000	US 1996-99
Average annual age-adjusted incidence rates*	12.7	16.7	5.1	6.7
Rank among cancer incidence rates	7	6	13	13
Average annual number of new cases	89	19,700	42	9,840
Percent of all new cancer cases	2.7 %	3.1 %	1.5 %	1.6 %
Lifetime risk of this cancer (00-79 years)	1 in 85	1 in 59	1 in 191	1 in 146
Average annual age-adjusted mortality rates*	2.7	4.5	1.0	1.7
Rank among cancer mortality rates	16	13	18	18
Average annual number of deaths	18	5,160	8	2,640
Percent of all cancer deaths	1.5	1.8	0.8	1.02
* Rates per 100,000 and standardized to the 2000 U.S. population				

Cancers of the oral cavity and pharynx account for less than three percent of all cancers. These tumors are primarily squamous cell carcinomas and occur most commonly on the tongue, lip, and floor of the mouth. Other sites include the soft palate, tonsils, salivary glands, and back of the throat (oral pharynx). Incidence rates for cancers of the oral cavity and pharynx, as a group, declined during the period 1981-2000.

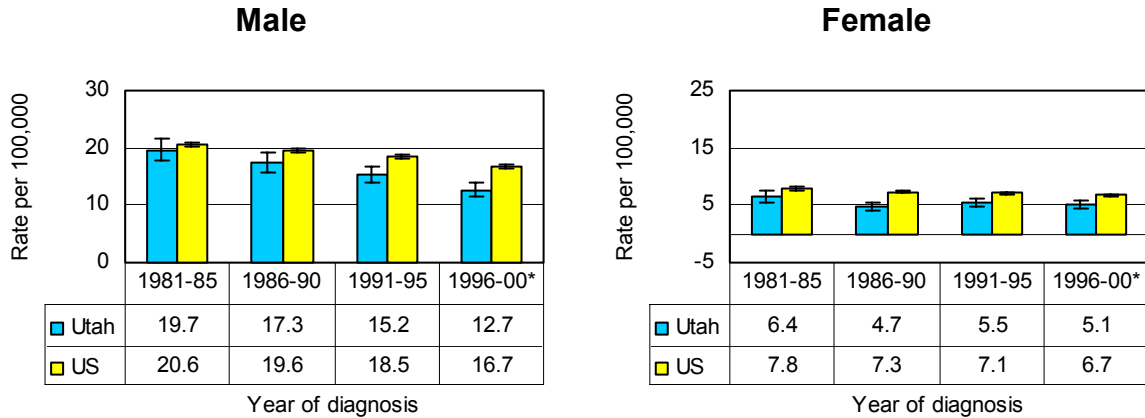
Most oral and pharyngeal tumors in the United States are caused by tobacco and alcohol consumption. Smoking accounts for most of the oral cancers, but chewing and snuff dipping also cause this disease. There is evidence that combined exposure to both alcohol and tobacco increases the risk beyond that which would be expected by simply adding together the separate effects of each exposure. Current evidence suggests that individuals who frequently consume fresh fruits and vegetables are at reduced risk of this disease.

The most important preventive measures for cancers of the oral cavity and pharynx are to avoid exposure to tobacco products and to use alcohol only in moderation. Approximately one-half of all individuals with these tumors are diagnosed at advanced stages and these patients have the worst prognosis. The efficacy of screening for oral cancers has not been adequately evaluated, but examination of the oral cavity for neoplasms could be accomplished at minimal cost during routine dental care and might be beneficial.

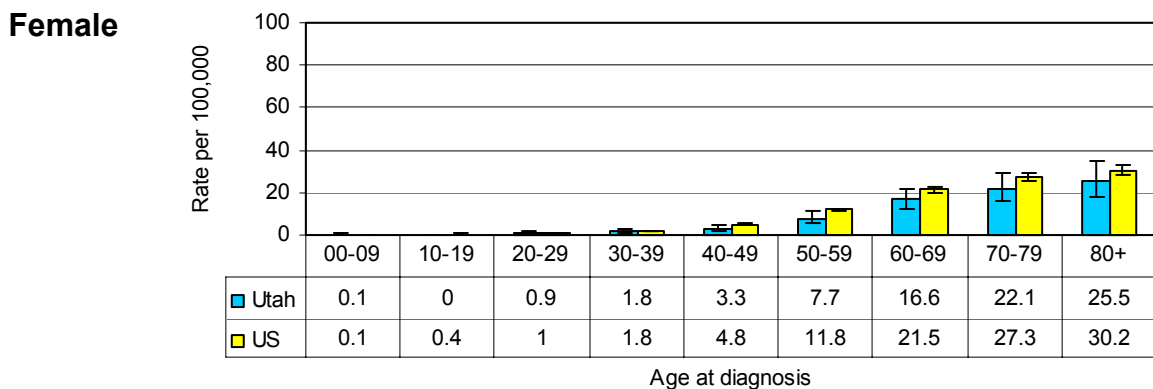
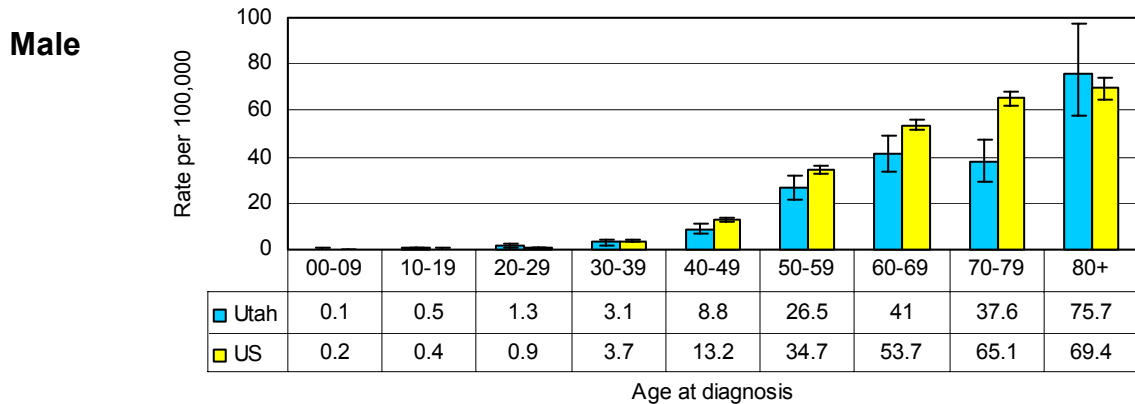
Cancer in Utah

Oral Cavity & Pharynx	Incidence
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Average annual age-adjusted incidence rates per 100,000 (US 2000 standard) by 5-year time period and sex, 1981-2000



