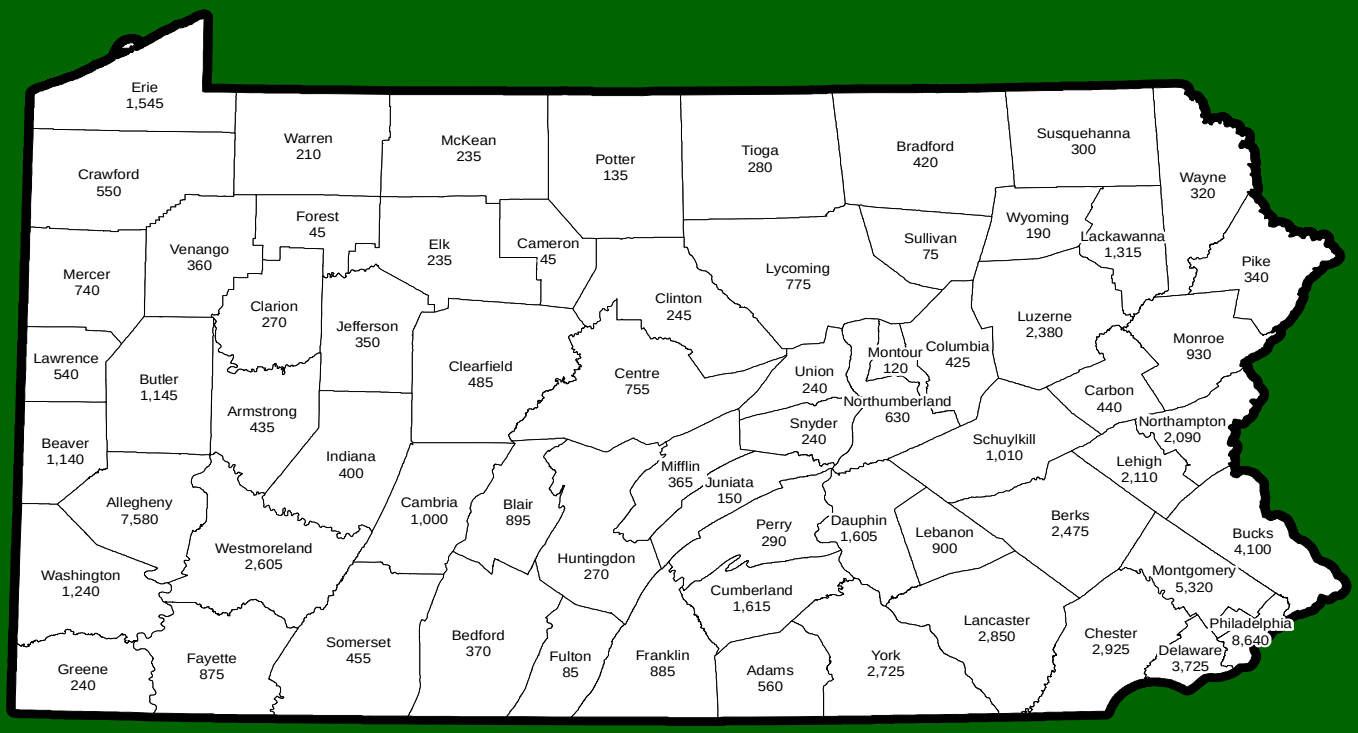
CANCER FACTS and FIGURES

Pennsylvania, 2014

Estimated Number of New Cancer Cases For 2014 By County



State Total: 79,300

Pennsylvania Cancer Registry
Bureau of Health Statistics and Research

pennsylvania
DEPARTMENT OF HEALTH

INTRODUCTION

This publication presents observed and 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.

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
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Harrisburg, PA 17101-1914
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Cancer incidence data were collected by the Pennsylvania Cancer Registry (PCR) located in the Bureau of Health Statistics and Research. The PCR is a full participant in the National Program of Cancer Registries (NPCR) of the Centers for Disease Control and Prevention (CDC).

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/**.

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

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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 the PCR were used to project the expected number of cancer cases listed in this report. Primary cancer sites follow the definitions used by the National Cancer Institute's SEER Program and are therefore comparable. Unless noted, in situ cases for sites other than urinary bladder cancer are not included in any calculation or projection contained in this report. Cancer cases were coded using International Classification of Diseases for Oncology – Third Edition (ICD-O-3) and staged according to the "SEER Summary Staging Manual" categories. Currently, 2011 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 numbers of Pennsylvania cancer deaths reported were used to forecast the expected number of cancer deaths listed in this report. Currently, 2012 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 2007 through 2011. 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, the population standard error of the estimate is computed. This estimate measures the variability of the line. The population standard deviation of the dependent variable (year of diagnosis) is also computed. This is a measure of the variability of projected cancer cases based on the arithmetic mean of cancer cases for the five years of 2007 through 2011. The population standard error of the estimate was then compared to 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 2008 through 2012 was used to project the number of cancer deaths.

Precision of projections:
Estimates 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 for 18 age groups) 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 Pennsylvania State Data Center of Penn State at Harrisburg.

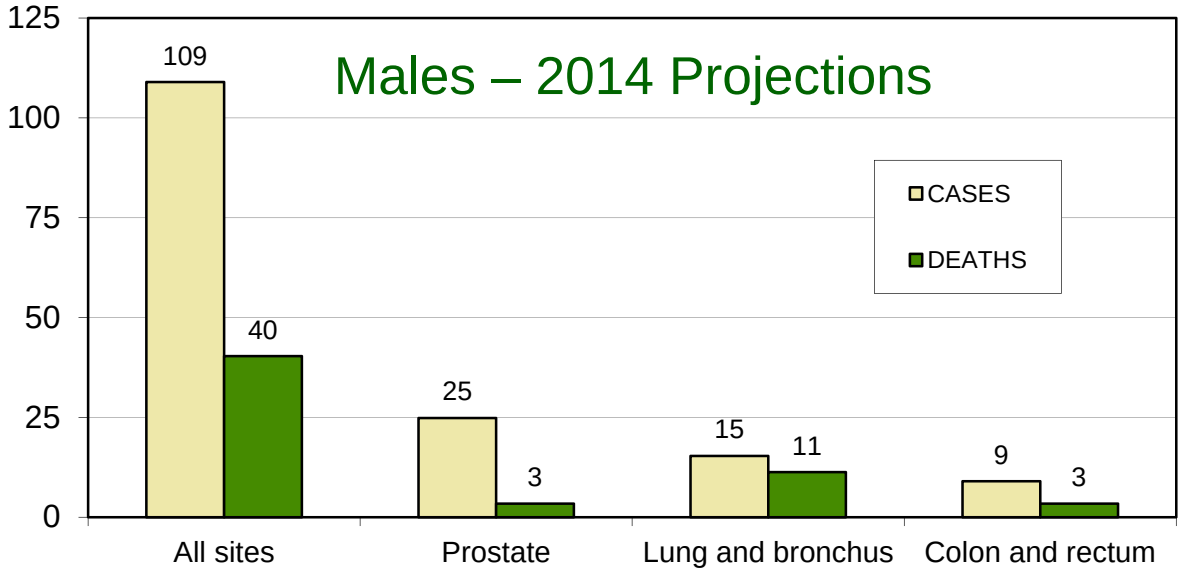
Data use and limitations:
It is highly recommended that any user of the data presented in this report read the information provided in the Technical Notes section carefully and review as many of the cited references as possible. Of primary concern when using forecasted values is the high probability 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.

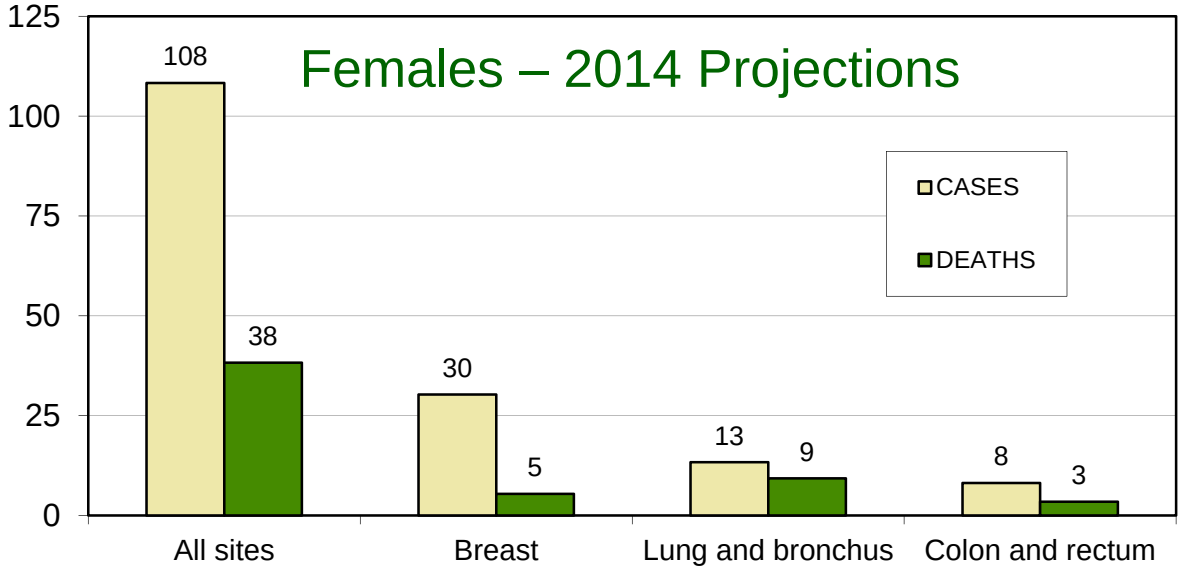
An Average Day of Projected Cancer Cases and Deaths For Major Primary Sites by Sex, Pennsylvania, 2014

Using a basic statistical model, the Pennsylvania Department of Health calculates the estimated number of cancer diagnoses among Pennsylvania residents in 2014.

Males – According to the projections, the average day in 2014 will see 109 new cancer cases and 40 deaths caused by cancer among Pennsylvanian males. Prostate cancer is expected be the most common cancer diagnosis in men, with 9,065 cases. That averages to 25 cases per day. The deadliest type is projected to be lung and bronchus cancer. In Pennsylvania, 11 men are expected to die every day of lung and bronchus cancers in 2014, totaling 4,115 deaths for the year.

Females – The effect of cancer on female Pennsylvanians in 2014 will likely be similar to that among males: 108 new cases and 38 deaths each day. Breast cancer will be by far the most common cancer diagnosis for women. An expected 11,060 new cases, about 30 a day, of invasive breast cancer will be diagnosed. As with males, lung and bronchus cancers will be the most common cause of cancer death in 2014, predicted to kill 1,980 women, about 9 per day.





BASIC FACTS ABOUT CANCER IN PENNSYLVANIA

What is cancer?

- Cancer is a 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?

- Tobacco, diet and obesity are believed to be major contributors of cancer.
- Other contributors are believed to include sedentary lifestyle, occupation, family history, viruses/biologic agents, prenatal factors/growth, reproductive factors, alcohol, socioeconomic status, environmental pollution, ionizing/ultraviolet radiation and some drugs/prescription medicines.

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?

1. Lung and bronchus: 10,581
2. Female breast: 10,561
3. Prostate: 10,235
4. Colon and rectum: 7,017
5. Urinary bladder: 4,093**

Source: 2011 Pennsylvania Cancer Incidence

How many new cancer cases and deaths will there be this year?

- About 79,300** Pennsylvanians are projected to be diagnosed with invasive cancer in 2014.
- There were 78,164** Pennsylvania residents diagnosed with invasive cancer in 2011.
- About 28,690 Pennsylvanians are projected to die from cancer in 2014.
- There were 28,627 Pennsylvania residents who died of cancer in 2012.

** includes in situ stage for urinary bladder cancer

Are cancer incidence rates increasing in Pennsylvania?

- Overall, annual age-adjusted cancer rates have increased between 1990 (443.2 per 100,000) and 2011 (498.1).
- The number of invasive cancers increased from 58,588 in 1990 to an all time high of 78,164 cases in 2011.

Are cancer death rates declining in Pennsylvania?

- In 2012, the age-adjusted rate (173.1) for cancer deaths was the lowest recorded during the period 1990-2012.
- Similarly, cancer death rates among men and women have declined since 1990, and both had their lowest rates in 2012.

What is a cancer cluster?

