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Mortality and incidence trends for leading cancers in Queensland, 1982 to 2004

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Summary

- The aim of this publication is to provide information on the cancer mortality and incidence trends in Queensland using the latest data available (1982 to 2004). Trends are presented for all cancers combined and for seven of the eight[a] National Health Priority cancers: lung, colorectal (large bowel), prostate, breast, cervix, melanoma, and non-Hodgkin's lymphoma. Results for six other important cancers are also reported, namely stomach, ovary, bladder, kidney, uterus and mesothelioma. Trends for males and females are presented separately.

- For certain cancers the trend was not the same over the entire period 1982 to 2004. For example, a slow increase occurred for breast cancer mortality between 1982 and 1993, followed by a decrease in more recent years. A statistical technique called "joinpoint analysis"[1] was used to describe changing trends over successive segments of time (see Appendix A).

- Mortality rates for all cancers combined have been decreasing for both sexes since the mid-1990s. For women, the overall decline in cancer mortality rate corresponds with improvements in mortality due to non-Hodgkin's lymphoma, breast and kidney cancers, and continuing decreases in mortality from colorectal, cervical, stomach and ovarian cancers. For men, the recent decline in the overall cancer death rate appears to be mainly driven by recent improvements in the mortality rate of prostate cancer and non-Hodgkin's lymphoma, and continuing improvements in mortality rates for lung, colorectal and stomach cancers.

- The mortality rate for lung cancer has continued to decrease among men but increase significantly among women. Lung cancer was the leading cause of female cancer deaths in 2004.

- The incidence and mortality rates of mesothelioma in both men and women are increasing rapidly from a low base.

- The mortality rates of non-Hodgkin's lymphoma in both males and females have begun to decrease in recent years.

- Cancer incidence rate trends are sometimes difficult to interpret and may be related to changes in screening practices and public awareness, rather than a real change in the underlying risk of the specific cancer.

- The incidence rate (or rate of new cases) of cancers among women increased consistently from 1982 until the early 2000's, followed by a decrease in the trend in recent years. The initial increase in this trend was driven mainly by increases in breast, lung, colorectal, kidney, pancreatic and uterine cancers as well as non-Hodgkin's lymphoma and melanoma. However, the recent change in trend to a decreasing incidence rate was largely attributed to a corresponding decrease in breast cancer incidence as well as a drop in the incidence of cervical, ovarian and stomach cancers over time.

- Trends in the incidence of cancer among men have decreased since 1993. This is mainly associated with continuing decreases in the incidence of lung and stomach cancers. However, the incidence of colorectal cancer, prostate cancer, non-Hodgkin's Lymphoma, melanoma and mesothelioma continues to increase among men.

Incidence trends for all cancers combined

A total of 19,153 new cancers (incidence) were diagnosed in Queensland during 2004. Of these, 10,841 new cancers were reported for males and 8,312 for females.

For females, the overall cancer incidence rate increased by 1.3% per year until 2000, but has since decreased by 1.7% per year between 2000-2004 (Figures 1 and 2, Appendix B). The initial increase in overall cancer incidence rates was driven by increases in the incidence rates of breast cancer (mainly due to increased screening), lung, colorectal, kidney, pancreatic and uterine cancers as well as non-Hodgkin's lymphoma and melanoma. The change in trend to a decreasing incidence rate in 2000 coincided with a similar change in the trend for breast cancer, where the incidence rate increased by 2.1% per year until 2000, but then decreased by 1.8% per year from 2000-2004. There have been significant decreases in incidence rates for ovarian, cervical and stomach cancers.

[a] Trends for the eighth National Health Priority cancer, non-melanocytic skin cancer, are not presented in this report because incidence data for this cancer are not routinely collected by the Queensland Cancer Registry (or any of the other state or territory registries).

Figure 1: Incidence trends for all cancers combined by sex, Queensland, 1982-2004