Average annual age-specific incidence rates per 100,000 by sex, 1996-2000

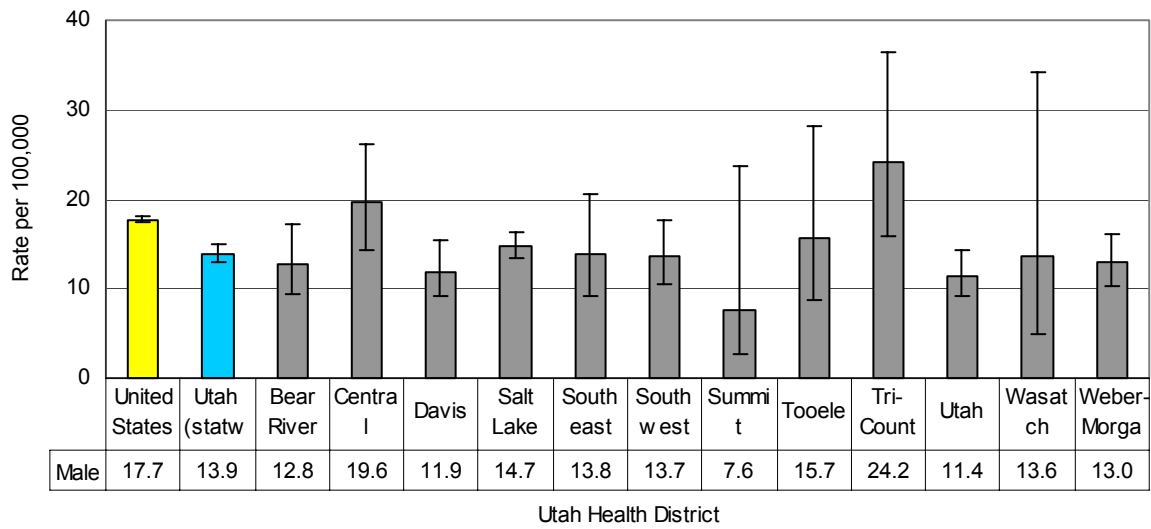


Cancer in Utah

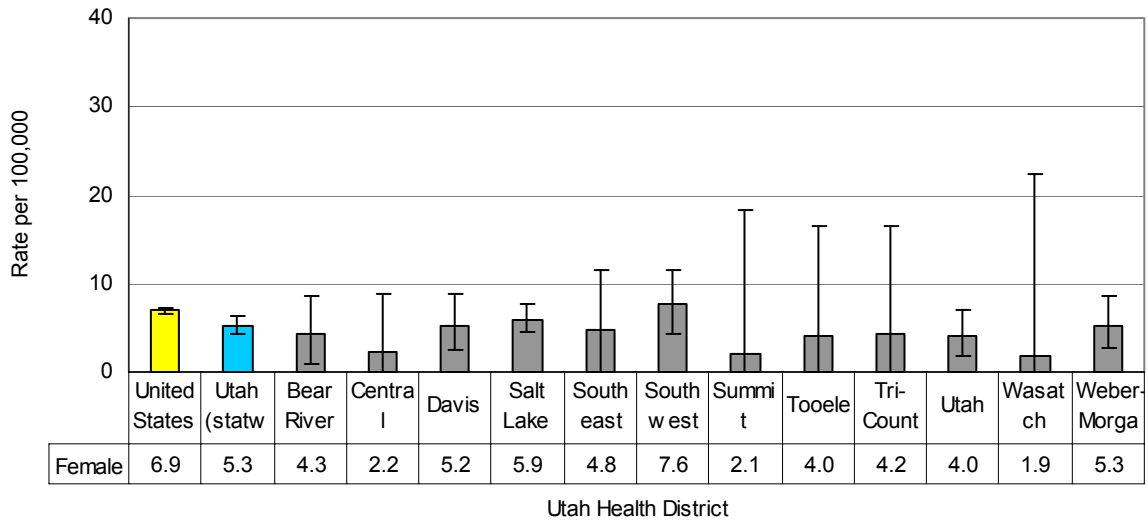
Oral Cavity & Pharynx	Incidence
----------------------------------	------------------

Average annual age-adjusted incidence rates per 100,000 (US 2000 standard) for twelve Utah Health Districts, by sex, for the time period 1991-2000, with rates from Utah (statewide) and the United States for comparison

Male



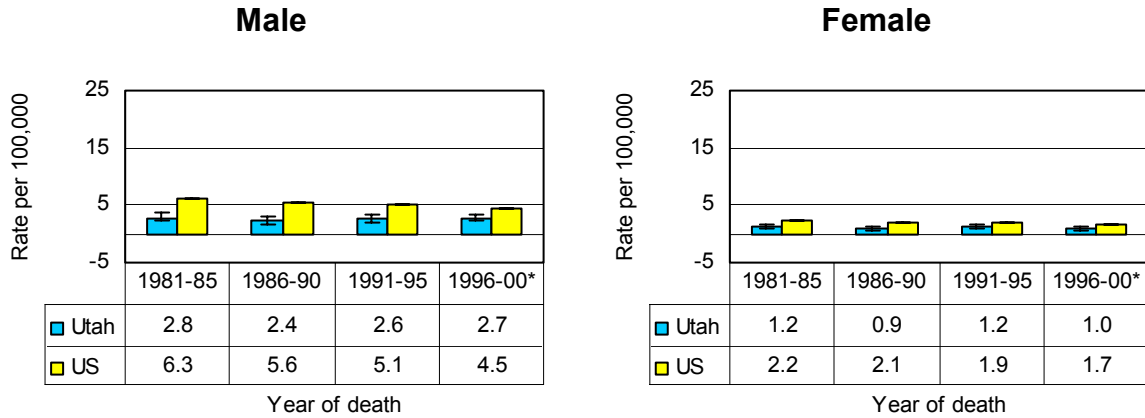
Female



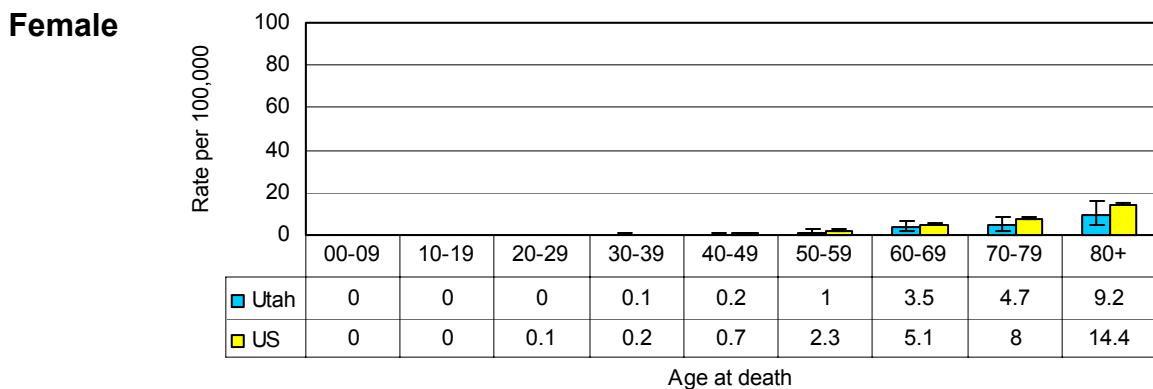
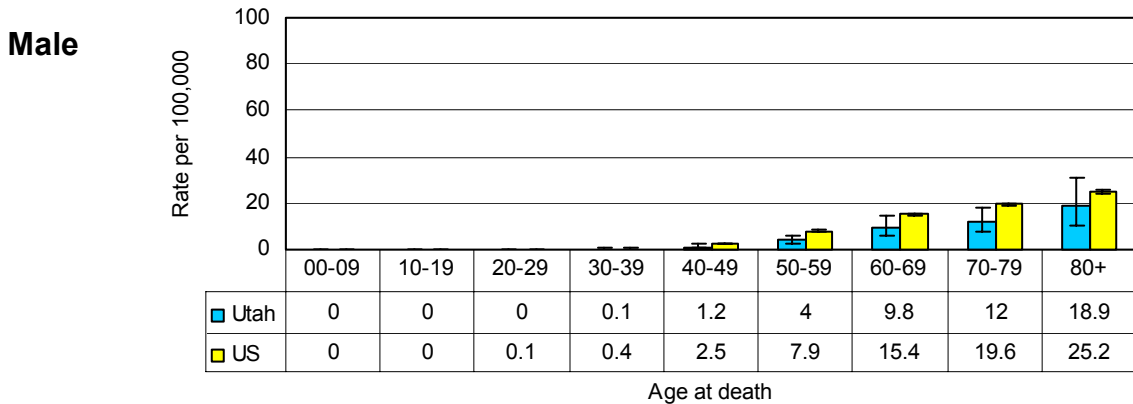
Cancer in Utah