- A cancer cluster is a 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 www.cancer.gov
  - American Cancer Society www.cancer.org
  - Cancer Care www.cancercare.org
  - ABCD: After Breast Cancer Diagnosis www.abcdbreastcancersupport.org
  - Prostate cancer:
    - US TOO International www.ustoo.org
    - Prostate Cancer Foundation www.pcf.org
    - Zero – The Project to End Prostate Cancer www.zerocancer.org
  - Skin cancer:
    - American Academy of Dermatology www.aad.org
    - Skin Cancer Foundation www.skincancer.org
  - National Ovarian Cancer Coalition www.ovarian.org
- State and local statistics and information
  - Pennsylvania Department of Health:
    - Health Statistics www.health.state.pa.us/stats 717-783-2548
    - Cancer Prevention/Control Section www.health.state.pa.us/cancer 717-787-5251
  - Your local American Cancer Society
  - Your local department of health
  - Your local American Lung Association

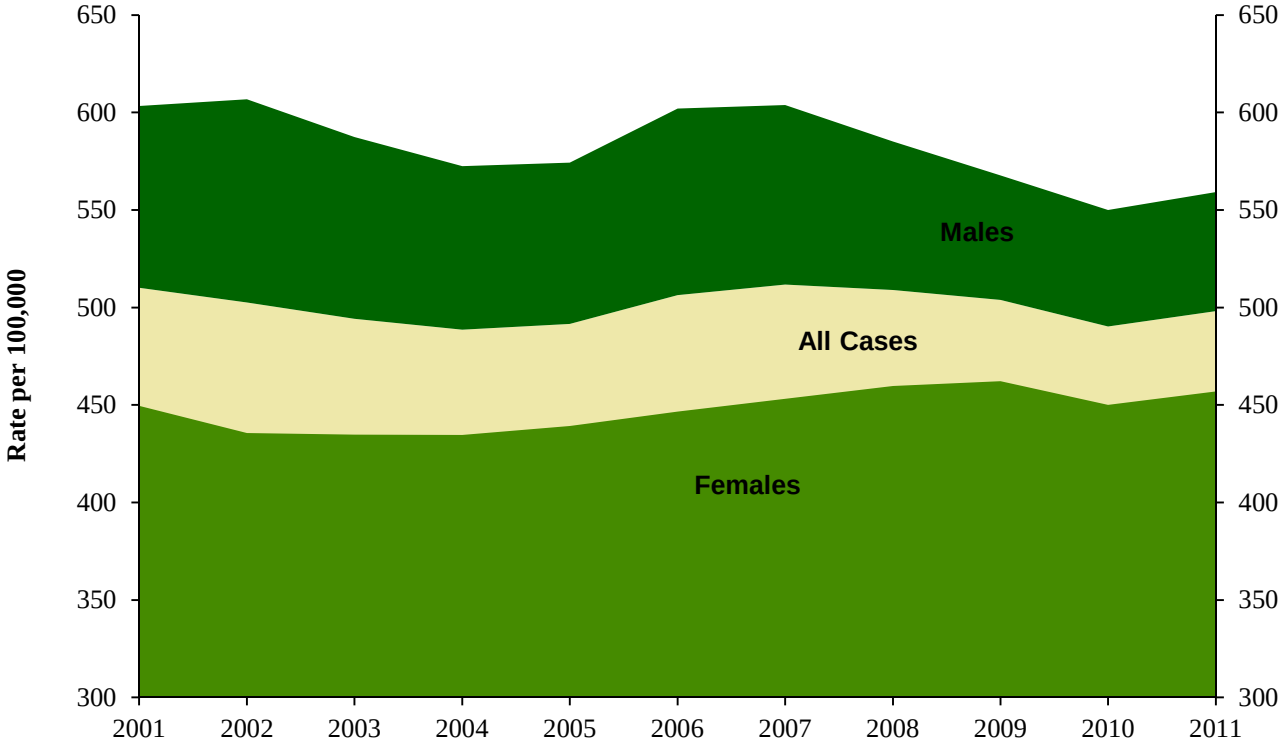
INCIDENCE TRENDS: All Cancers by Sex

All cancer cases – The age-adjusted incidence rate for all cancer in 2011 (498.1 per 100,000) was 2.4 percent lower than it was in 2001 (510.2). This rate has fallen and risen multiple times in recent years. After 2001, the rate decreased each year until it was 488.6 in 2004, the lowest point in the 11-year period of 2001-2011. It then climbed to 511.7 in 2007, the highest point in the same period. Another decreasing trend followed this peak, until the rate reached 490.2 in 2010. However, 2011 reversed that trend. Upon review, the increase in rates seems spread across nearly all primary cancer sites instead of a large increase in one or two. The sites which contributed most to the increased rate were prostate, female breast, leukemia, cervix uteri, non-Hodgkin lymphoma, melanoma of the skin, and oral cavity/pharynx cancers. The only major cancer sites that saw a decrease from 2010 to 2011 were the testis, stomach, ovary and brain/other nervous system.

Males – In 2001, the age-adjusted incidence rate among male Pennsylvanians was 603.3 per 100,000. Comparatively, the 2011 rate of 559.2 was 7.3 percent lower. Between those years, the annual male rates rose and fell several times, with more pronounced variability than the female rates. The highest rate during this period was 603.8 in 2007. The rate for 2011 was second lowest since 2001, being only slightly above the 2010 rate of 550.0. The highest age-adjusted rates among male Pennsylvanians were for prostate (136.5), lung and bronchus (80.1), and colon and rectum cancers (51.3). Male age-adjusted incidence rates have been at least 22.2 percent higher than those among females for every year from 2001 to 2011. The largest difference came in 2002, when the male rate was 39.3 percent higher.

Females – The 2011 age-adjusted incidence rate of cancer among female Pennsylvanians was 456.9 per 100,000: an increase of 1.6 percent compared to the 2001 rate of 449.6. From 2001 to 2003, the female rate declined, remained flat in 2004 at 434.6, and started increasing in 2005. It reached a peak of 462.2 in 2009 before dipping to 450.0 in 2010. The rates for breast (128.1), lung and bronchus (56.0), and colon and rectum (38.3) contribute most to the overall cancer rate among females. Despite remaining below the male rate every year from 2001 to 2011, the female rate has ultimately trended upward over this period, as opposed to the male rate's trend downward.

Age-Adjusted Invasive Cancer Incidence Rates by Sex, 2001-2011



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

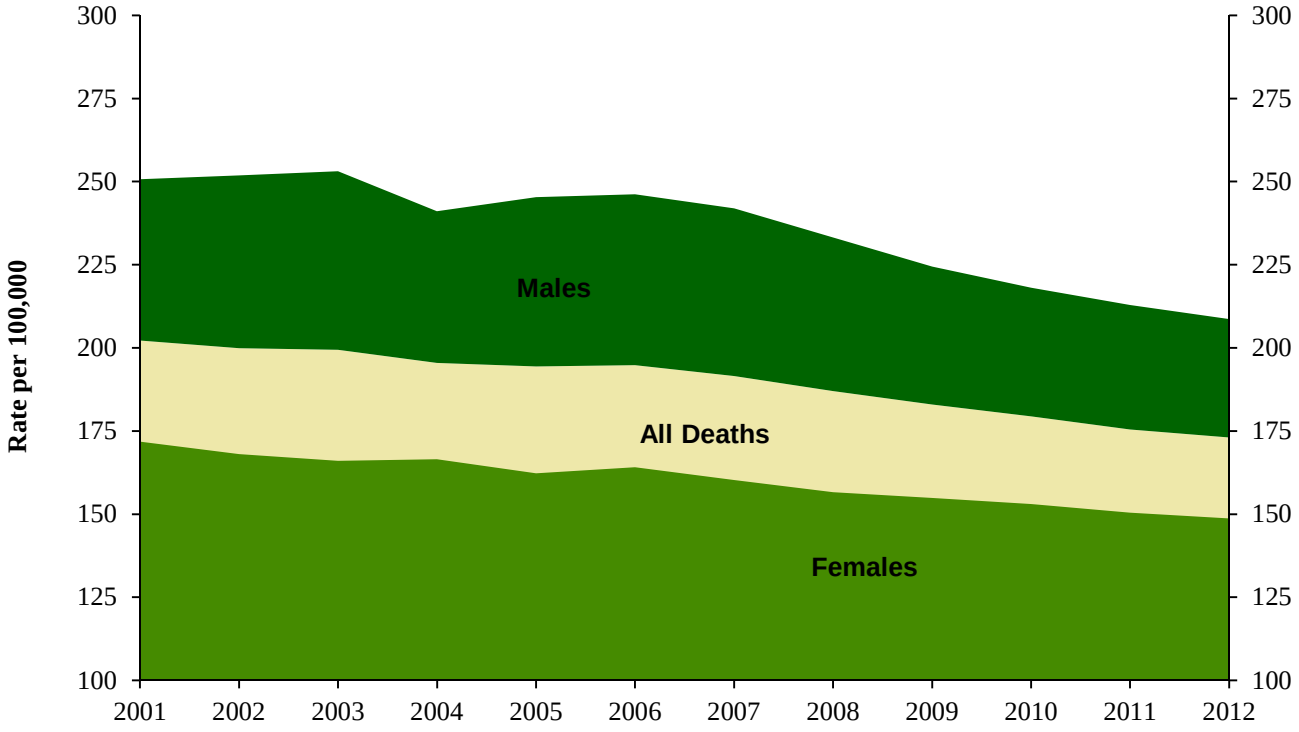
MORTALITY TRENDS: All Cancers by Sex

All cancer deaths – The age-adjusted cancer death rate among Pennsylvanians declined steadily from 202.2 per 100,000 in 2001 to 173.1 in 2012: a total decrease of 14.4 percent. An increase only occurred once, when the rate went from 194.4 in 2005 to 194.8 in 2006. On average, each year saw a 1.4 percent decrease in the rate compared to the previous year. The rate of lung and bronchus cancer deaths fell the most out of all the cancers, from 54.7 in 2001 to 46.4 in 2012. Only five of the 23 major cancer primary sites saw an increase, but the largest gain among those was for liver and intrahepatic bile duct cancer. Its rate rose over 50 percent from 4.0 in 2001 to 6.1 in 2011.

Males – Similar to that for all Pennsylvanians, the age-adjusted cancer mortality rate for male residents of the state has decreased 16.8 percent between 2001 and 2012, from 250.7 per 100,000 to 208.7. This was despite a temporary upwards trending from 2004 to 2006. Just as in the total population, lung and bronchus cancer mortality dropped the most, and the rate for liver and intrahepatic bile duct cancer death rose the most.

Females – The age-adjusted cancer mortality rate among female Pennsylvanians went down 13.4 percent from 171.8 per 100,000 in 2001 to 148.7 in 2012. Despite the smaller improvement compared to the male rate, the rate among females stayed an average of 31.9 percent lower than among males between 2001 and 2012. The mortality rates of both breast and colorectal cancer fell among females over the period, by 20.8 and 29.5 percent, respectively. The rate of liver and intrahepatic bile duct cancer death also rose, though not as dramatically as it did among males.

Age-Adjusted Cancer Death Rates by Sex, 2001-2012



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

INCIDENCE AND MORTALITY TRENDS by Race

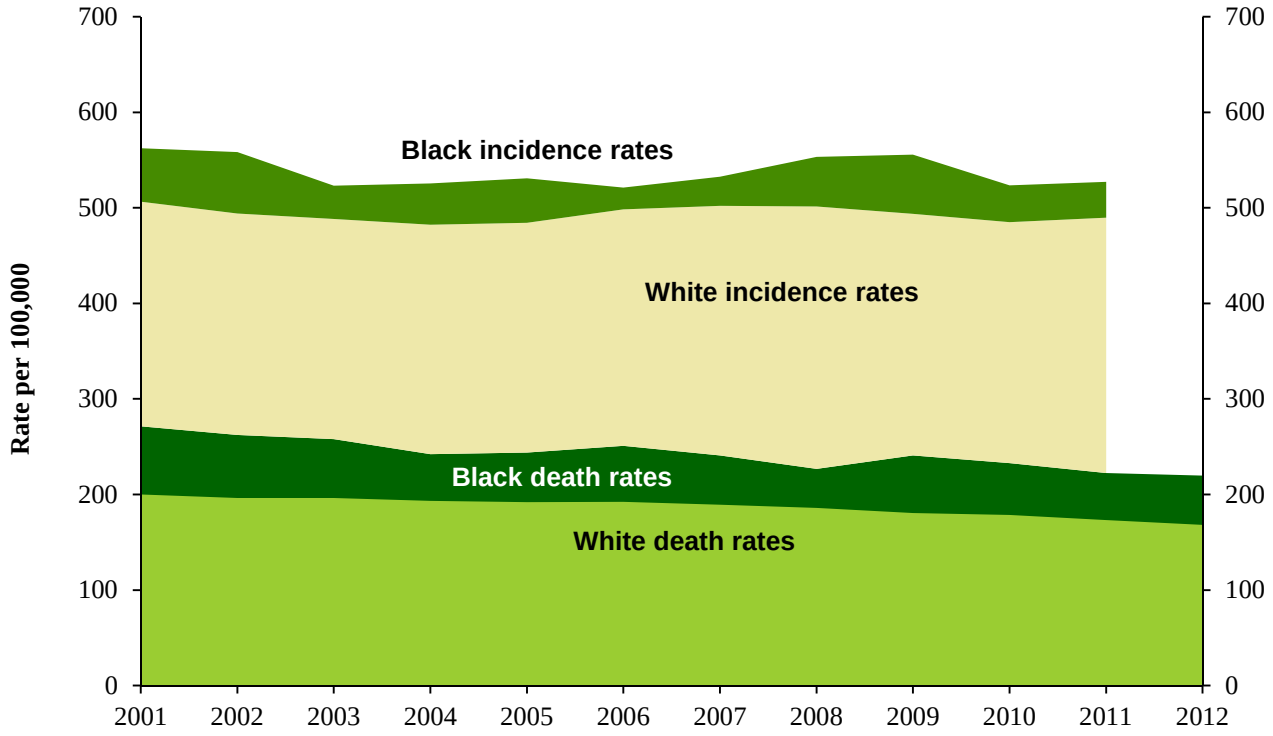
White incidence rates – During the 11-year period of 2001 to 2011, the annual age-adjusted incidence rate among white Pennsylvanians has not shown any apparent trend. It started at the period's high of 506.3 per 100,000 in 2001, slipped down to the period's low 482.3 in 2004, stepped back up to 502.0 in 2007, and retreated to 485.1 in 2010. In 2011, the rate increased to 489.8, which is still 3.3 percent lower than in 2001. In 2011, white Pennsylvanians had higher rates than black Pennsylvanians for melanoma of the skin, urinary bladder cancer and Non-Hodgkin lymphoma.