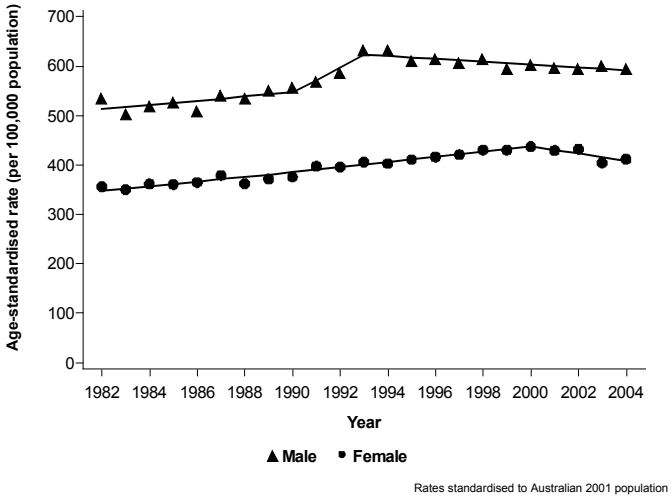
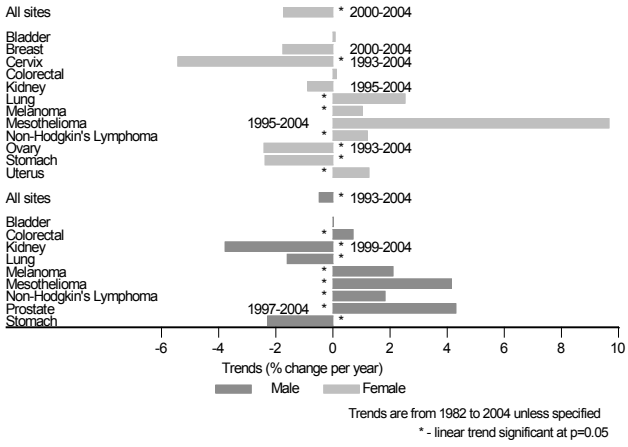


Figure 2: Recent trends in incidence by type of cancer and sex (annual percentage change), Queensland



For males, cancer incidence rates increased until 1993 but have decreased by 0.5% per year since then (Figures 1 and 2, Appendix B). This recent trend is due to significant decreases in the incidence rates of stomach and lung cancers, and a large fall in the incidence rate of prostate cancer during the mid-1990s, which may have resulted from a depletion in prevalent cases from the pool of men having prostate-specific antigen (PSA) testing during that time[2]. (The incidence rate of prostate cancer has increased again since 1997). The decreasing trend for all cancers has been somewhat offset by increases in the incidence rate of colorectal cancer.

Mortality trends for all cancers combined

In 2004 there were 7,013 deaths from cancer recorded in Queensland (4,082 males and 2,931 females).

Figure 3: Mortality trends for all cancers combined by sex, Queensland, 1982-2004

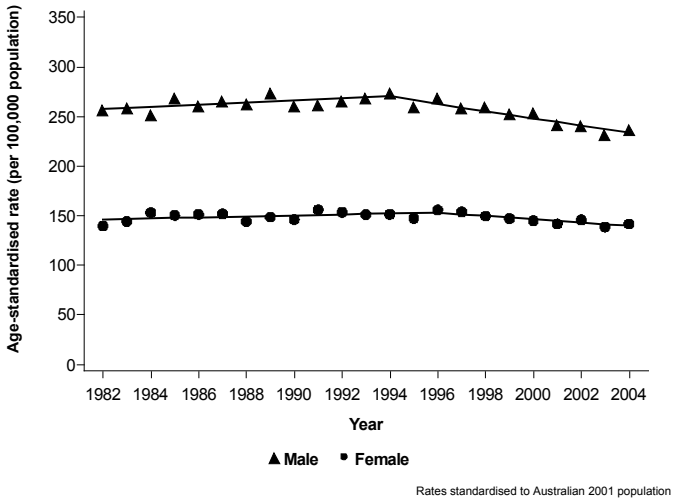
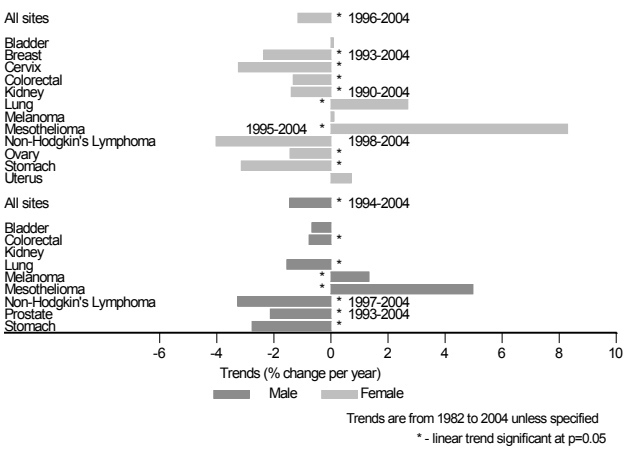


Figure 4: Recent trends in mortality by type of cancer and sex (annual percentage change), Queensland



For females, the mortality rate increased slightly (0.3% per year) from 1982 to 1996 but has since decreased by 1.2% per year, corresponding to an overall decrease in the mortality rate for women of 8.8% between 1996 and 2004 (Figures 3 and 4, Appendix C). This decrease in the cancer mortality rate for females is due to a falling trend in mortality for breast and kidney cancers since 1993, continuing decreases in the mortality rates for stomach, cervical, ovarian and colorectal cancers and a more recent decrease in mortality rates for non-Hodgkin's lymphoma from 1998. In contrast to the decline in overall mortality rates, there have been large increases in mortality rates among women for lung cancer, with the rate increasing by 2.7% per year.