Oral Cavity & Pharynx	Mortality
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Average annual age-adjusted mortality rates per 100,000 (US 2000 standard) by 5-year time period and sex, 1981-2000



Average annual age-specific mortality rates per 100,000 by sex, 1996-2000

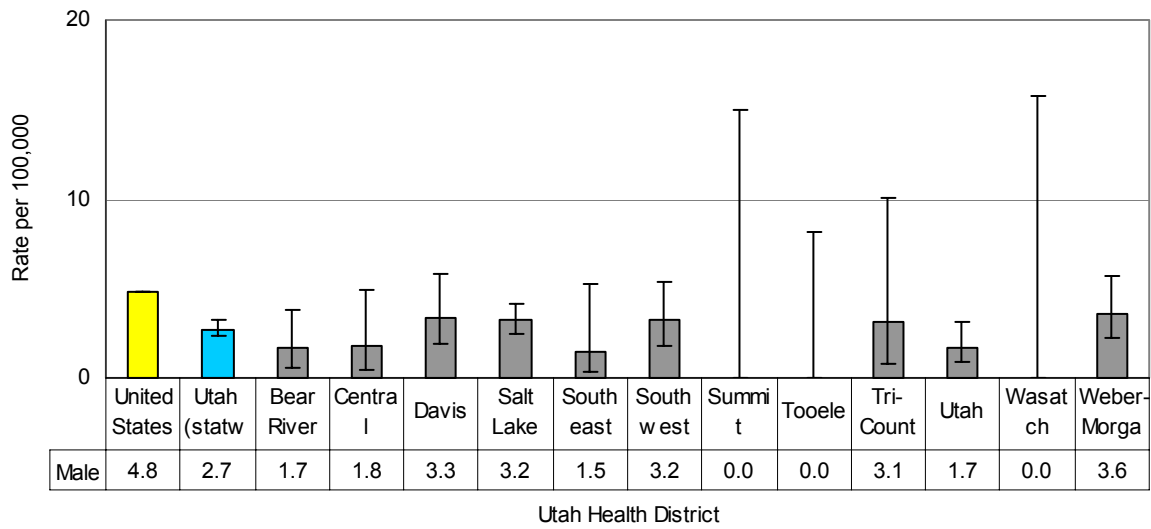


Cancer in Utah

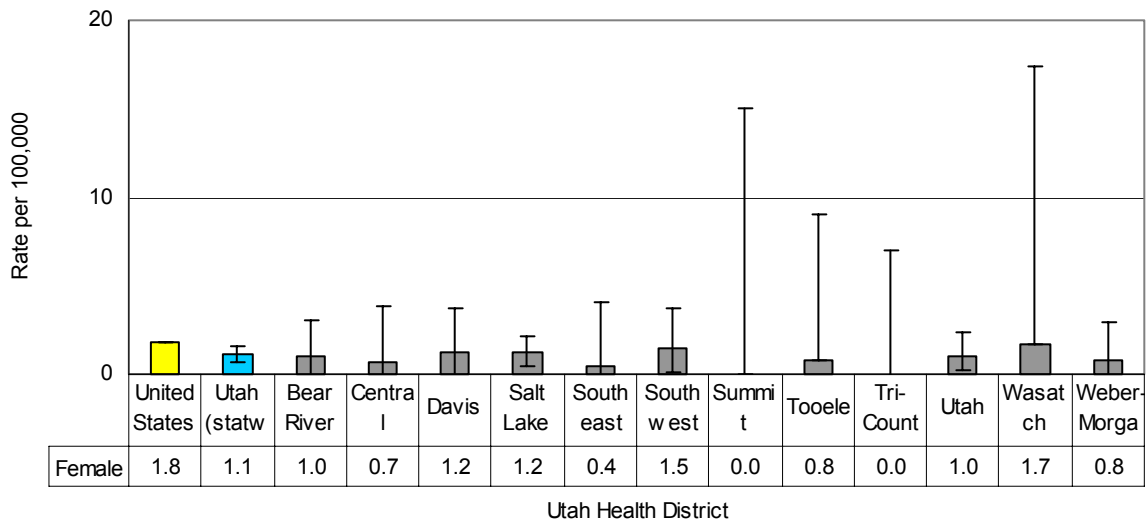
Oral Cavity & Pharynx	Mortality
----------------------------------	------------------

Average annual age-adjusted mortality rates per 100,000 (US 2000 standard) for twelve Utah Health Districts, by sex, for the time period 1991-2000, with rates from Utah (statewide) and the United States for comparison

Male



Female

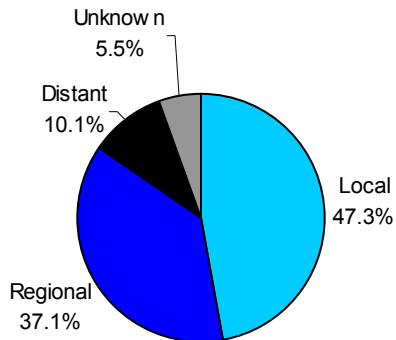


Cancer in Utah

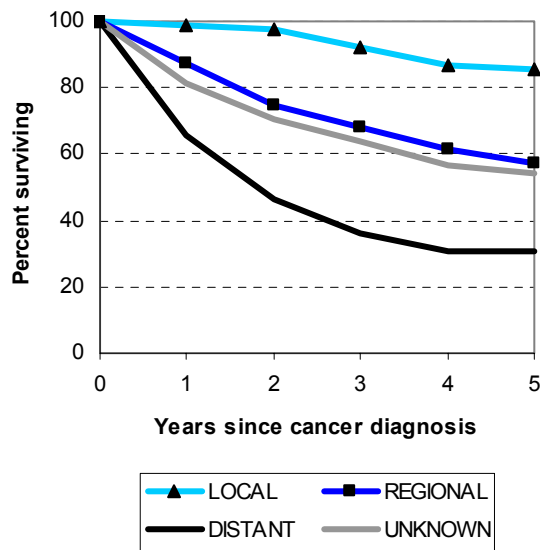
Oral Cavity & Pharynx

Stage and Survival

Stage of disease at diagnosis:
Utah residents diagnosed 1996-2000



5-year relative survival by stage:
Utah residents diagnosed 1991-95



Cancer in Utah

Esophagus

<i>Summary</i>	Male		Female	
	Utah 1996-2000	US 1996-99	Utah 1996-2000	US 1996-99
Average annual age-adjusted incidence rates*	5.1	8.1	1.0	2.1
Rank among cancer incidence rates	14	11	<20	<20
Average annual number of new cases	34	9,340	8	3,250
Percent of all new cancer cases	1.1 %	1.5 %	0.3 %	0.5 %
Lifetime risk of this cancer (00-79 years)	1 in 204	1 in 114	1 in 991	1 in 433
Average annual age-adjusted mortality rates*	4.7	7.6	0.8	1.8
Rank among cancer mortality rates	10	6	20	16
Average annual of deaths	31	8,729	7	2,819
Percent of all cancer deaths	2.6 %	3.1 %	0.6 %	1.1 %
* Rates per 100,000 and standardized to the 2000 U.S. population				

Incidence rates for esophageal cancer vary widely throughout the world. Among the highest rates are those reported in an area encompassing northern Iran, Turkmenistan, Kazakhstan, and Uzbekistan, and in Northern and Western China. The risk of this disease in these areas is as much as thirty times that experienced in the United States. These diverse geographic patterns, and a decrease in esophageal cancer rates in migrants who move from a high- to a low-risk area, suggest that environmental factors play an important role in the etiology of this disease.