Black incidence rates – The age-adjusted cancer incidence rate among black Pennsylvanians varied more noticeably over the years in comparison to the rate among whites. Like whites, however, 2001 started off the most recent 11-year period of data with its highest rate at 562.4 per 100,000. Since then, there have been three troughs (523.3 in 2003, 521.2 in 2006, and 523.6 in 2010) and two peaks (530.9 in 2005 and 555.7 in 2009). The 2011 rate of 527.2 measures as 6.3 percent lower than the rate in 2001. When compared to white Pennsylvanians, blacks experienced higher rates of liver and intrahepatic bile duct cancer, myeloma, and stomach cancer. The rate of all invasive cancer among blacks stayed above that among whites during the entire period of 2001 to 2011, averaging as 9.0 percent higher.

White death rates – During the most recent 12 years of available death data, the annual age-adjusted cancer death rate among white Pennsylvanians went down 15.7 percent from 199.8 per 100,000 in 2001 to 168.3 in 2012. The rate only saw an increase in 2003 and 2006, and both of these differences were less than 1 percent.

Black death rates – The annual age-adjusted cancer mortality rates among black Pennsylvanians did not have as steady a trend compared to whites. It has certainly improved, starting at 271.3 per 100,000 in 2001 and ending at 219.6 in 2012. While all the rates after 2001 were lower than that year's, they peaked in 2006 (250.9) and 2009 (240.8). The rate's overall reduction across the 12-year period of 19.1 percent among blacks was greater than among whites. Still, the 2012 death rate was 30.5 percent higher among blacks.

TRENDS: Cancer Incidence and Death
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. Incidence data is only available up to 2011; see technical notes.

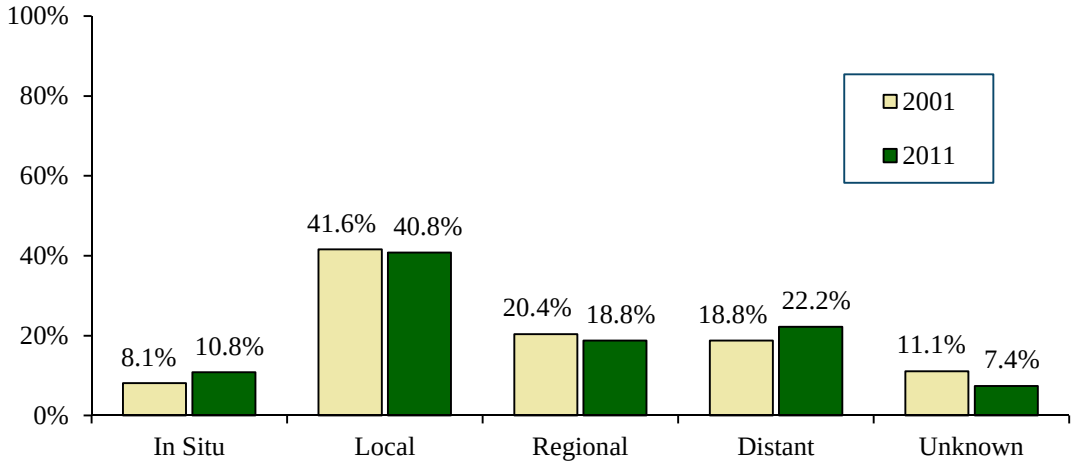
Percent of Cancer Cases by Stage of Disease at Diagnosis
All Cancers by Sex, Pennsylvania Residents, 2001 and 2011

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. According to the National Cancer Institute's Surveillance, Epidemiology and End Results (SEER) program, late stage cancer diagnoses are more difficult to treat successfully and have lower survival rates than early stage diagnoses. Note that these stage statistics exclude cervix uteri cancers in situ, which are not collected by the registry, and all lymphomas, which use the Ann Arbor staging system.

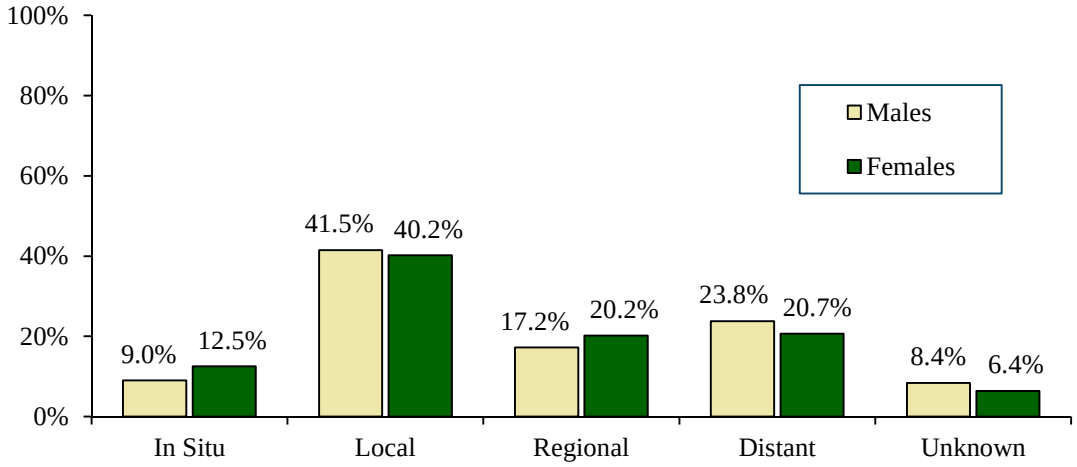
2001 and 2011 – In both 2001 and 2011, about half of all diagnosed cancers were caught at an early stage; 49.7 percent in 2001 and 51.6 in 2011. Seemingly in spite of this increase, the percentage of cancers diagnosed at a late stage also increased over the period, from 39.2 to 41.0. This is because the number of cancers reported with an unknown stage dropped by a third, from 11.1 to 7.4 percent.

Males and females – A comparison of the distribution of stage at diagnosis for male and female Pennsylvanians shows a tendency for males to have worse prognoses. The percentage of early-staged diagnoses in females is 2.1 points higher than in males. The percentages of late-staged diagnoses are nearly identical, at 41.0 in males and 40.9 in females. However, the percentage of unknown-staged diagnoses among males is nearly a third higher than among females (8.4 and 6.4 percent, respectively).

2001 and 2011: Percentage of Cancer Cases by Stage



Males and Females: Percentage of Cancer Cases by Stage, 2011

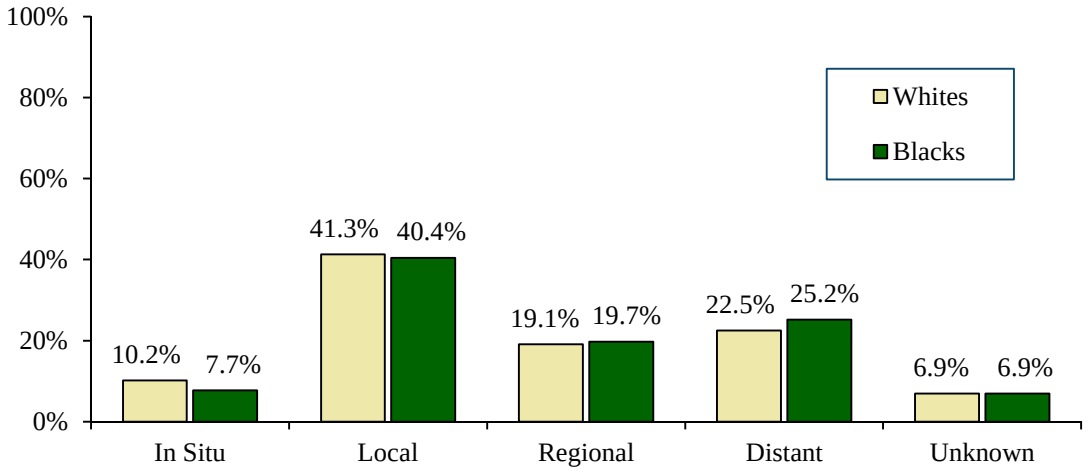


Percent of Cancer Cases by Stage of Disease at Diagnosis
All Cancers by Race, Pennsylvania Residents, 2001 and 2011

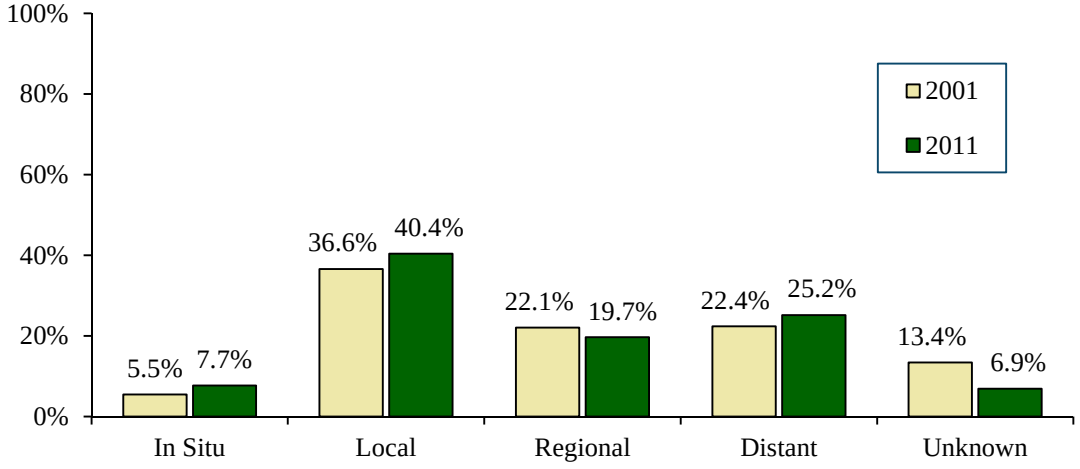
Whites and blacks – Among Pennsylvania residents in 2011, a lower percentage of cancers were diagnosed at an early stage among blacks than among whites (48.1 and 51.5 percent, respectively). Blacks had a higher percentage of late-staged cancer diagnoses in 2011 compared to whites (44.9 and 41.6 percent, respectively).

Blacks: 2001 vs. 2011 – Although the 2011 percentage of early-staged diagnoses in black Pennsylvanians was lower than the percentage in whites, the gap has been closing. In 2001, there was a difference of 8.2 percentage points. In 2011, there was a difference of 3.4 percentage points. The percentage of late-stage diagnoses among blacks increased as well, but only by 0.4 percentage points. This increase comes entirely from a higher proportion of distant-staged diagnoses, which have worse prognoses than regional-staged. The percentage of diagnoses with an unknown stage dropped by nearly half, from 13.4 percent in 2001 to 6.9 percent in 2011.