The pattern of mortality rates for males for all cancers combined is very similar to that observed for females. The mortality rate increased by 0.4% per year between

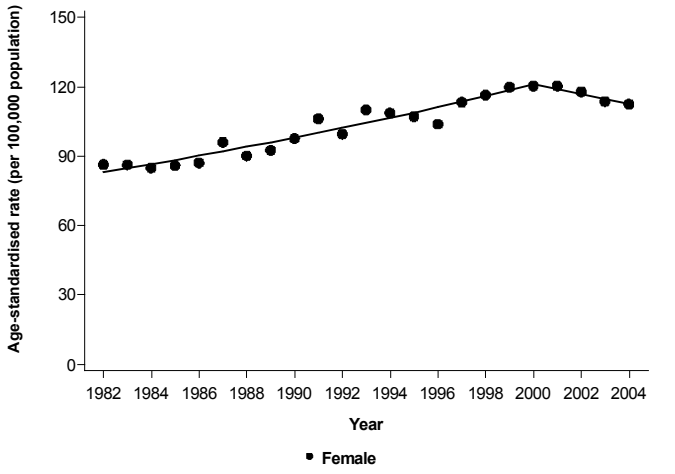
1982 and 1994, followed by a decrease of 1.4% per year from 1994 onwards (Figures 3 and 4, Appendix C). This represents a decrease in the cancer mortality rate for males of 13.4% for the ten years from 1994 to 2004. The down turn in mortality rates for males is due to recent decreases in the mortality rate for prostate and colorectal cancers and non-Hodgkin's lymphoma and continuing improvements in mortality rates for lung, stomach and bladder cancers.

Specific cancers

Breast cancer

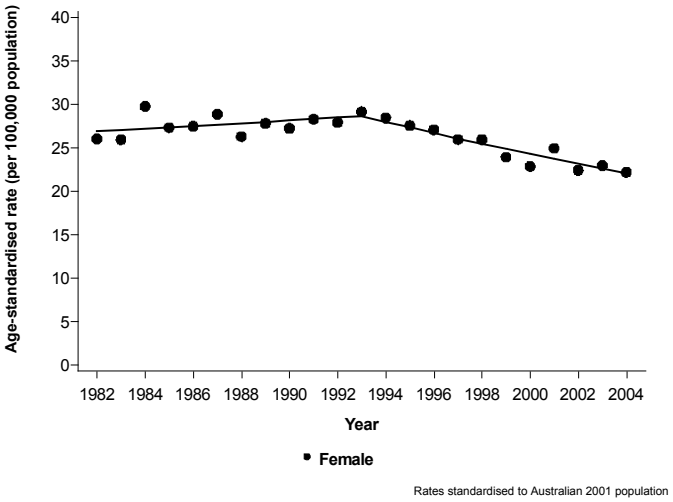
The incidence rate of breast cancer increased by 2.1% per year between 1982 and 2000, but then decreased at a rate of 1.8% per year from 2000 to 2004, although this decreasing rate was not statistically significant (Figure 5). Much of the earlier increase in incidence was due to increased breast cancer screening. However, a decrease in the incidence rate over recent years may be the result of a successful breast screening program where a large proportion of the Queensland target population has now been screened and the rate of detection of new cases is starting to settle to an equilibrium level. One or two more years of data will be needed to confirm this trend.

Figure 5: Incidence trend for breast cancer, Queensland, 1982-2004



Breast cancer mortality rates increased slowly by 0.6% per year between 1982 and 1993, but since then the trend has been reversed with breast cancer mortality rates decreasing by 2.4% per year (Figure 6). This corresponds to an overall decrease in the mortality rate of 22.8% for the eleven years from 1993 to 2004.

Figure 6: Mortality trend for breast cancer, Queensland, 1982-2004



A decline in breast cancer mortality rates has also been observed in the other states of Australia and in several other countries such as Britain and the United States[2,3]. This decrease is commonly attributed to two main factors: screening and better treatment. Between January 2004 and December 2005, a total of 373,583 women were screened by the BreastScreen Queensland program. Of these, 238,764 women were in the 50-69 year old target group corresponding to a participation rate of 58.7% within that age group[4].