Incidence rates for esophageal cancer increased in the United States during the period 1981-2000. This increase was more pronounced for males than females. Similar trends were observed in Utah, though the rates of disease were lower here than elsewhere. Much of the increase in men was in rates of adenocarcinomas. The reason for these changes is unknown.

The relative importance of different risk factors for this disease varies by geographic region. Virtually all studies have found an inverse association between socioeconomic status and risk, and a relationship with malnutrition, notably deficiencies of riboflavin, zinc, and vitamins A and C. In the United States and other western countries, alcohol and cigarette consumption account for as much as 75 percent of all cases, but play a less prominent role in Asia, where nutritional and other factors are thought to be the most important determinants of this disease.

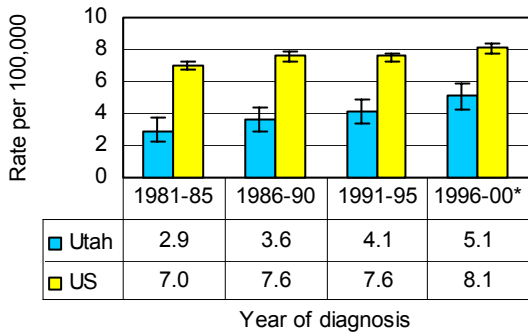
In the United States, the most important preventive measures are to limit alcohol consumption and to avoid the use of tobacco. Improving the nutritional status of the population, especially among those at increased risk for the disease, may further reduce risk. The efficacy of screening for this disease has not been established.

Cancer in Utah

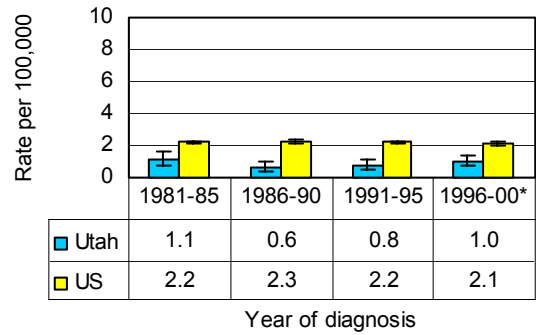
Esophagus	Incidence
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Average annual age-adjusted incidence rates per 100,000 (US 2000 standard) by 5-year time period and sex, 1981-2000

Male

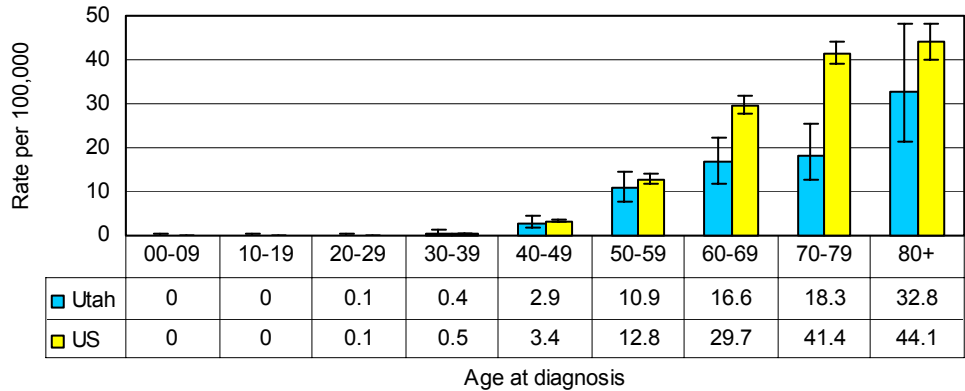


Female

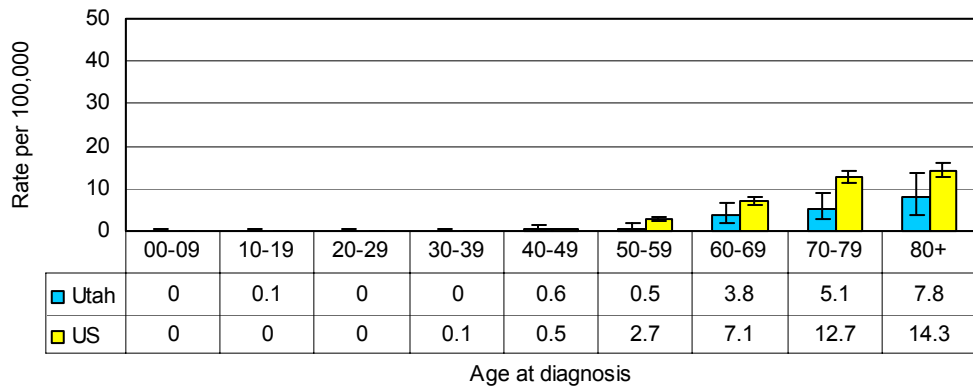


Average annual age-specific incidence rates per 100,000 by sex, 1996-2000

Male



Female

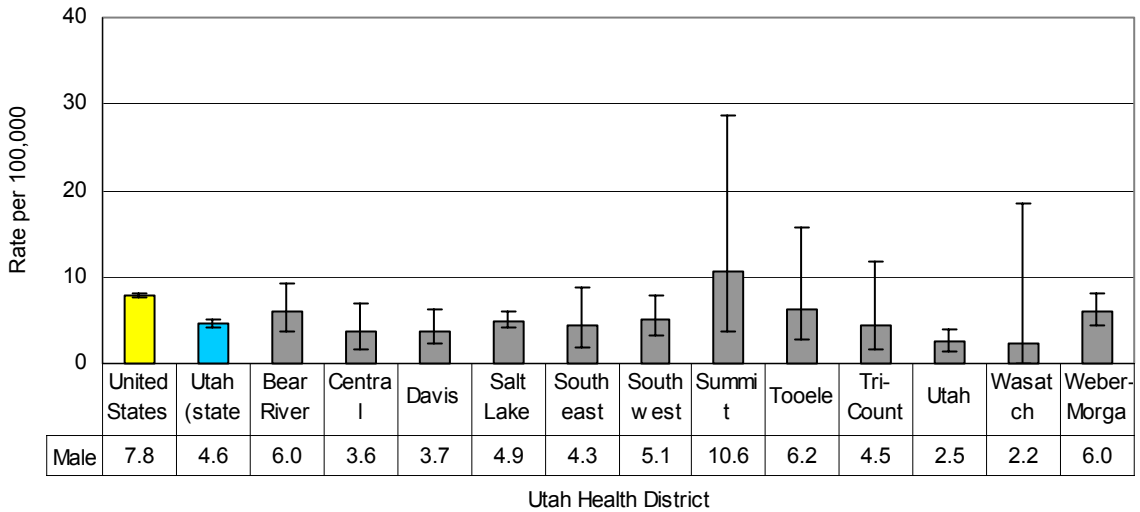


Cancer in Utah

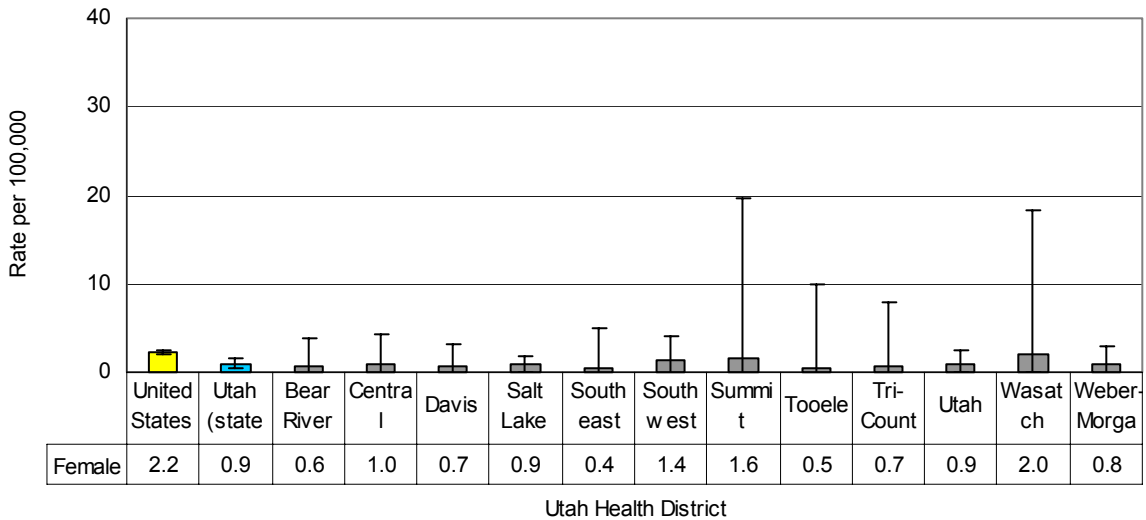
Esophagus	Incidence
------------------	------------------