Whites and Blacks: Percentage of Cancer Cases by Stage, 2011



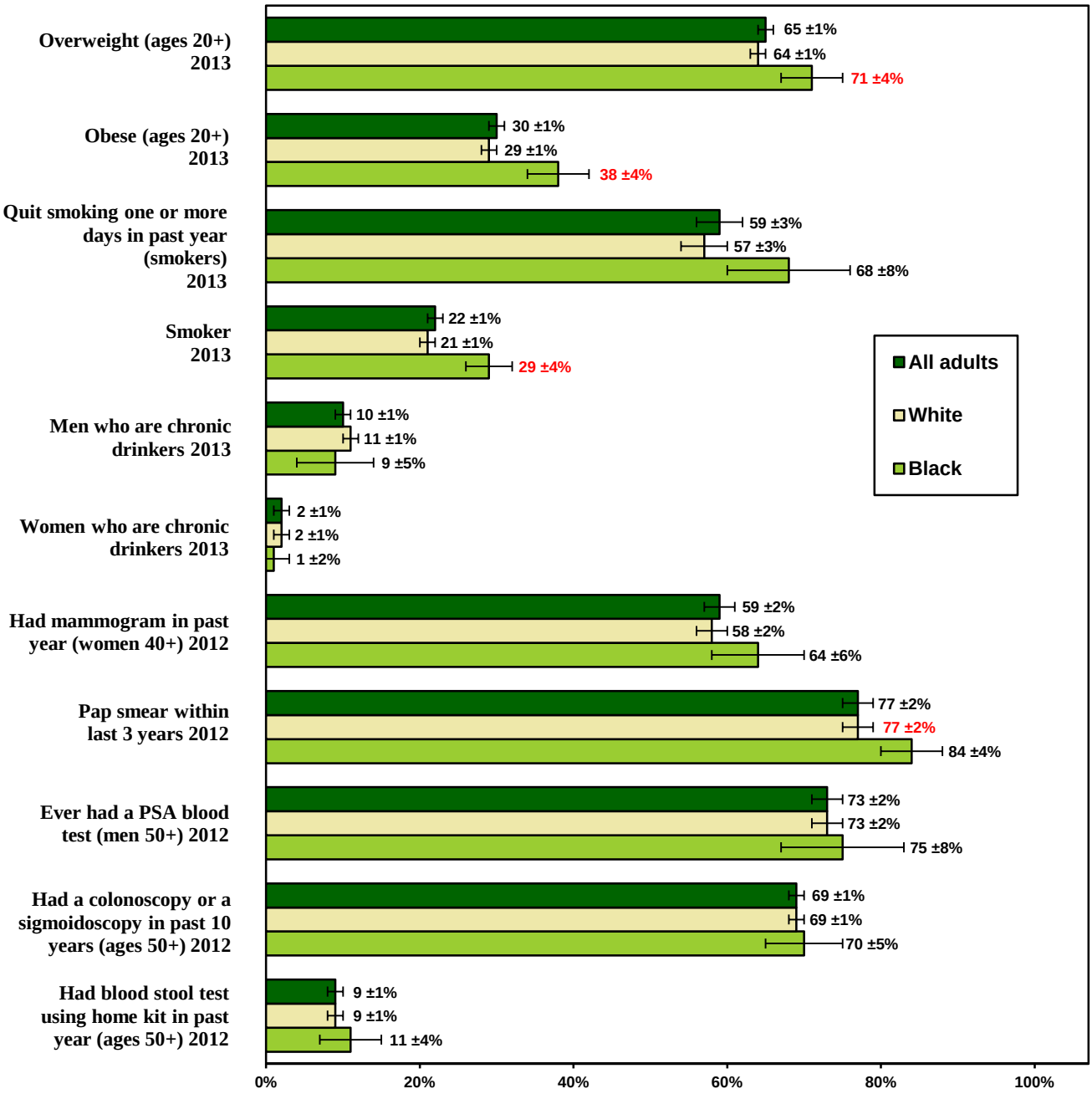
Blacks: Percentage of Cancer Cases by Stage, 2001 and 2011



Behavioral Risk Factors

The Pennsylvania Department of Health conducts an annual telephone survey of adult residents (ages 18+) as part of its Behavioral Risk Factor Surveillance System (BRFSS). The chart below shows select age-adjusted prevalence rates from the 2012 and 2013 surveys concerning behaviors that affect the chance of developing cancer for all, white (non-Hispanic), and black (non-Hispanic) residents. In Pennsylvania, blacks were 10.9 percent more likely than whites to have a body mass index (BMI) over the normal weight. Further, obesity's prevalence among blacks was 31.0 percent higher than among whites. Blacks were more likely to be a current smoker than whites (29 percent to 21 percent). One category in which white Pennsylvanians showed worse performance than blacks was the prevalence of having had a Pap smear in the previous 3 years (77 percent to 84 percent, respectively).

Selected Behavioral Risk Factors by Race, Pennsylvania Adults, 2012-2013



NOTES: The 2011 survey marks the first year in which the Pennsylvania BRFSS collected data from both landline and cell phone respondents. To allow for the incorporation of cell phone data, a new weighting methodology called iterative proportional fitting, or raking, was implemented in 2011. Data include 95% confidence intervals (±). Data for whites and blacks exclude Hispanics. Rates highlighted in **red** indicate a significant race disparity.

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

All cancers* – Throughout the period of 2001 to 2011, Pennsylvania's age-adjusted rate for cancer incidence stayed significantly higher than the overall U.S. rate. Changes in the Pennsylvania rate resembled those in the U.S. until 2011, in which the Pennsylvania rate increased and the U.S. rate decreased.

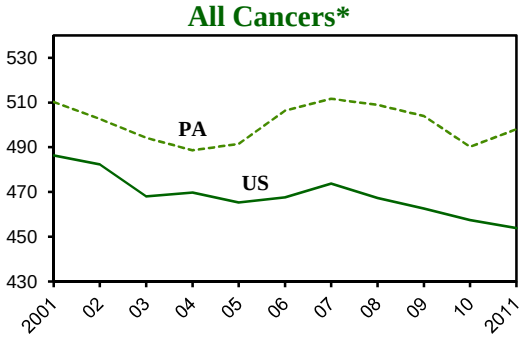
Prostate cancer – The age-adjusted rates of prostate cancer in Pennsylvania and the U.S. have both shown a decreasing trend from 2001 to 2011, with a sharp rise and fall in 2006 and 2007. Outside of that period, the Pennsylvania rate stayed lower than the U.S. rate.

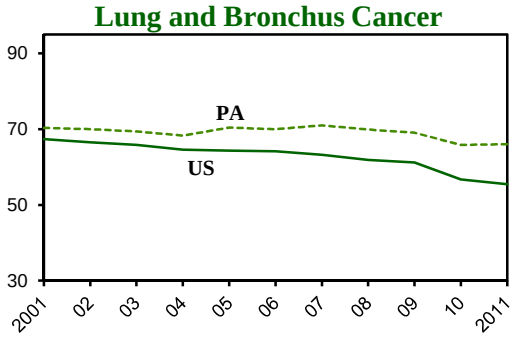
Female breast cancer – Both the U.S. and Pennsylvania experienced a noticeable drop in age-adjusted female breast rates between 2001 and 2003. Since then, their rates have been slowly climbing, with Pennsylvania's rate spiking in 2008 and 2009.

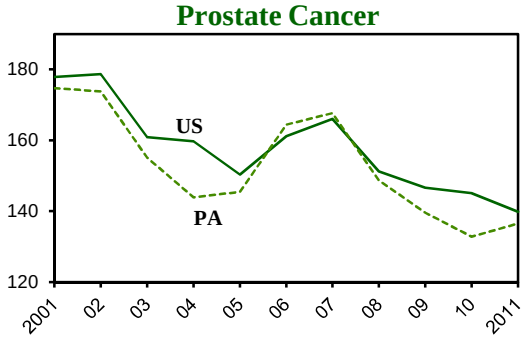
Lung and bronchus – The U.S. age-adjusted rate for lung and bronchus cancer steadily shrank from 2001 to 2011. However, the rate in Pennsylvania saw no obvious change until 2010, when it dipped by 4.6 percent.

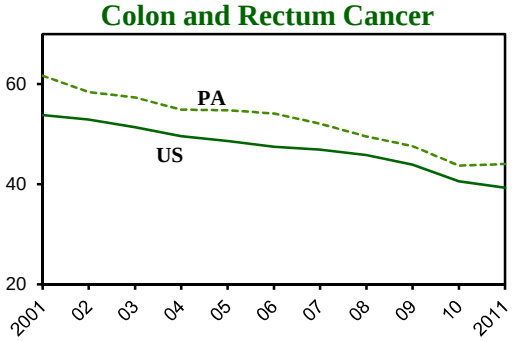
Colon and rectum cancer – Between 2001 and 2011, the age-adjusted rate for colorectal cancer has consistently decreased in Pennsylvania and the U.S., though the Pennsylvania rate has consistently been more than 7 percent higher than the U.S. rate.

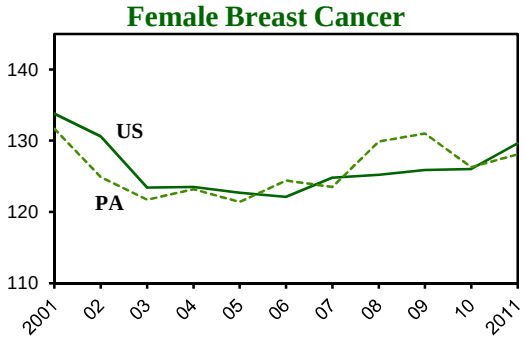
Urinary bladder cancer* – The age-adjusted rates for urinary bladder cancer in Pennsylvania and the U.S. held steady from 2001 to 2011. During this period, the Pennsylvania rate averaged as 19.3 percent higher than the U.S. rate.

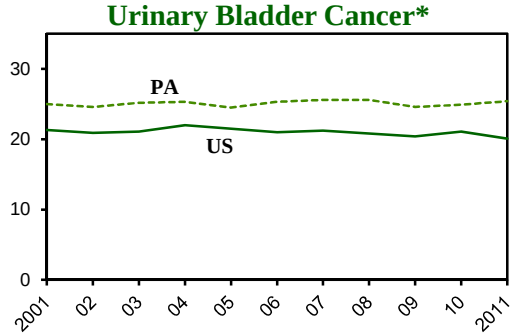






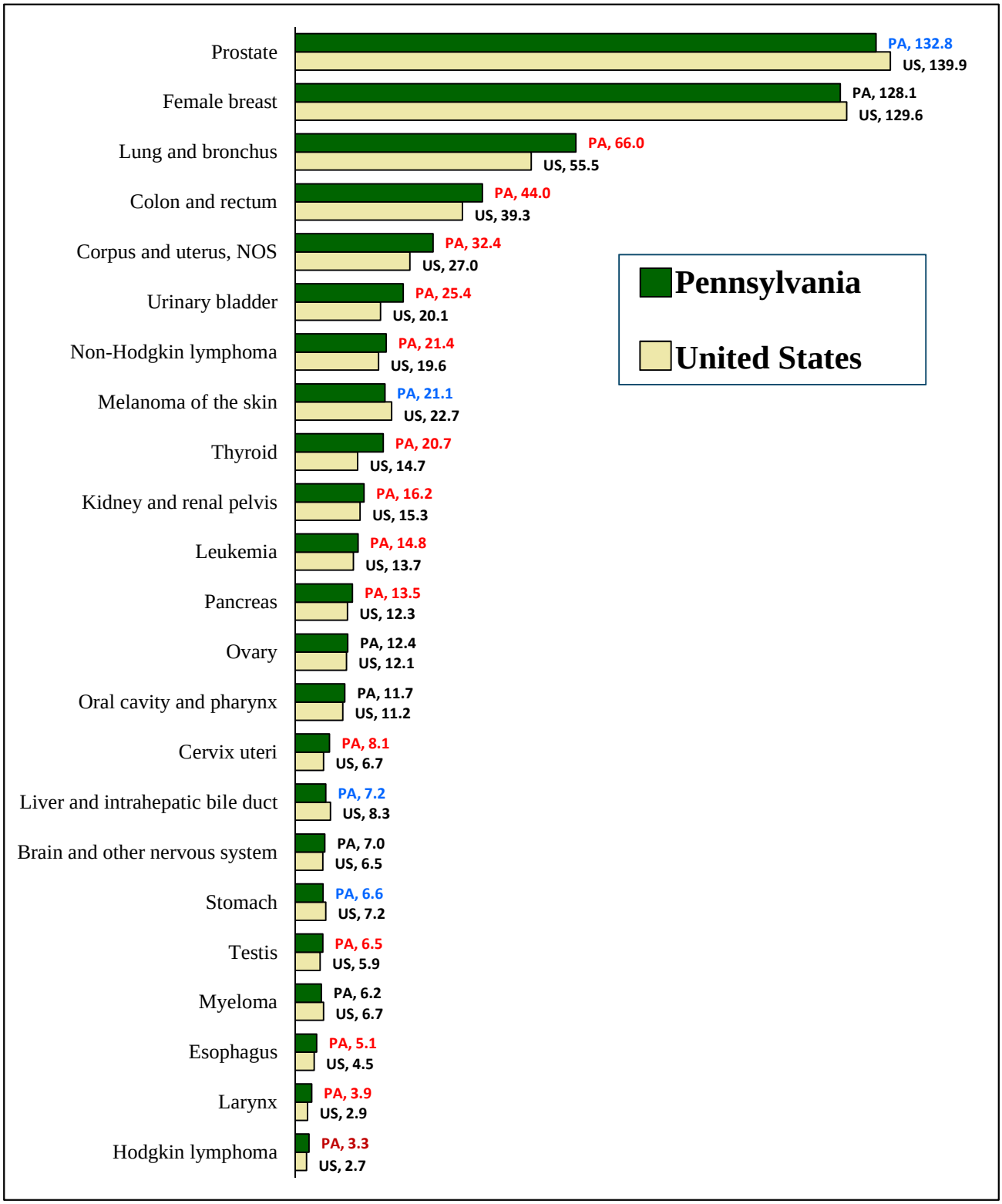






NOTES: Age-adjusted rates are computed by the direct method using the 2000 U.S. standard million population. U.S. age-adjusted rates were calculated from the National Cancer Institute's SEER program (based on nine registries).
*Includes in situ urinary bladder cancers

Comparison of Age-Adjusted Cancer Incidence Rates, by 23 Sites for Pennsylvania and United States, 2011



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. Pennsylvania rates highlighted in **red** indicate they are significantly higher than the corresponding U.S. rates. Pennsylvania rates highlighted in **blue** indicate they are significantly lower than the corresponding U.S. rates. U.S. age-adjusted rates were based on the National Cancer Institute's SEER program (nine registries).