Bladder cancer

The incidence rate for bladder cancer remained relatively constant for both males and females between 1982 and 2004 (Figure 7). There was a slight increase in the trend for Queensland males of 0.1% per year which is similar to the trend observed in Australian males, although this trend is not statistically significant. Some of this observed increase may be a result of the increased use of screening for prostate cancer leading to a diagnosis of bladder cancer as part of diagnostic testing[5].

Figure 7: Incidence trends for bladder cancer by sex, Queensland, 1982-2004

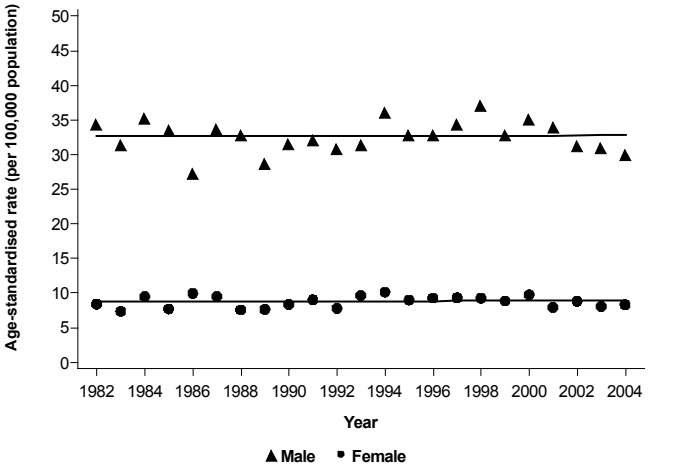
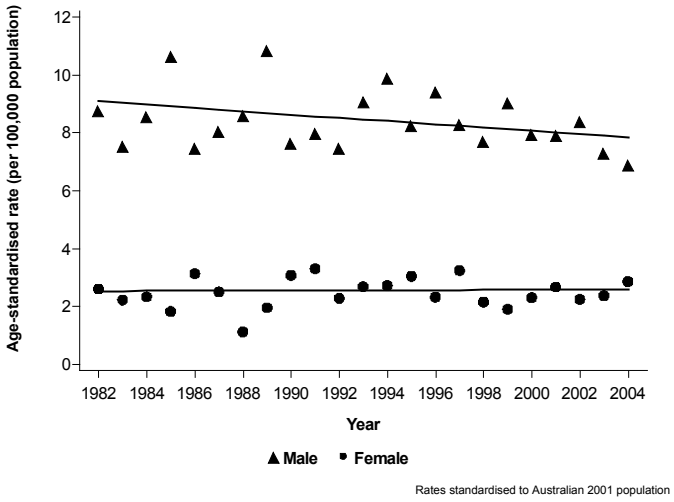


Figure 8: Mortality trends for bladder cancer by sex, Queensland, 1982-2004

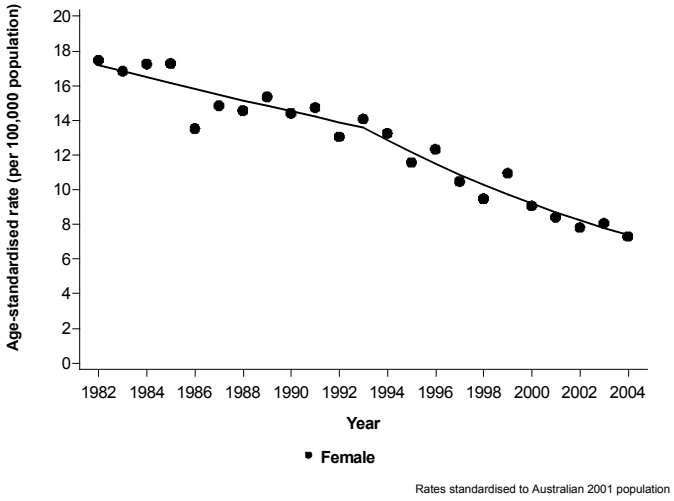


During this same period mortality rates for males fell by 0.7% per year, equating to a total fall of 13.6% over the period of 22 years (Figure 8). There was a very slight increase in the mortality rate for females of 0.1% per year however, this trend was not statistically significant.