Average annual age-adjusted incidence rates per 100,000 (US 2000 standard) for twelve Utah Health Districts, by sex, for the time period 1991-2000, with rates from Utah (statewide) and the United States for comparison

Male



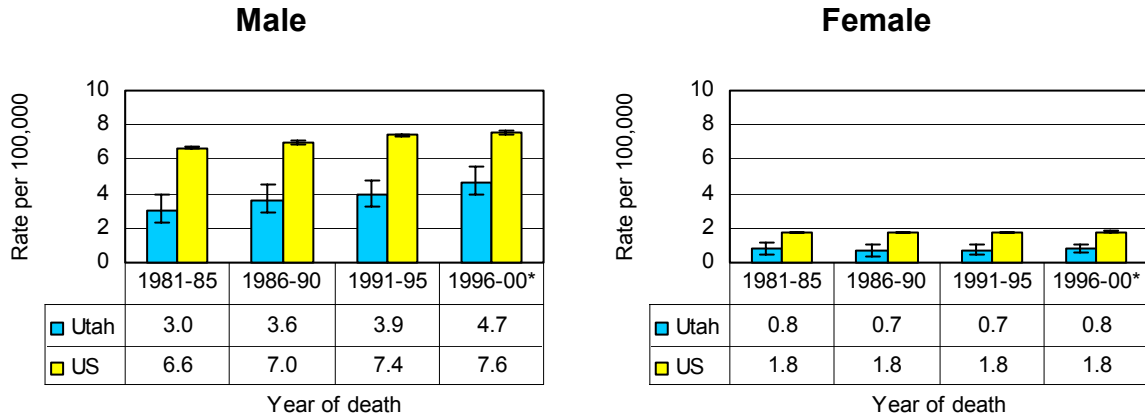
Female



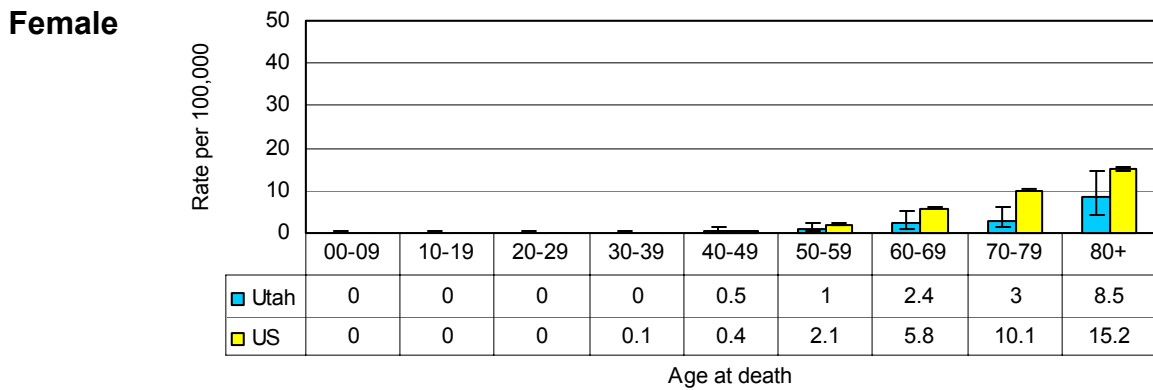
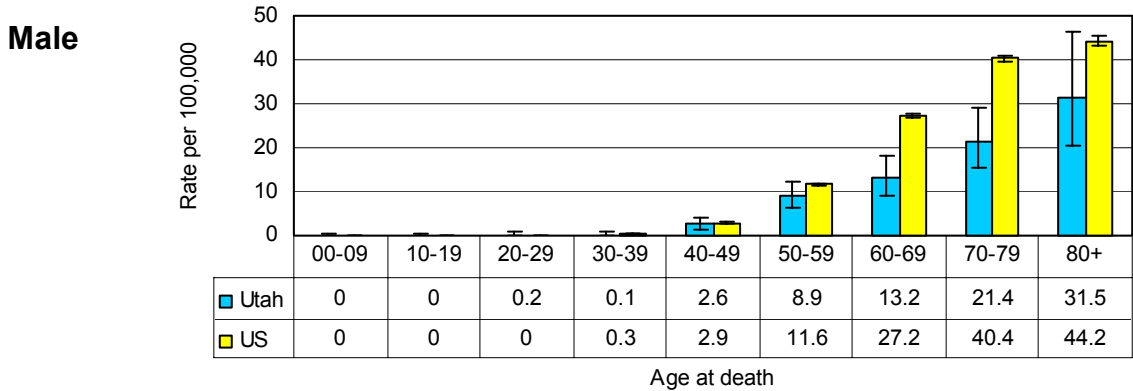
Cancer in Utah

Esophagus	Mortality
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Average annual age-adjusted mortality rates per 100,000 (US 2000 standard) by 5-year time period and sex, 1981-2000