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

All cancers – While the age-adjusted mortality rate has been decreasing for both Pennsylvania and the U.S., Pennsylvania's rate has remained higher. In 2006, the Pennsylvania rate was 7.0 percent higher than the U.S. rate, but the difference was only 4.0 percent in 2011.

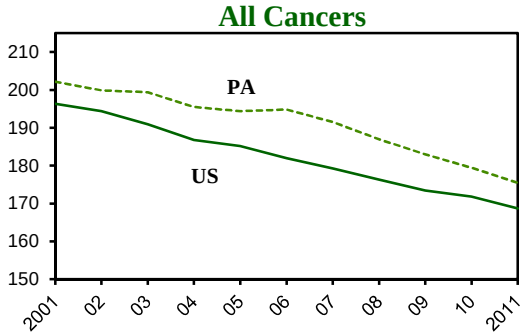
Prostate cancer – Across the period from 2001 to 2011, age-adjusted prostate cancer mortality rates have declined in Pennsylvania and the United States. While rising and falling multiple times, the Pennsylvania rate ended up only 1 percent lower than the U.S. rate in 2011.

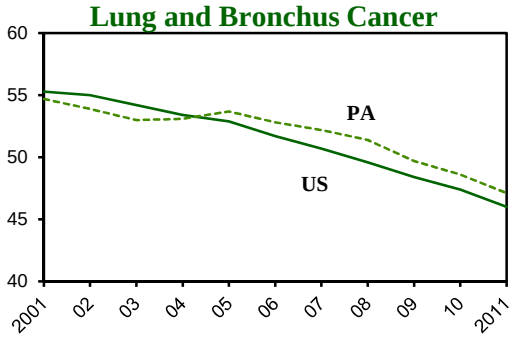
Female breast cancer – The downward trends of the Pennsylvania and U.S. age-adjusted mortality rates of female breast cancer from 2001 to 2011 have been similar, aside from Pennsylvania's rate sharply spiking in 2004 and dropping in 2005.

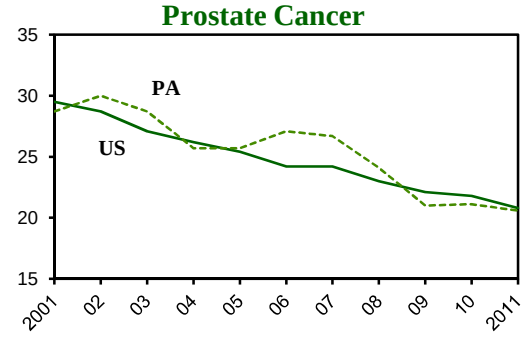
Lung and bronchus cancer – The annual age-adjusted mortality rate for lung and bronchus cancer in Pennsylvania started lower than the U.S. rate in 2001 but exceeded it in 2005. While both the Pennsylvania and U.S. rates have declined since then, Pennsylvania's rate has remained higher.

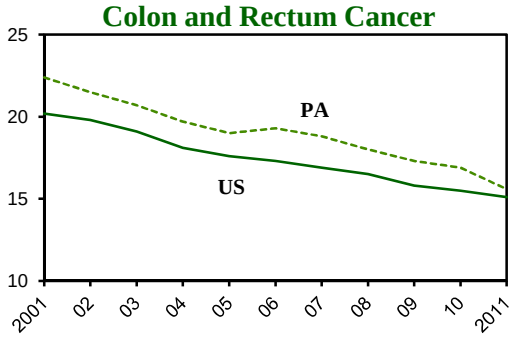
Colon and rectum cancer – Both Pennsylvania and the U.S. have seen an overall reduction for their age-adjusted mortality rates for colorectal cancer between 2001 and 2011. The Pennsylvania rate was 11.6 percent higher than the U.S. rate in 2006, compared to 3.3 percent higher in 2011.

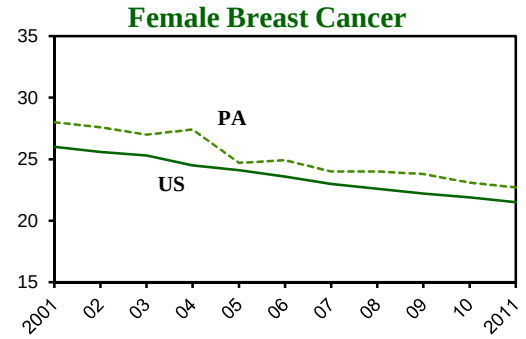
Urinary bladder cancer – The age-adjusted mortality rate for urinary bladder cancer has shown no apparent trend in the U.S., and Pennsylvania's rate has only increased slightly since 2008.

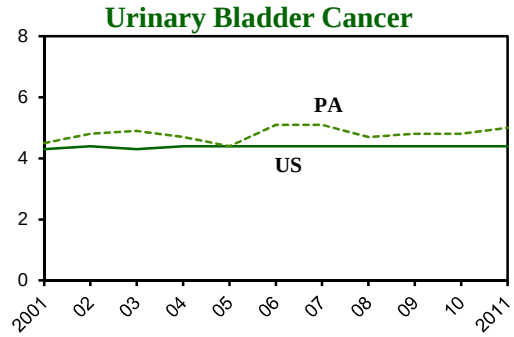






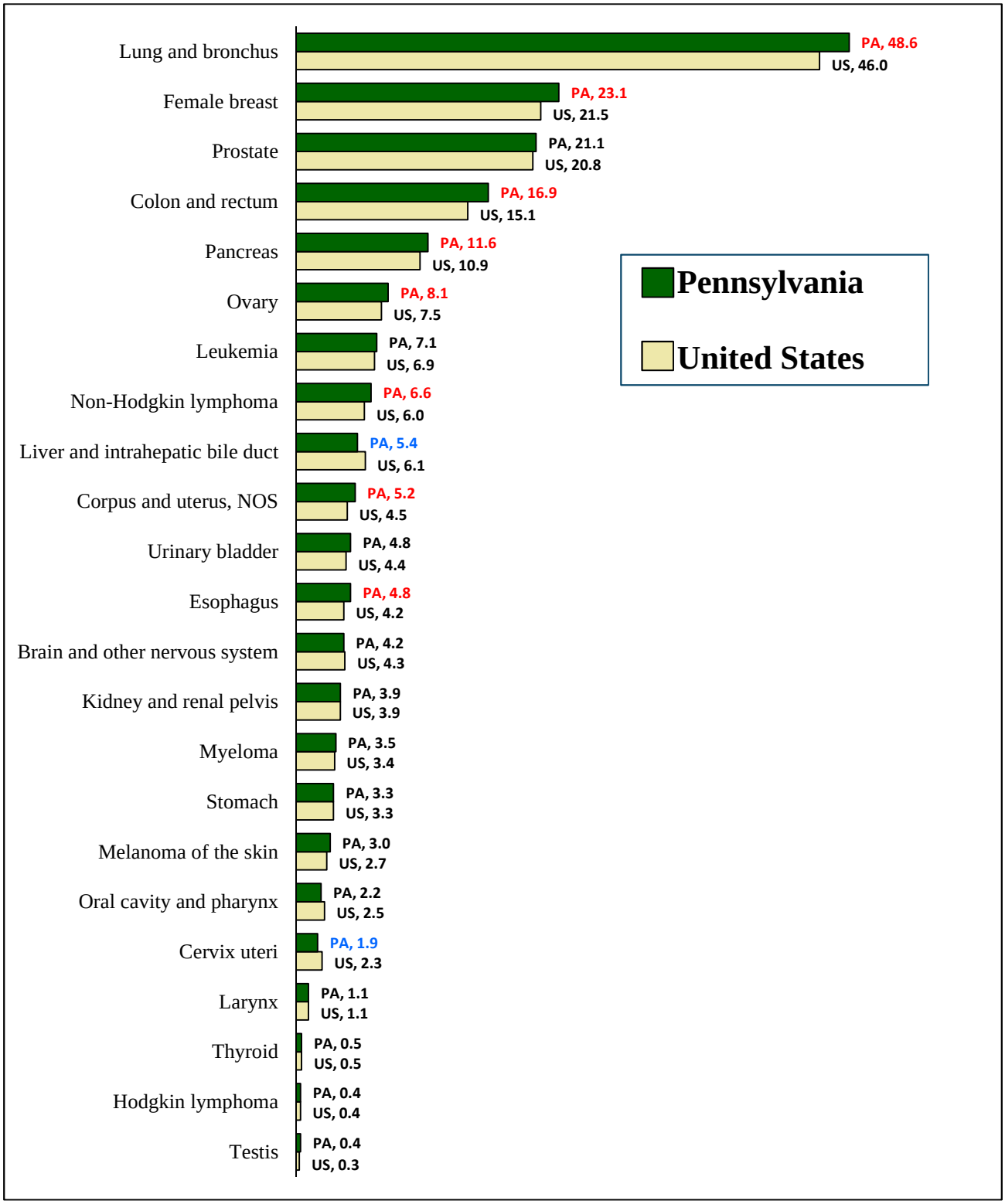






NOTES: Age-adjusted rates are computed by the direct method using the 2000 U.S. standard million population. U.S. age-adjusted rates were calculated from the National Cancer Institute's SEER program. 2011 is the latest data available for U.S. mortality rates.

Comparison of Age-Adjusted Cancer Death Rates, by 23 Sites for Pennsylvania and United States, 2011

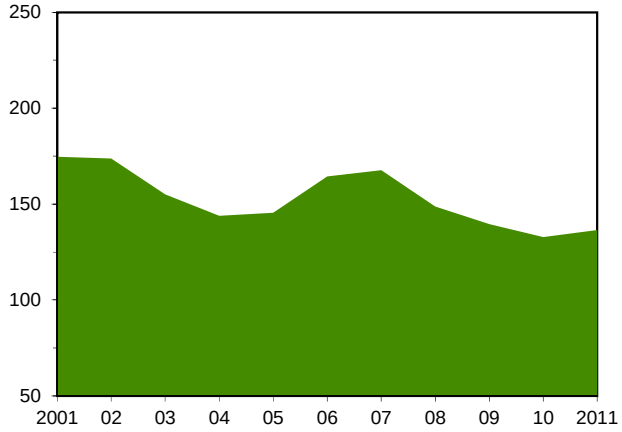


NOTES: Age-adjusted rates are computed by the direct method using the 2000 U.S. standard million population. Pennsylvania rates highlighted in **red** indicate they are statistically significantly higher than the corresponding U.S. rates. Pennsylvania rates highlighted in **blue** indicate they are statistically significantly lower than the corresponding U.S. rates. U.S. age-adjusted rates were based on the National Cancer Institute's SEER Program . 2011 is the latest data available for U.S. mortality rates.

Prostate Cancer

Trends:

During the period 2001-2011, the state's annual age-adjusted incidence rate for prostate cancer began going down but then increased each year in 2005 to 2007. Still, the rate in 2007 (167.7 per 100,000) was lower than in 2001 (174.7). The rate decreased after 2007 to a period low of 132.8 in 2010. The 2011 rate interrupted the trend, coming in at 136.5.



Signs and symptoms:

Things to look for include weak/interrupted urine flow; inability to urinate or difficulty starting or stopping flow; need to urinate frequently, especially at night; blood in urine; and impotence. At advanced stages, prostate cancer commonly spreads to the bones, causing pain in the hips, spine, ribs and other areas.

Risk factors:

According to the American Cancer Society, about six out of 10 prostate cancers in the United States are diagnosed in men aged 65 or older. Blacks have the highest incidence rates in the world. There may be some familial tendency. Obesity and diets high in processed meats and dairy foods are believed to increase the risk.

Early detection:

See page 22.

Treatment:

Options include surgery, radiation, cryosurgery, chemotherapy, hormone treatment and vaccine treatment, depending on patient's age, tumor grade and cancer stage. "Watchful waiting" may be appropriate, especially for older men and/or less aggressive tumors.