Cervical cancer

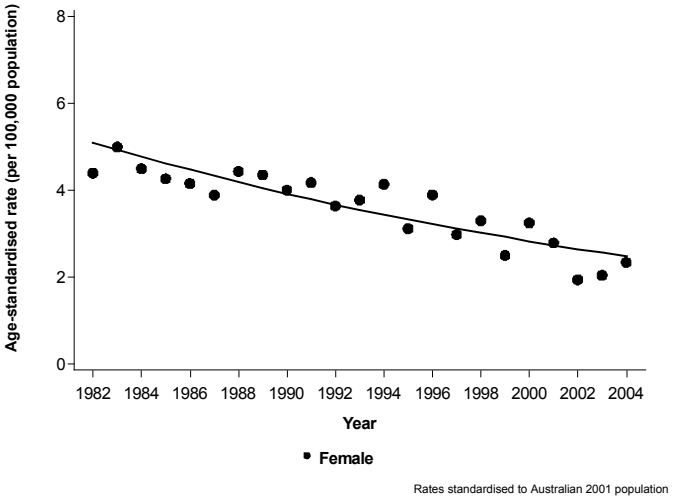
Between 1982 and 1993 the incidence rate for cervical cancer declined by an average of 2.1% per year. Since 1993 the incidence rate of cervical cancer has decreased sharply by 5.4% per year. This corresponds to an overall decrease in the incidence rate of 45.0% for the eleven years from 1993 to 2004 (Figure 9).

Figure 9: Incidence trend for cervical cancer, Queensland, 1982-2004



Mortality rates for cervical cancer have also shown a steady decline in Queensland during the study period (Figure 10). Between 1982 and 2004 the mortality rate decreased by a total of 51.0%.

Figure 10: Mortality trend for cervical cancer, Queensland, 1982-2004



Experts agree that the continuing decrease in mortality rates is largely due to the organised cervical screening program[6]. A total of 632,577 women aged 20-69 years old were screened for cervical cancer in Queensland in the years 2004 and 2005, giving an age-standardised participation rate of 58.3% within the target cohort[4].

Colorectal cancer

There has been a continuous increase in the incidence rate of colorectal cancer for both men (0.7% per year) and women (0.1% per year). However, the trend for women failed to reach statistical significance (Figure 11). The mortality rates for females and males have been continuously decreasing from 1982 at 1.3% per year and 0.8% per year, respectively (Figure 12). This represents an overall improvement in the mortality rate since 1982 of 15.5% for men and 25.2% for women.

Figure 11: Incidence trends for colorectal cancer by sex, Queensland, 1982-2004

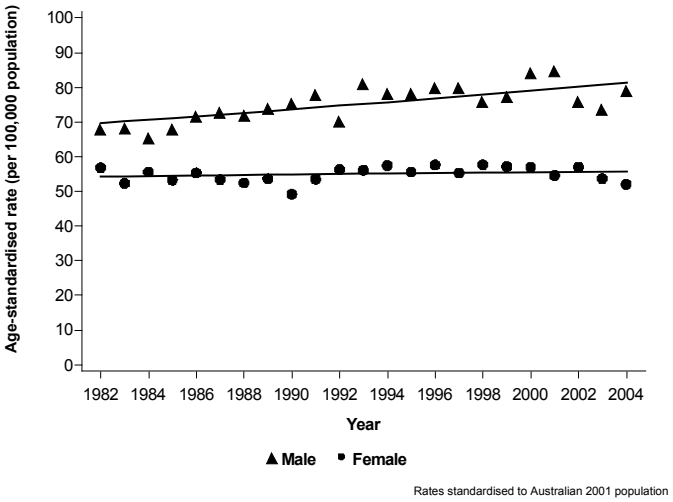
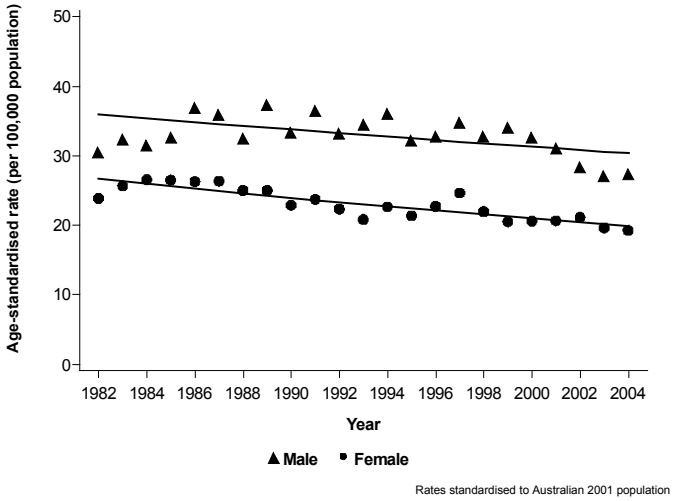