Average annual age-specific mortality rates per 100,000 by sex, 1996-2000

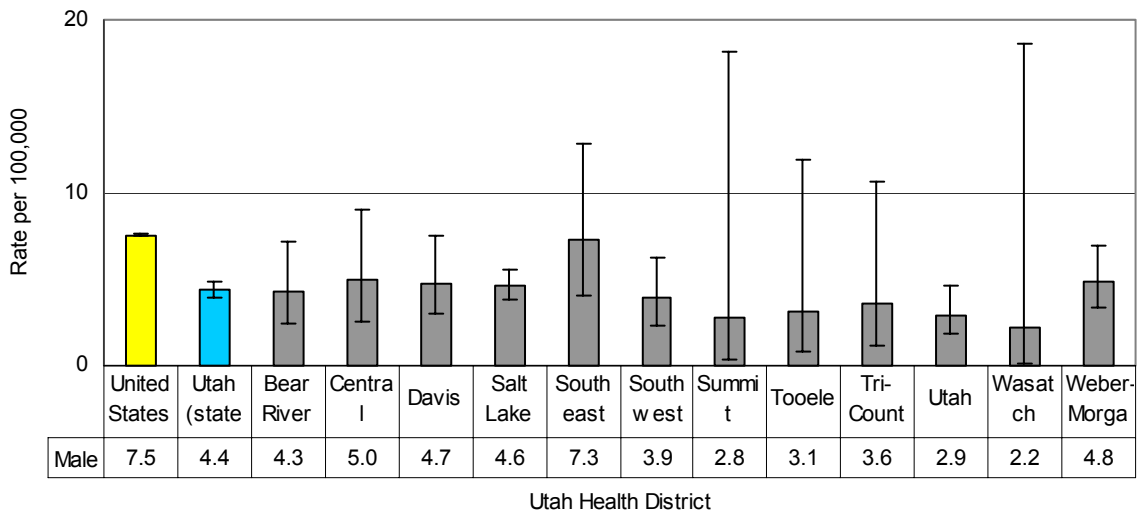


Cancer in Utah

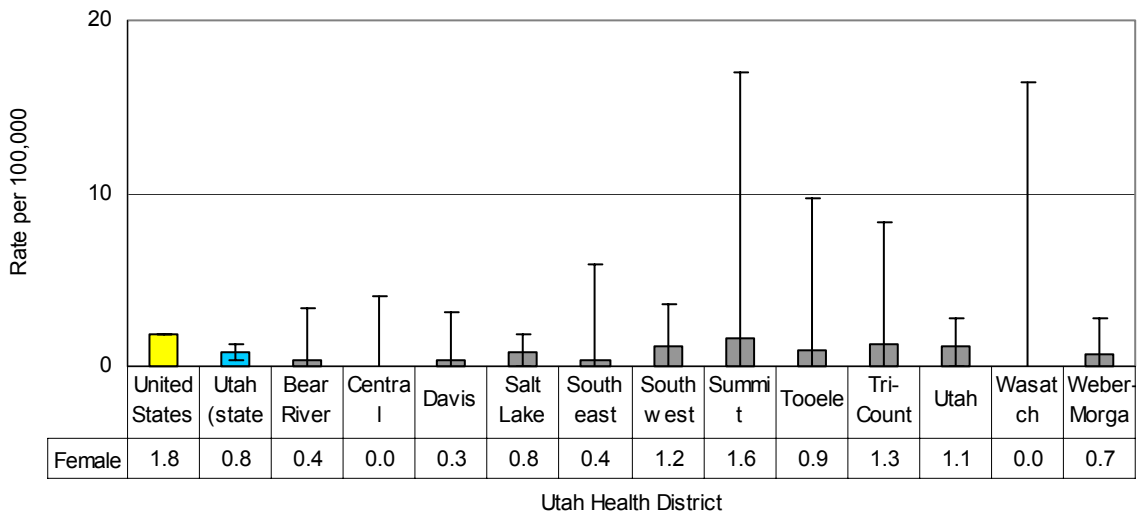
Esophagus	Mortality
------------------	------------------

Average annual age-adjusted mortality rates per 100,000 (US 2000 standard) for twelve Utah Health Districts, by sex, for the time period 1991-2000, with rates from Utah (statewide) and the United States for comparison

Male



Female

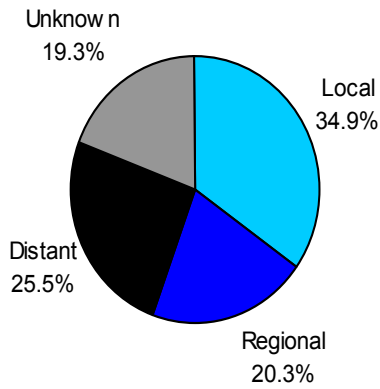


Cancer in Utah

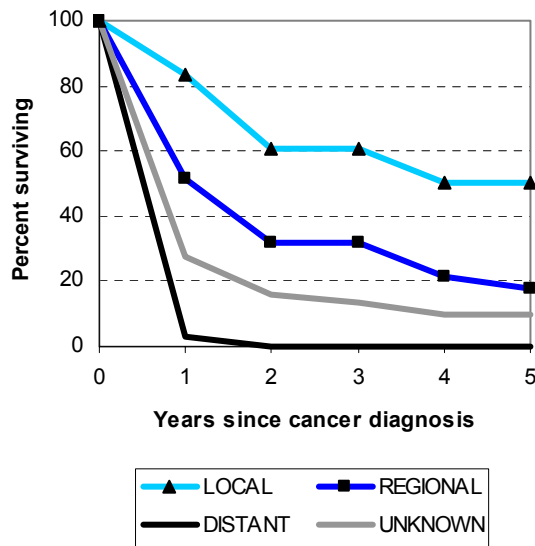
Esophagus

Stage and Survival

Stage of disease at diagnosis:
Utah residents diagnosed 1996-2000



5-year relative survival by stage:
Utah residents diagnosed 1991-95



Cancer in Utah

Stomach

<i>Summary</i>	Male		Female	
	Utah 1996-2000	US 1996-98	Utah 1996-2000	US 1996-98
Average annual age-adjusted incidence rates*	7.7	12.2	4.3	5.7
Rank among cancer incidence rates	11	9	14	14
Average annual number of new cases	49	13,610	35	8,860
Percent of all new cancer cases	1.5 %	2.1 %	1.2 %	1.4 %
Lifetime risk of this cancer (00-79 years)	1 in 141	1 in 83	1 in 235	1 in 187
Average annual age-adjusted mortality rates*	5.0	7.0	3.1	3.4
Rank among cancer mortality rates	9	8	10	9
Average annual of deaths	30	7,662	25	5,354
Percent of all cancer deaths	2.5 %	2.7 %	2.4 %	2.1 %
* Rates per 100,000 and standardized to the 2000 U.S. population				

In the 1930's, stomach cancer was the leading cause of cancer death for males and the third leading cause for females in the United States. Since that time, the United States has experienced a dramatic decline in the occurrence of this disease. Stomach cancer incidence rates continued to decline in both Utah and the United States during the period 1981-2000.

The bacteria *helicobacter pylori* has emerged as an important etiologic agent for stomach cancer. Nonetheless, the series of events that leads to stomach cancer is still being researched and the precise cause of the decline in incidence and mortality rates in the last century is unknown. Much attention has focused on dietary factors, especially smoked and cured foods high in nitrates. In cooking and through the digestive process, nitrates are converted into a class of compounds called nitrosamines, which are potent carcinogens. A diet rich in fresh fruits and vegetables may reduce the risk of this disease. Smoking and alcohol enhance risk of gastritis, but have not conclusively been related to risk of stomach cancer.

Symptoms of stomach cancer are not often manifest until the disease has spread to other parts of the body. Consequently, a majority of tumors have already reached the regional and distant stages at the time of diagnosis.

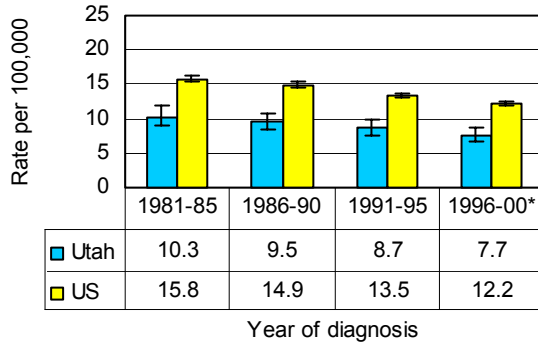
Although no specific means of primary prevention are available, it may be beneficial to limit consumption of smoked and cured foods, and to eat a diet rich in fresh fruits and vegetables. Limited evidence from Japan suggests that radiologic screening for stomach cancer may be efficacious, but widespread screening in the United States seems unwarranted due to the low frequency of the disease.