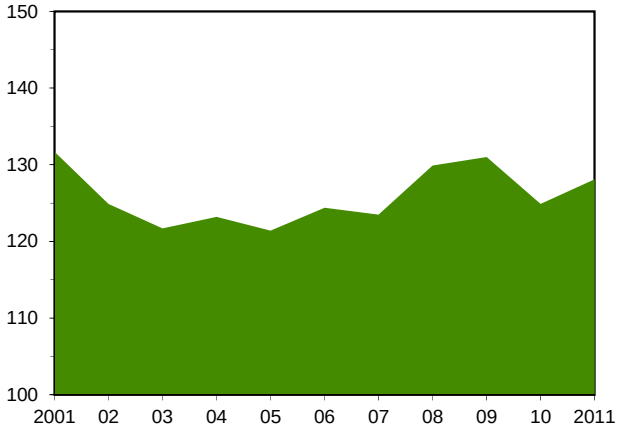
Survival (United States):

Recent data show that men diagnosed with invasive prostate cancer at the local or regional stage have a five-year relative survival rate of nearly 100 percent. Distant-staged diagnoses only have a five-year relative survival rate of 28.0 percent.

Breast Cancer

Trends:

The age-adjusted incidence rate of female breast cancer has shown no clear trend between 2001 and 2011. It started at a high of 131.7 per 100,000, dipped to 121.7 in 2003, then erratically rose to 130.0 in 2009. The rate fell 4.7 percent between then and 2010. Following this was another gain in 2011, with a final rate of 128.1 at the end of the 11-year period.



Signs and symptoms:

The earliest sign is an abnormality appearing on a mammogram before it can be felt by touch. Physically detectable symptoms include a lump, thickening, swelling, distortion or tenderness, skin irritation or dimpling, breast or nipple pain, scaliness, ulceration, retraction or spontaneous discharge, and underarm swelling of lymph nodes causing a lump. Breast pain is not usually a first symptom of breast cancer.

Risk factors:

Risk increases with age and family history of breast cancer, long menstrual history, increased breast density, obesity after menopause, recent use of oral contraceptives or postmenopausal combined hormone therapy, alcohol/tobacco use, physical inactivity, and never having children or having a first child after age 30.

Early detection:

See page 22.

Treatment:

Options usually include lumpectomy or mastectomy and removal of lymph nodes under the arm, radiation therapy, chemotherapy, or hormone therapy. In early stages, lumpectomy combined with radiation therapy has survival rates similar to mastectomy.

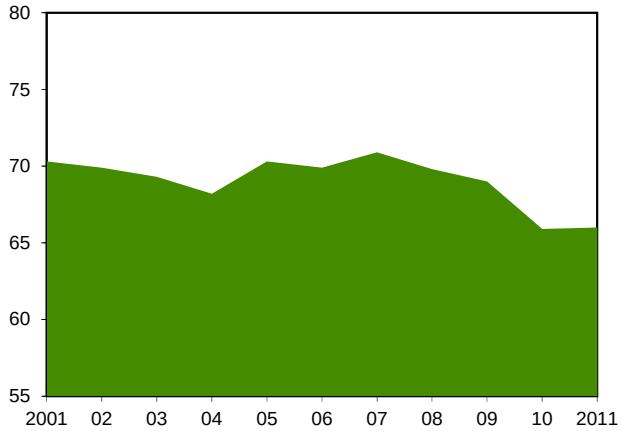
Survival (United States):

The five-year relative survival rate for localized breast cancer is nearly 98.5 percent. Regional-staged diagnoses have a somewhat lower rate of 84.6 percent, and distant-staged ones have a much lower rate of 25.0 percent.

Lung/Bronchus Cancer

Trends:

The Pennsylvania age-adjusted rate of invasive lung and bronchus cancer incidence started at 70.3 per 100,000 in 2001 and ended 6.0 percent lower at 66.0 in 2011. In that time, there was a period of decline from 2001 to 2004, followed by a general increase until 2007. The rate then declined again until 2010, when the rate (65.9) was not statistically different from the 2011 rate.



Signs and symptoms:

These include persistent cough, hoarseness, sputum streaked with blood, chest pain, loss of appetite, weight loss, fatigue, and recurring pneumonia or bronchitis.

Risk factors:

Tobacco smoking is by far the most important risk factor in the development of lung cancer, followed by exposure to radon gas. Other factors include occupational or environmental exposure to certain metals (e.g., chromium, cadmium and arsenic), some organic chemicals, asbestos, radiation, air pollution, diesel exhaust and second-hand tobacco smoke.

Early detection:

See page 22.

Treatment:

Options include surgery, radiation therapy and chemotherapy determined by type and stage of the disease. For later stage diagnoses, treatment regimens commonly combine radiation therapy and chemotherapy with surgery. Chemotherapy alone or combined with radiation is the usual treatment for small cell lung cancer.

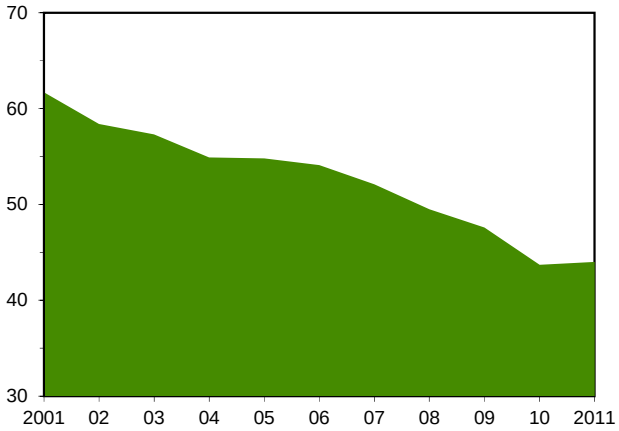
Survival (United States):

Invasive lung and bronchus cancer has extremely low survival rates, partially because many cases are diagnosed at a distant stage: 57 percent between 2004 and 2010. Patients with distant-staged diagnoses only have a 4.0 percent five-year relative survival rate, as opposed to 54.0 percent for local-stage. The one-year rate for all cases is 44.4 percent.

Colon/Rectum Cancer

Trends:

The age-adjusted incidence rate of invasive colorectal cancer among Pennsylvanians largely fell from 61.7 per 100,000 in 2001 to 44.0 in 2011: a difference of 28.6 percent. Starting in 2001, the rate fell every year, even if only slightly, until it reached 43.7 in 2010. After this, the rate increased slightly in 2011.



Signs and symptoms:

Symptoms of advanced stages include rectal bleeding, blood in the stool, a change in bowel habits, cramps, abdomen pain and sometimes anemia, which leads to weakness, fatigue and weight loss.

Risk factors:

Being over age 50 and/or having familial history of colon cancer or polyps and inflammatory bowel disease have been associated with increased risk. Other risk factors include obesity, tobacco smoking, physical inactivity, diets high in red or processed meats, heavy alcohol use, as well as inadequate consumption of fruits and vegetables.

Early detection:

See page 22.

Treatment:

Surgery is the main form of treatment and frequently results in a cure for cancers that have not spread. Chemotherapy, possibly paired with radiation therapy, before or after surgery is recommended for patients whose cancer has significantly penetrated the bowel wall or spread to the lymph nodes. Colostomy is seldom needed for colon cancer patients.

Survival (United States):

When caught at the local or regional stage, the five-year relative survival rate is 89.9 or 70.5 percent, respectively. When diagnosed with distant-staged colorectal cancer, a patient only has a five-year relative survival rate of 12.9 percent.

2014 PROJECTED CANCER CASES by SITE and SEX

All cases – The number of invasive cancer cases among Pennsylvania residents is projected to increase by 1.5 percent between 2011 and 2014, from 78,164 to 79,300. Three primary sites – melanoma of the skin, female breast, and thyroid – are projected to have the largest increases in cases. Leukemia, while not expected to increase in count as much as those three sites, is projected to increase by a large percentage: 13.5. In total, 13 of the 23 primary sites are projected to increase between 2011 and 2014, though only 10 of these should increase by more than 5 percent. Prostate and colorectal cancers are the only notable expected decreases, with more than 10 percent fewer cases each.

Males – In 2011, 39,744 cancers were diagnosed among male Pennsylvanians. The projected number of cases for 2014 is 39,765, a mere 0.1 percent difference. Of the sites which are projected to see an increase, melanoma of the skin, non-Hodgkin lymphoma, thyroid cancer, and leukemia are each projected to increase by over 150 cases. Conversely, prostate cancer cases are predicted to decrease by 1,170, an 11.4 percent difference, between 2011 and 2014.

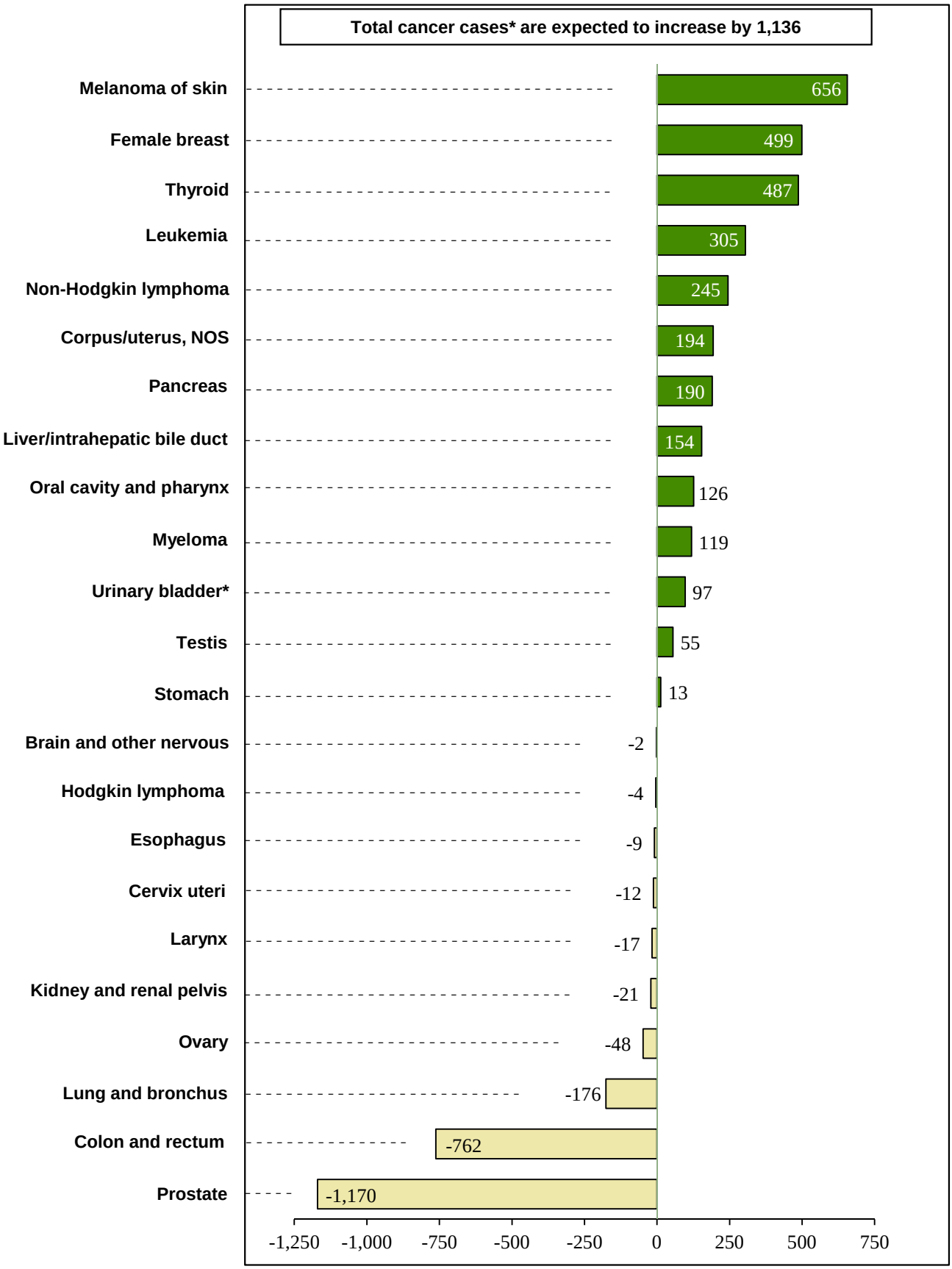
Females – In contrast to the male forecast, the prediction for female Pennsylvanians shows an increase in cancer cases by 1,115. The majority of these additional cases are expected to be breast cancer, melanoma of the skin and uterine cancer. The largest and only sizeable decrease is expected to happen for colorectal cancer. Females in 2014 are predicted to see 459 fewer cases of this cancer, a 13.4 percent difference.