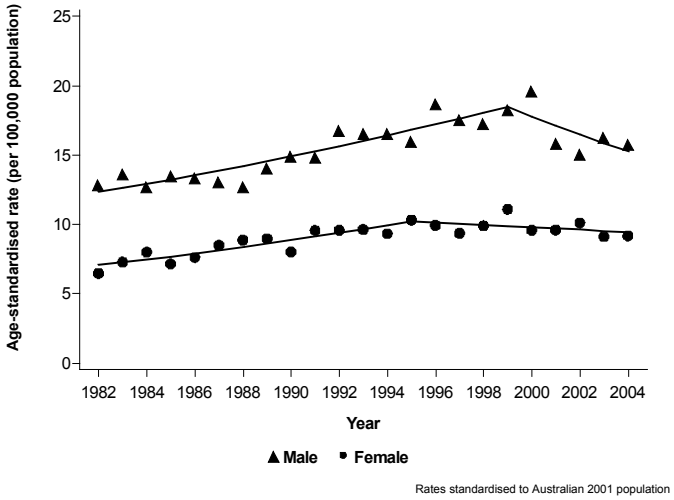
Figure 12: Mortality trends for colorectal cancer by sex, Queensland, 1982-2004



Kidney cancer

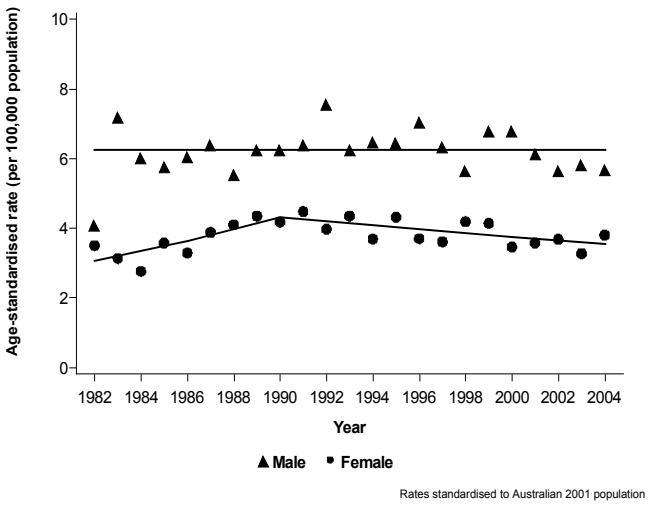
The trend in incidence rates of kidney cancer in males increased by 2.4% per year between 1982 and 1999, subsequently decreasing by 3.8% per year from 1999 onwards. The incidence rates for females increased between 1982 and 1995 and then decreased by 0.9% per year (Figure 13). This decrease was not statistically significant.

Figure 13: Incidence trends for kidney cancer by sex, Queensland, 1982-2004



The trend for mortality rates of kidney cancer in males has remained stable over the 22 years from 1982 to 2004. Mortality rates showed a different pattern in females, where rates have decreased by 1.4% per year from 1998 after a significant increase in rates from 1982 to 1990 (Figure 14). Overall between 1990 and 2004 the mortality rate decreased by 17.7% for females.

Figure 14: Mortality trends for kidney cancer by sex, Queensland, 1982-2004



Lung cancer

Both incidence and mortality rates for lung cancer have shown ongoing improvement for males, decreasing by 1.6% per year and 1.5% per year respectively (Figures 15 and 16). Since 1982, this corresponds to a 28.8% decrease in the mortality rate for males in Queensland. However, the trends for females continue to increase, with incidence and mortality rates showing annual increases of 2.5% and 2.7% respectively (Figures 15 and 16). This corresponds to an 80.8% increase in mortality for females between 1982 and 2004.