Cancer in Utah

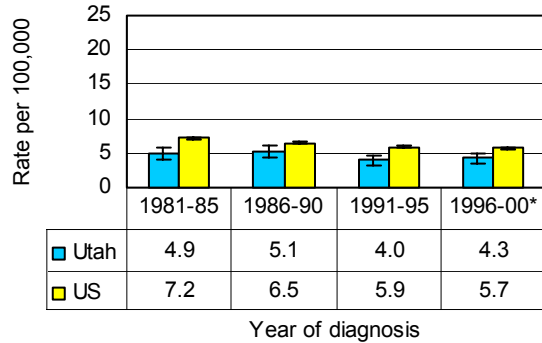
Stomach	Incidence
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Average annual age-adjusted incidence rates per 100,000 (US 2000 standard) by 5-year time period and sex, 1981-2000

Male

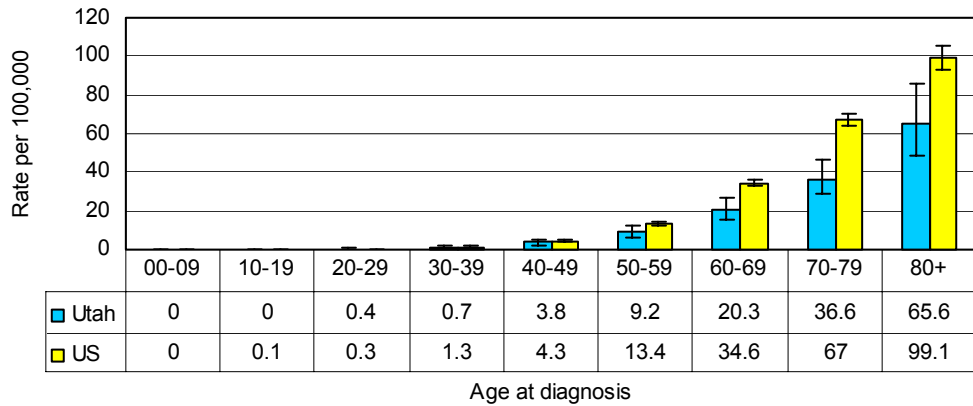


Female

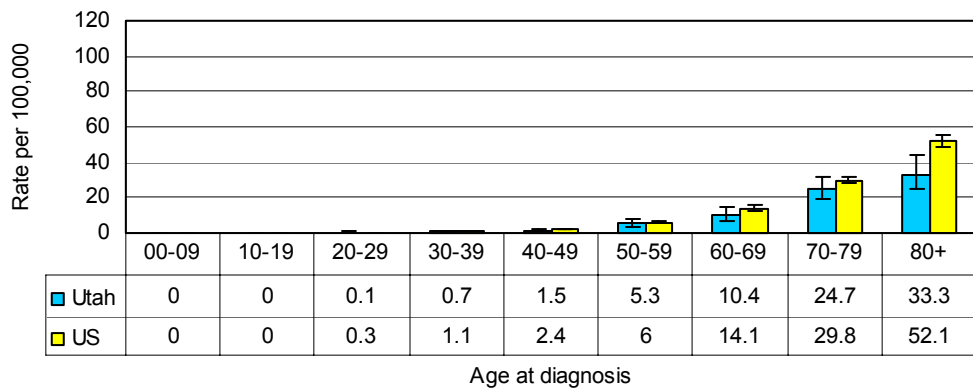


Average annual age-specific incidence rates per 100,000 by sex, 1996-2000

Male



Female

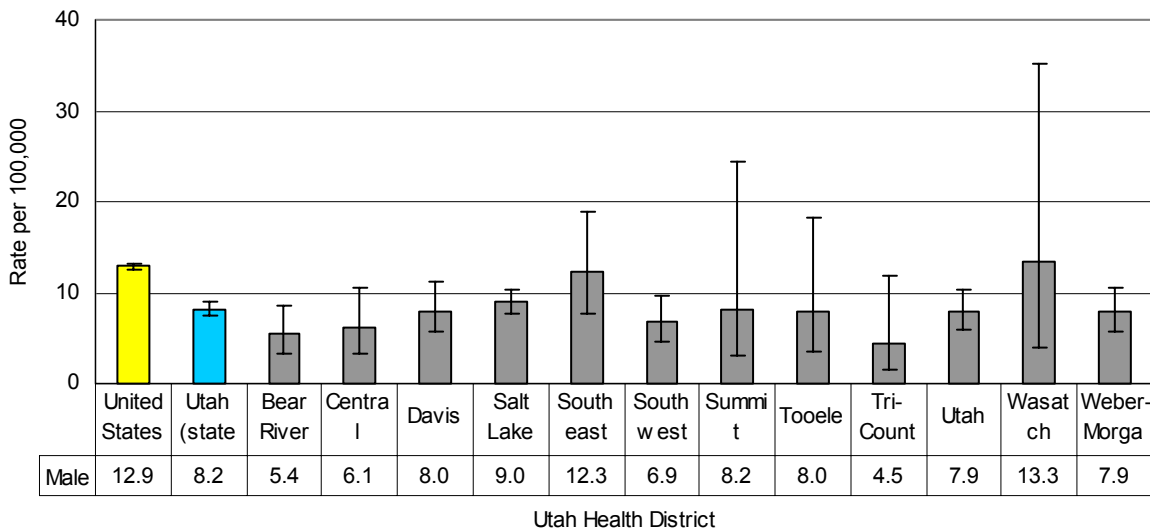


Cancer in Utah

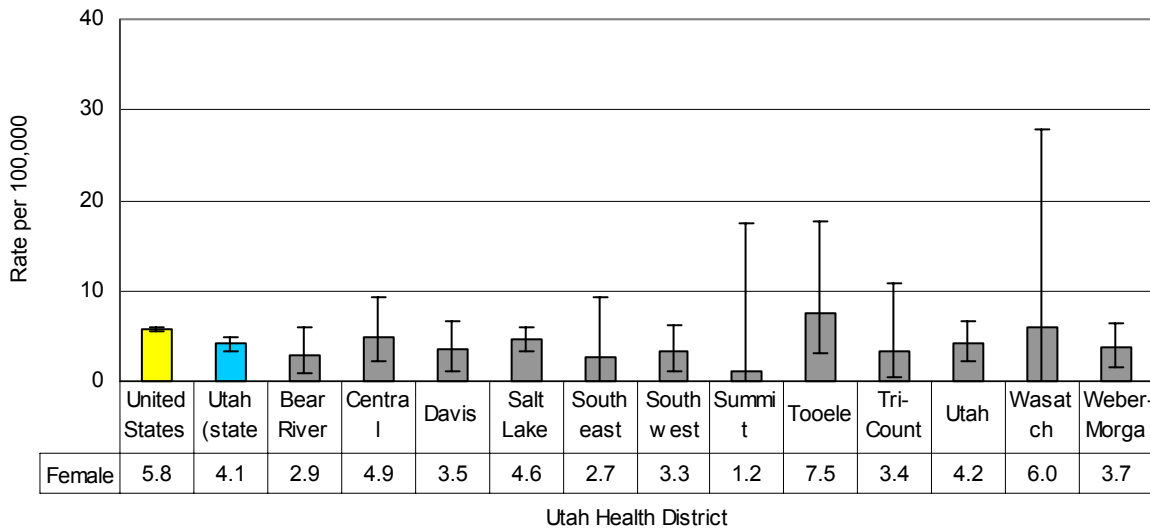
Stomach	Incidence
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Average annual age-adjusted incidence rates per 100,000 (US 2000 standard) for twelve Utah Health Districts, by sex, for the time period 1991-2000, with rates from Utah (statewide) and the United States for comparison