2014 Projected and 2011 Observed Invasive Cancer Cases, Pennsylvania Residents Percent Change 2011 vs. 2014, All Cancers and 23 Selected Sites by Sex

	ALL CASES			MALES			FEMALES		
Cancer site	2014 Projected	2011 Observed	Percent change	2014 Projected	2011 Observed	Percent change	2014 Projected	2011 Observed	Percent change
All cancers **	79,300	78,164	1.5	39,765	39,744	0.1	39,535	38,420	2.9
Brain and other Nervous system	1,005 *	1,007	-0.2	540 *	539	0.2	425	468	-9.2
Cervix uteri	540 *	552	-2.2	-	-	-	540 *	552	-2.2
Colon and rectum	6,255	7,017	-10.9	3,285	3,588	-8.4	2,970	3,429	-13.4
Corpus/uterus, NOS	2,980	2,786	7.0	-	-	-	2,980	2,786	7.0
Esophagus	830 *	839	-1.1	650 *	677	-4.0	150	162	-7.4
Female breast	11,060	10,561	4.7	-	-	-	11,060	10,561	4.7
Hodgkin lymphoma	425 *	429	-0.9	225 *	233	-3.4	195 *	196	-0.5
Kidney/renal pelvis	2,495 *	2,516	-0.8	1,540 *	1,582	-2.7	955 *	934	2.2
Larynx	610 *	627	-2.7	485 *	481	0.8	165	146	13.0
Leukemia	2,560	2,255	13.5	1,420	1,261	12.6	1,145	994	15.2
Liver/ intrahepatic bile duct	1,345	1,191	12.9	960	862	11.4	385	329	17.0
Lung and bronchus	10,405	10,581	-1.7	5,600 *	5,637	-0.7	4,870	4,944	-1.5
Melanoma of skin	3,850	3,194	20.5	2,220	1,821	21.9	1,630	1,373	18.7
Myeloma	1,105	986	12.1	615	549	12.0	485	437	11.0
Non-Hodgkin lymphoma	3,610	3,365	7.3	2,070	1,880	10.1	1,500 *	1,485	1.0
Oral cavity/pharynx	1,970	1,844	6.8	1,415	1,296	9.2	540 *	548	-1.5
Ovary	985	1,033	-4.6	-	-	-	985	1,033	-4.6
Pancreas	2,385	2,195	8.7	1,185	1,075	10.2	1,200	1,120	7.1
Prostate	9,065	10,235	-11.4	9,065	10,235	-11.4	-	-	-
Stomach	1,075 *	1,062	1.2	680 *	666	2.1	420	396	6.1
Testis	435	380	14.5	435	380	14.5	-	-	-
Thyroid	3,320	2,833	17.2	860	691	24.5	2,460	2,142	14.8
Urinary bladder **	4,190	4,093	2.4	3,135	3,039	3.2	995 *	1,054	-5.6

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 2007-2011 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, 2011 vs. 2014



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

2014 PROJECTED CANCER DEATHS by SITE and SEX

All deaths – The predicted number of cancer deaths among Pennsylvanians in 2014 (28,690) is only slightly higher than the 28,627 deaths in 2012. Out of the 23 major cancer sites, deaths from pancreatic cancers are expected to increase the most by 118. The number of deaths from lung and bronchus cancers is expected to drop by 134, more than any other site.

Males – An expected 14,730 cancer deaths will occur among Pennsylvania males in 2014, as compared to the 14,711 seen in 2012. As with the total state population, predictions show pancreatic cancer deaths increasing and lung and bronchus cancers decreasing the most. However, deaths from kidney and renal pelvis cancers are expected to increase among the total population and decrease among males.

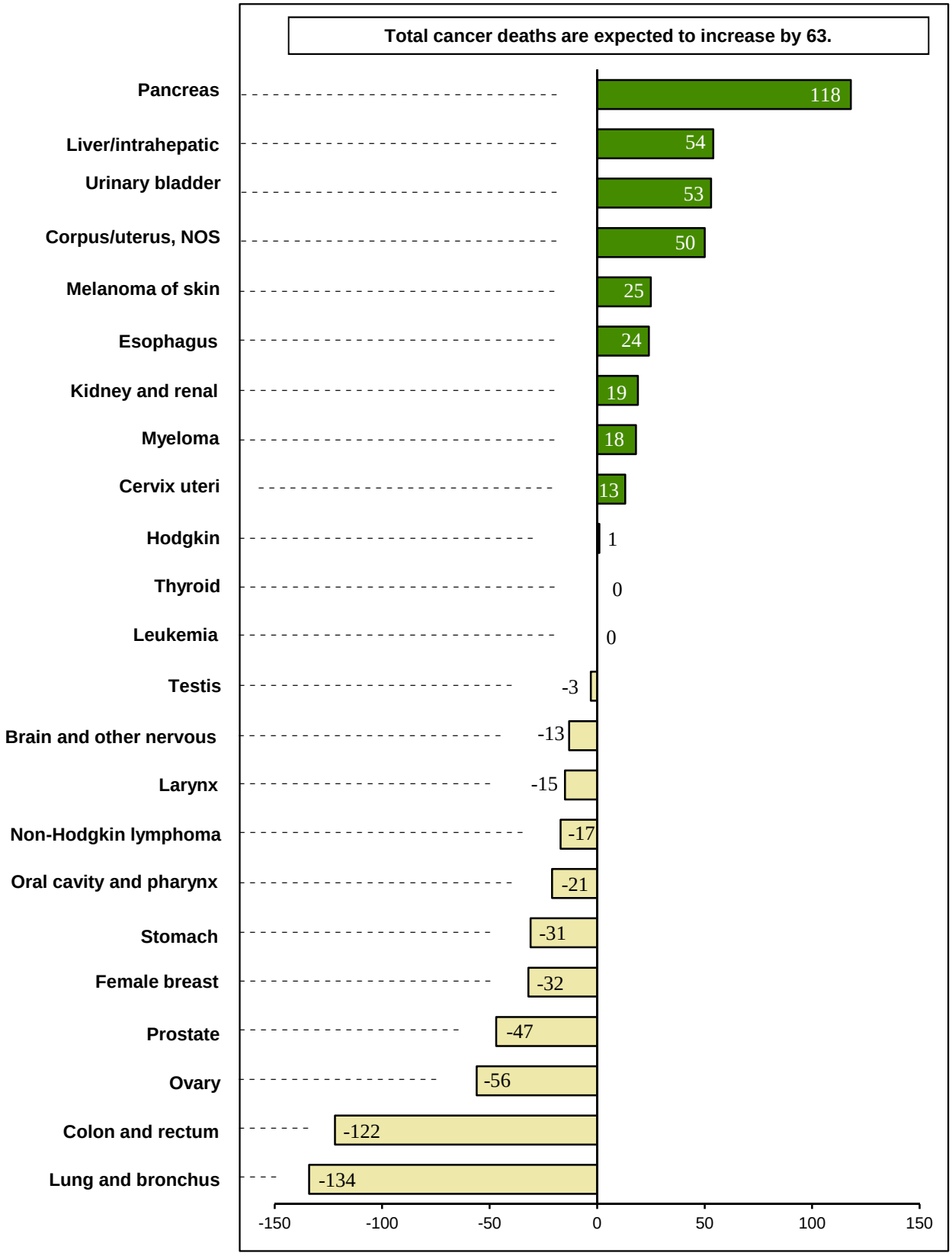
Females – The relative projected increase in the number of cancer deaths among female Pennsylvanians is slightly higher than among males: a 0.3 percent increase from 13,916 to 13,960. Colorectal and ovarian cancers are expected to have the largest decrease of female deaths. The largest projected increases in deaths are for pancreatic and corpus uteri cancers.

2014 Projected and 2012 Observed Cancer Deaths, Pennsylvania Residents Percent Change 2012 vs. 2014, All Cancers and 23 Selected Sites by Sex

	ALL DEATHS			MALES			FEMALES		
Cancer site	2014 Projected	2012 Observed	Percent change	2014 Projected	2012 Observed	Percent change	2014 Projected	2012 Observed	Percent change
All cancers	28,690 *	28,627	0.2	14,730 *	14,711	0.1	13,960 *	13,916	0.3
Brain and other Nervous system	635 *	648	-2.0	375	356	5.3	285 *	292	-2.4
Cervix uteri	165 *	152	8.6	-	-	-	165 *	152	8.6
Colon and rectum	2,490	2,612	-4.7	1,240	1,301	-4.7	1,250	1,311	-4.7
Corpus/uterus, NOS	525	475	10.5	-	-	-	525	475	10.5
Esophagus	800	776	3.1	615 *	634	-3.0	155 *	142	9.2
Female breast	1,980	2,012	-1.6	-	-	-	1,980	2,012	-1.6
Hodgkin lymphoma	65	64	1.6	35	35	0.0	30	29	3.4
Kidney/renal pelvis	670	651	2.9	385 *	404	-4.7	265	247	7.3
Larynx	165	180	-8.3	120	138	-13.0	50	42	19.0
Leukemia	1,170 *	1,170	0.0	655 *	654	0.2	520	516	0.8
Liver/ intrahepatic Bile duct	1,075	1,021	5.3	705	687	2.6	370	334	10.8
Lung and bronchus	7,505	7,639	-1.8	4,115	4,230	-2.7	3,390	3,409	-0.6
Melanoma of skin	455 *	430	5.8	290 *	269	7.8	165 *	161	2.5
Myeloma	535 *	517	3.5	275 *	267	3.0	255 *	250	2.0
Non-Hodgkin lymphoma	1,045	1,062	-1.6	580 *	573	1.2	460	489	-5.9
Oral cavity/pharynx	330	351	-6.0	215	225	-4.4	115 *	126	-8.7
Ovary	665	721	-7.8	-	-	-	665	721	-7.8
Pancreas	2,035	1,917	6.2	1,010	949	6.4	1,025	968	5.9
Prostate	1,235	1,282	-3.7	1,235	1,282	-3.7	-	-	-
Stomach	445	476	-6.5	255	286	-10.8	200 *	190	5.3
Testis	10	13	-23.1	10	13	-23.1	-	-	-
Thyroid	85 *	85	0.0	40	33	21.2	50 *	52	-3.8
Urinary bladder	855	802	6.6	610	568	7.4	235 *	234	0.4

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 2008-2012 was used to estimate the number of deaths. See Technical Notes for additional information.

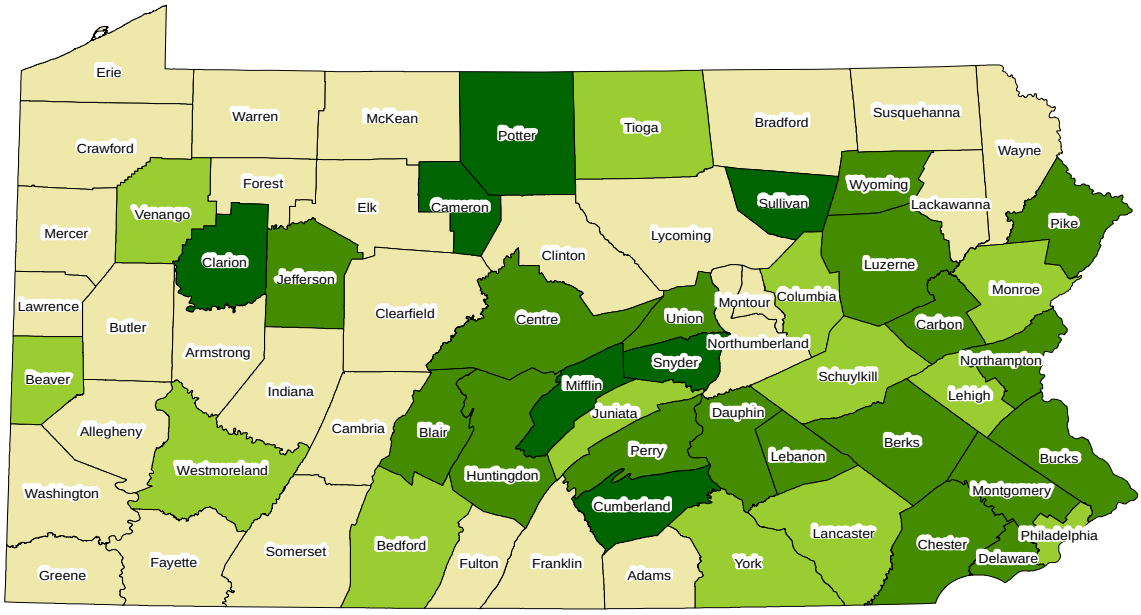
Expected Change in Number of Cancer Deaths, 2012 vs. 2014
All Cancers and 23 Selected Sites



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

2014 Projected and 2011 Observed Invasive Cancer Cases**
Percent Change 2011 vs. 2014 by Pennsylvania County of Residence