Figure 15: Incidence trends for lung cancer by sex, Queensland, 1982-2004

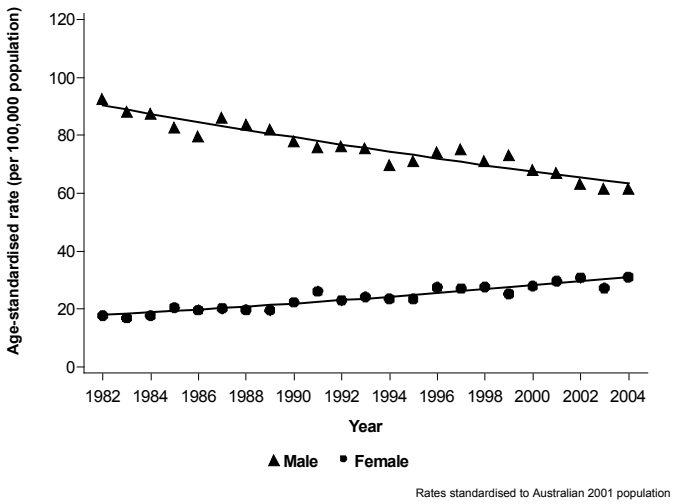


Figure 16: Mortality trends for lung cancer by sex, Queensland, 1982-2004

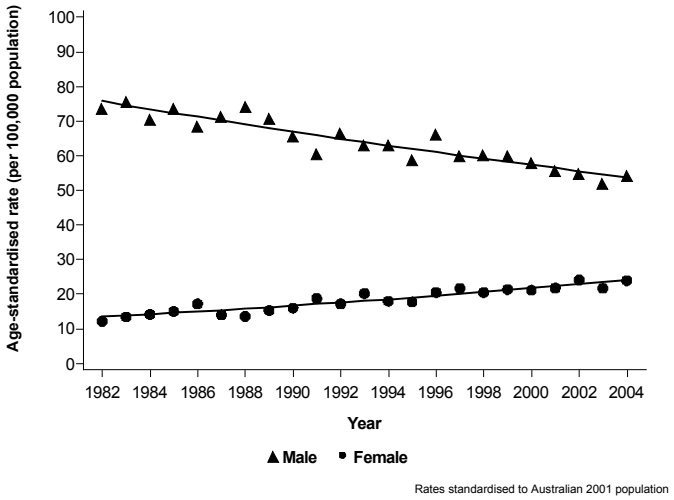
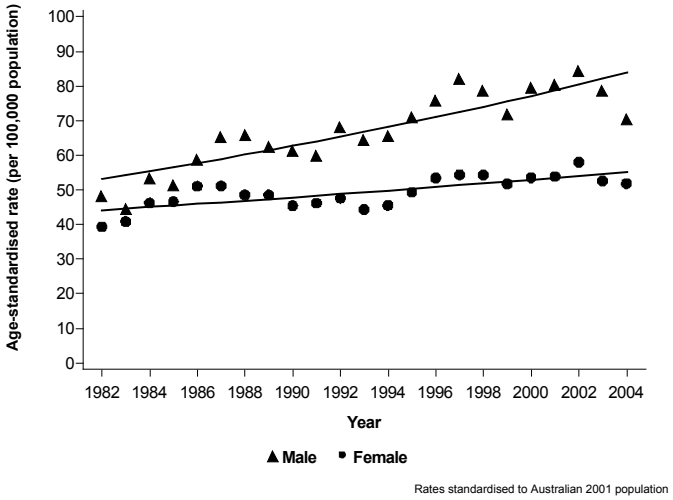


Figure 17: Incidence trends for melanoma by sex, Queensland, 1982-2004



In 2004, lung cancer was responsible for more deaths in females than any other cancer, including breast cancer. This is the second year in which lung cancer mortality rates have exceeded those of breast cancer. The first year this occurred was 2002. With the continuing increase in lung cancer mortality rates and decrease in breast cancer rates, lung cancer now appears to be superseding breast cancer as the leading cause of female cancer deaths.

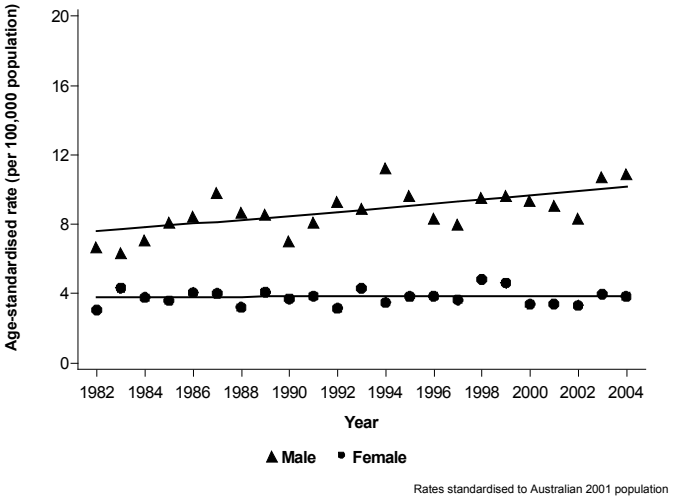
Despite these differing trends, both the incidence and mortality rates for men remain around twofold those currently experienced by women. The differences observed in lung cancer rates between males and females can be attributed to past patterns of smoking prevalence. It is widely accepted that smoking is the cause of most lung cancers, with current incidence rates reflecting smoking behaviour 20 or more years earlier[7].

Melanoma

Australia has the highest incidence rate of melanoma of any country in the world, and Queensland in turn has a much higher rate of melanoma incidence than any other state or territory[2,8]. Incidence rates of melanoma can fluctuate according to public awareness. For example, notifications tend to increase following publicity about skin cancer on television. Nevertheless, the long-term trend in the incidence rate for both men and women is increasing, with the growth being more pronounced for men (2.1% increase per year compared with 1.0% for women, Figure 17).