Male



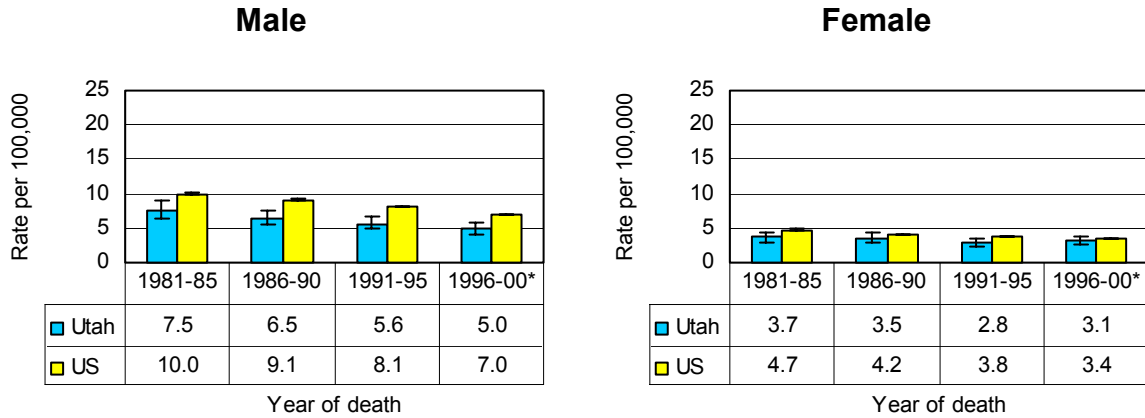
Female



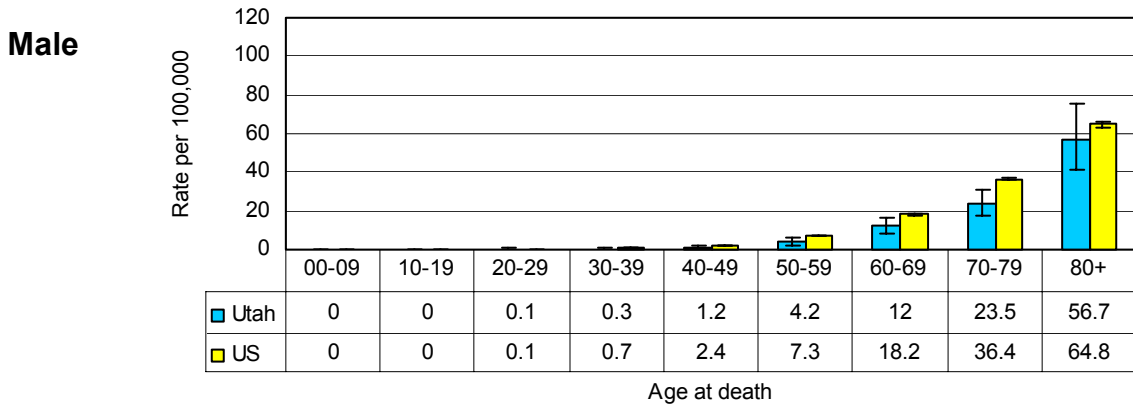
Cancer in Utah

Stomach	Mortality
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Average annual age-adjusted mortality rates per 100,000 (US 2000 standard) by 5-year time period and sex, 1981-2000



Average annual age-specific mortality rates per 100,000 by sex, 1996-2000

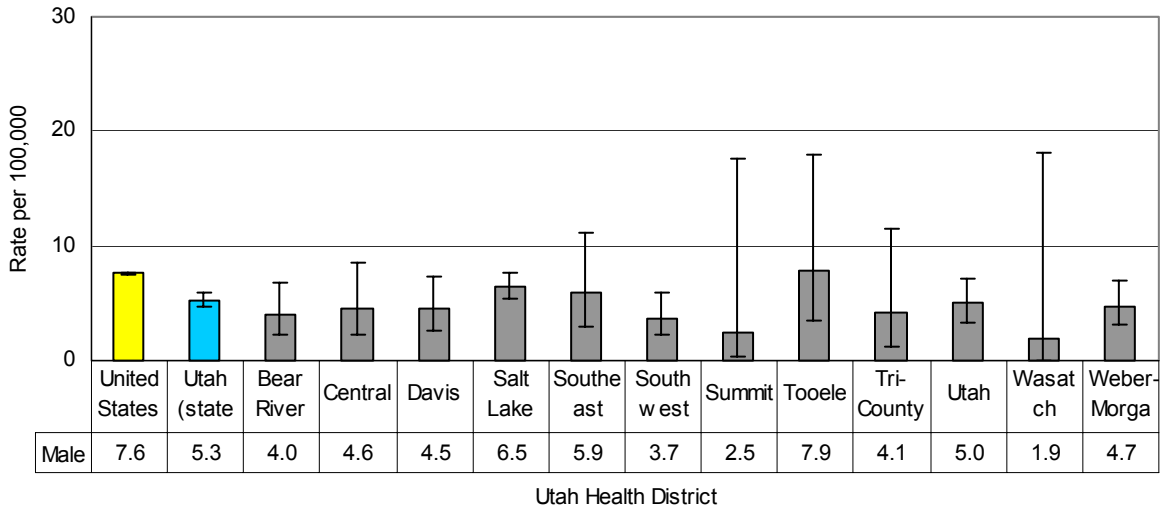


Cancer in Utah

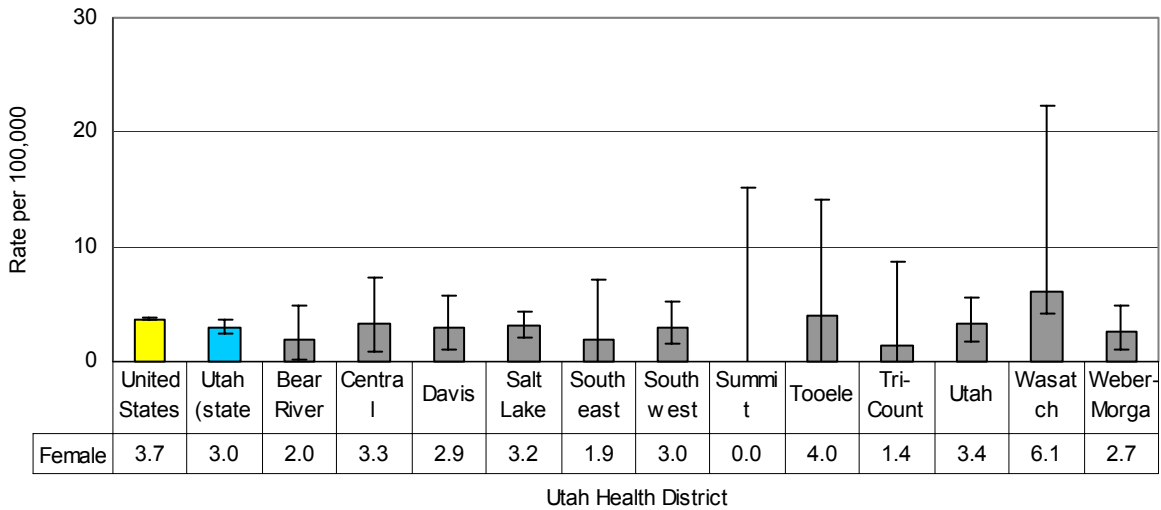
Stomach	Mortality
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Average annual age-adjusted mortality rates per 100,000 (US 2000 standard) for twelve Utah Health Districts, by sex, for the time period 1991-2000, with rates from Utah (statewide) and the United States for comparison

Male



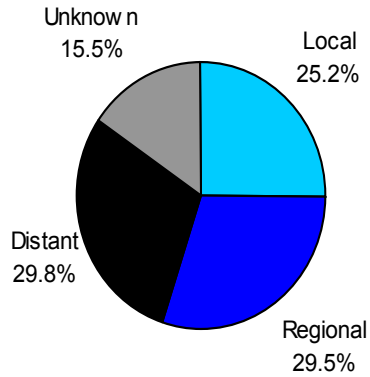
Female



Cancer in Utah

Stomach Stage and Survival

Stage of disease at diagnosis:
Utah residents diagnosed 1996-2000



5-year relative survival by stage:
Utah residents diagnosed 1991-95