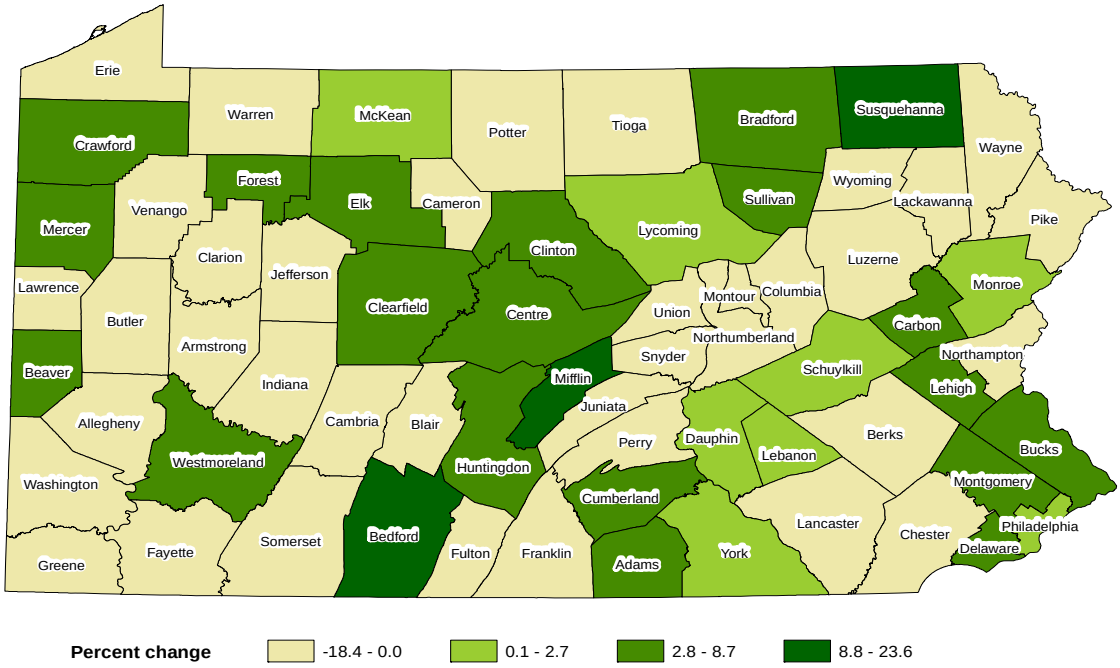
County	2014 Projected	2011 Observed	Percent change	County	2014 Projected	2011 Observed	Percent change
All Counties	79,300	78,164	1.5	Juniata	150	149	0.7
Adams	560 *	564	-0.7	Lackawanna	1,315	1,340	-1.9
Allegheny	7,580	7,971	-4.9	Lancaster	2,850	2,830	0.7
Armstrong	435 *	449	-3.1	Lawrence	540	619	-12.8
Beaver	1,140	1,131	0.8	Lebanon	900	837	7.5
Bedford	370	364	1.6	Lehigh	2,110	2,062	2.3
Berks	2,475	2,381	3.9	Luzerne	2,380	2,236	6.4
Blair	895	857	4.4	Lycoming	775 *	788	-1.6
Bradford	420 *	441	-4.8	McKean	235	267	-12.0
Bucks	4,100	3,950	3.8	Mercer	740	816	-9.3
Butler	1,145 *	1,158	-1.1	Mifflin	365	325	12.3
Cambria	1,000 *	1,031	-3.0	Monroe	930	911	2.1
Cameron	45 *	38	18.4	Montgomery	5,320	5,009	6.2
Carbon	440 *	426	3.3	Montour	120 *	126	-4.8
Centre	755	710	6.3	Northampton	2,090	1,943	7.6
Chester	2,925	2,834	3.2	Northumberland	630 *	636	-0.9
Clarion	270 *	241	12.0	Perry	290	272	6.6
Clearfield	485	509	-4.7	Philadelphia	8,640	8,570	0.8
Clinton	245 *	254	-3.5	Pike	340 *	320	6.3
Columbia	425 *	421	1.0	Potter	135	120	12.5
Crawford	550 *	564	-2.5	Schuylkill	1,010 *	1,001	0.9
Cumberland	1,615	1,379	17.1	Snyder	240	216	11.1
Dauphin	1,605	1,487	7.9	Somerset	455	467	-2.6
Delaware	3,725	3,570	4.3	Sullivan	75	67	11.9
Elk	235 *	258	-8.9	Susquehanna	300	300	0.0
Erie	1,545 *	1,548	-0.2	Tioga	280 *	274	2.2
Fayette	875	917	-4.6	Union	240 *	221	8.6
Forest	45 *	52	-13.5	Venango	360 *	355	1.4
Franklin	885 *	889	-0.4	Warren	210	256	-18.0
Fulton	85 *	91	-6.6	Washington	1,240	1,337	-7.3
Greene	240 *	240	0.0	Wayne	320 *	358	-10.6
Huntingdon	270	261	3.4	Westmoreland	2,605	2,554	2.0
Indiana	400	438	-8.7	Wyoming	190 *	177	7.3
Jefferson	350	327	7.0	York	2,725	2,654	2.7



NOTE: Projections were rounded to the nearest whole five.
*The arithmetic mean for the five-year period of 2007-2011 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.

2014 Projected and 2012 Observed Cancer Deaths
Percent Change 2012 vs. 2014 by Pennsylvania County of Residence

County	2014 Projected	2012 Observed	Percent change	County	2014 Projected	2012 Observed	Percent change
All Counties	28,690 *	28,627	0.2	Juniata	55 *	55	0.0
Adams	230	222	3.6	Lackawanna	505	540	-6.5
Allegheny	3,050	3,095	-1.5	Lancaster	965	1,060	-9.0
Armstrong	180 *	189	-4.8	Lawrence	235	251	-6.4
Beaver	460 *	445	3.4	Lebanon	325 *	321	1.2
Bedford	110 *	89	23.6	Lehigh	815	774	5.3
Berks	775	789	-1.8	Luzerne	775	833	-7.0
Blair	275	314	-12.4	Lycoming	300	295	1.7
Bradford	165 *	159	3.8	McKean	75	73	2.7
Bucks	1,345	1,288	4.4	Mercer	320 *	307	4.2
Butler	400 *	410	-2.4	Mifflin	125	112	11.6
Cambria	330	351	-6.0	Monroe	340	332	2.4
Cameron	15 *	18	-16.7	Montgomery	1,735	1,631	6.4
Carbon	205	196	4.6	Montour	40 *	49	-18.4
Centre	225	216	4.2	Northampton	655 *	657	-0.3
Chester	890 *	920	-3.3	Northumberland	250 *	253	-1.2
Clarion	90	92	-2.2	Perry	105 *	105	0.0
Clearfield	205 *	192	6.8	Philadelphia	3,280 *	3,252	0.9
Clinton	110	105	4.8	Pike	100 *	113	-11.5
Columbia	130	130	0.0	Potter	50 *	56	-10.7
Crawford	220 *	204	7.8	Schuylkill	415 *	408	1.7
Cumberland	510	485	5.2	Snyder	75 *	84	-10.7
Dauphin	535 *	521	2.7	Somerset	185 *	186	-0.5
Delaware	1,260 *	1,218	3.4	Sullivan	20 *	19	5.3
Elk	100	92	8.7	Susquehanna	105 *	93	12.9
Erie	625 *	647	-3.4	Tioga	100 *	102	-2.0
Fayette	410 *	432	-5.1	Union	70	74	-5.4
Forest	25	23	8.7	Venango	150	162	-7.4
Franklin	320 *	323	-0.9	Warren	95	99	-4.0
Fulton	30 *	31	-3.2	Washington	570 *	578	-1.4
Greene	100 *	107	-6.5	Wayne	125	130	-3.8
Huntingdon	120	111	8.1	Westmoreland	1,015	975	4.1
Indiana	160	161	-0.6	Wyoming	65 *	67	-3.0
Jefferson	120 *	123	-2.4	York	900	883	1.9



NOTE: Projections were rounded to the nearest whole five.
*The arithmetic mean for the five-year period of 2008-2012 was used to estimate the number of deaths. See Technical Notes for additional information.

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

Cancer Site	Recommendation
General cancer-related checkup	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, testes, ovaries, lymph nodes, oral cavity and skin, as well as for some nonmalignant diseases.
Breast	• Starting at age 20, women should be aware of the benefits and limitations of breast self-examinations and should report breast changes promptly to a health care provider. • A clinical breast exam is recommended at least every three years for women ages 20-39 and every year starting at age 40. • Starting at age 40, women in good health should have annual mammograms following a clinical breast exam.
Colon and rectum	Beginning at age 50, men and women should follow one of the exam schedules below: 1. Fecal occult blood test (FOBT) with at least 50 percent test sensitivity for cancer, or fecal immunochemical test (FIT) every year†; 2. Stool DNA test (interval uncertain); 3. Flexible sigmoidoscopy (FSIG) every five years; 4. Double-contrast barium enema every five years; 5. Colonoscopy every 10 years; or 6. CT Colonography (Virtual Colonoscopy) every five years. † FOBT during a digital rectal exam in the doctor's office is not adequate for screening. A take home sample kit should be used. Guaiac-based FOBT is not recommended.
Lung	Patients aged 55 to 74 years who have at least a 30-pack-year smoking history, currently smoke or have quit within the past 15 years, and who are in relatively good health should initiate a discussion about lung cancer screening with their physicians.
Prostate	The ACS recommends that, beginning at age 50, men with a life expectancy of at least 10 years be given information about the benefits and limitations of prostate cancer screening so that an informed decision can be made. The prostate-specific antigen (PSA) blood test and a digital rectal exam (DRE) are used to screen for prostate cancer.
Cervix	Beginning at age 21, women should have a conventional or a liquid-based Pap test every three years. At or after age 30, screening should be done every five years with both the HPV and Pap tests or every three years with the Pap test alone. Women aged 65 or older who have had three or more negative Pap tests or two or more negative HPV and Pap tests in a row within the previous 10 years (the most recent test having been done within the previous five years) should not continue screening. Screening is not necessary after a total hysterectomy. Annual screening should not be done at any age.

The above guidelines on cancer screening summarize the recommendations put together by the American Cancer Society as reported in their "2014 Cancer Facts and Figures." These guidelines are continuously reviewed and updated as needed. Additional guidelines for cancer screening can be found from other organizations. For additional information on guidelines for early cancer detection, go to the American Cancer Society's website at **www.cancer.org** or the U.S. Preventive Service Task Force's website at **www.USPreventiveServicesTaskForce.org**. Please note that the Pennsylvania Department of Health does not explicitly endorse one set of guidelines over another.

Cancer Prevention and Control Initiatives
of the Pennsylvania Department of Health

The Pennsylvania Department of Health **wants you to know … what we know about cancer.**

79,300 → This many Pennsylvanians are expected to be diagnosed with cancer in 2014.

28,690 → This many Pennsylvanians are expected to die of cancer in 2013.

1 in 2 → Chance that men in the United States are expected to get cancer in their lifetime

1 in 3 → Chance that women in the United States are expected to get cancer in their lifetime

Lung Cancer:

- More people die from lung cancer than prostate, breast and colorectal cancer combined, making it the leading cancer killer in America.
- Quitting smoking remains the best way to reduce your risk of developing or dying from lung cancer, followed by testing your home for radon and fixing high levels.

Breast Cancer:

- Breast cancer is treatable if caught early.
- Remember to have your mammogram every year if you are 40 or older.

Cervical Cancer:

- No woman should die of cervical cancer.
- Regular Pap tests are the best way to find cancer early.
- We know that human papillomavirus (HPV) causes most cases of cervical cancer.
- There is a vaccine available to prevent cervical cancer.

Colorectal Cancer:

- Colorectal cancer is treatable if caught early.
- If you are 50 or older, talk to your health care provider about getting tested for colon cancer.

Prostate Cancer:

- One in seven men gets prostate cancer in their lifetime.
- Black men have the highest rates of prostate cancer in the United States.[*]
- Know the facts about prostate cancer screening and talk to your healthcare provider about the risks and benefits of prostate cancer screening.

Melanoma:

- About 9,710 people in the United States will die of melanoma in 2014.[†]
- Melanoma is the deadliest form of skin cancer.
- Skin cancer is preventable.

We offer **free breast and cervical cancer screening** to women ages 40 to 64. Call **1-800-215-7494** or visit our website at **www.PAHealthyWoman.com** to see if you are eligible.

[*] SEER Cancer Statistics Review, 1975-2011
[†] Cancer Facts and Figures 2014

Continued on page 24

Cancer Prevention and Control Initiatives (continued)

We offer **free colorectal cancer screening** to eligible men and women ages 50 to 64 who are residents of Philadelphia County. Call **1-215-685-6560** or visit our Web page at **www.health.state.pa.us/cancer** (click on Colorectal Cancer Control Program) to see if you are eligible.

We can bring our **free breast cancer photo exhibit, "**67 Women, 67 Counties: Facing Breast Cancer in Pennsylvania," to your community. Call **1-800-377-8828** to schedule a photo exhibit opening in your home town or visit **www.pbccexhibit.org**.

Now you know what we know about cancer.

Visit www.health.state.pa.us/cancer for **more information about cancer control programs in Pennsylvania.**

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