Melanoma mortality rates for both sexes have shown a generally increasing trend in the 22 years since 1982, despite fluctuations within that time. The mortality rate for males has increased by 1.3% per year, resulting in an overall increase of 33.9% from 1982 to 2004. The melanoma mortality rates for females increased slightly by 0.1% per year but this rate did not reach statistical significance.

Figure 18: Mortality trends for melanoma by sex, Queensland, 1982-2004



Mesothelioma

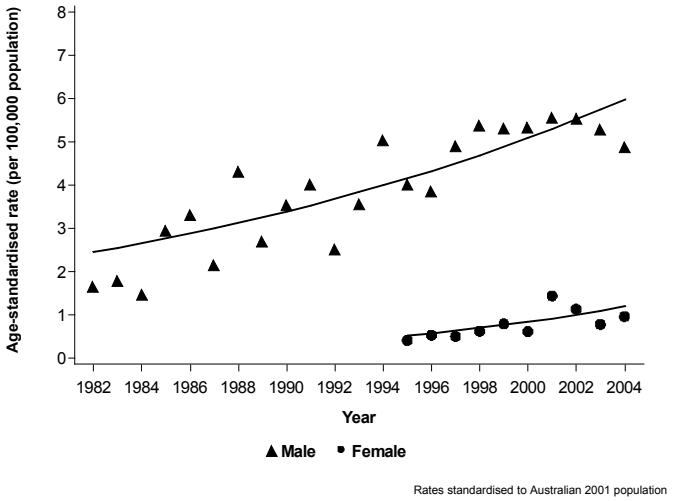
Mesothelioma is a rare cancer but it has a low relative survival rate after diagnosis, leading to very similar rates in incidence and mortality[5]. The incidence and mortality rates for both males and females are increasing dramatically due to occupational and environmental exposure to asbestos in past decades. In 1954, Australia had the highest per capita consumption of asbestos

in the western world, with the peak in Australian consumption occurring in 1975[9]. The Australian trend in mesothelioma incidence mirrors asbestos consumption with a time lag of approximately 35 years[10]. As a result of the long induction period between asbestos exposure and the onset of mesothelioma, incidence is predicted to reach a peak somewhere around the year 2020[9].

For males in Queensland, rates of incidence and mortality for mesothelioma are increasing at steady rates of 4.2% per year and 5.0% per year since 1982 respectively (Figure 19). This corresponds to an overall increase in the mortality rate for the twenty-two years from 1982 to 2004 of 198.7%.

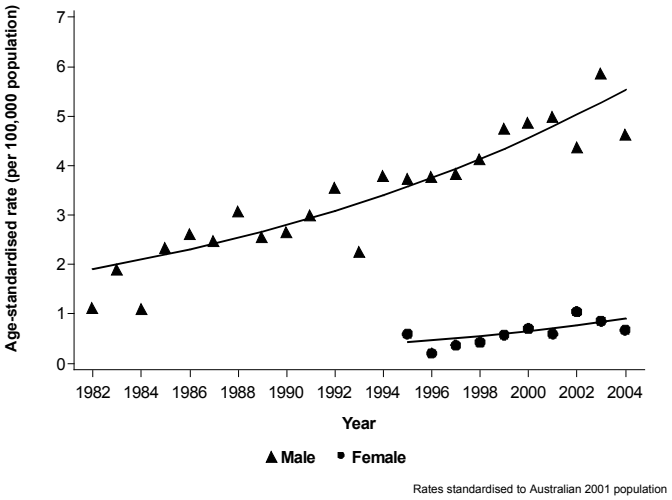
Both incidence and mortality for females were much lower than for males with 5-fold and 7-fold difference, respectively. Since 1995 however, both the incidence and mortality for females have increased at higher rates than those observed in males. Female mesothelioma incidence has increased by 9.7% each year since 1995 (although this increase is not statistically significant) and mortality rates have increased by 8.3% per year (Figure 20). This corresponds to an overall increase in the mortality rate of 110.9% for the nine years from 1995 to 2004.

Figure 19: Incidence trends for mesothelioma[b] by sex, Queensland, 1982-2004



[b] Due to small number of incidence and deaths in females between 1982 and 1994, trends in females are only reported for the period from 1995 to 2004.

Figure 20: Mortality trends for mesothelioma[b] by sex, Queensland, 1982-2004



Non-Hodgkin's lymphoma

Incidence rates for non-Hodgkin's lymphoma in Queensland have continued to go up, with an annual increase of 1.8% for males and 1.2% for females (Figure 21). Mortality rates for males increased by 2.2% per annum from 1982 to 1997 and the rates for females increasing by 1.8% per year from 1982 to 1998 (Figure 22). Mortality rates then decreased by 3.3% per annum for males and 4.0% annually for females (however the decrease for females did not achieve statistical significance). This corresponds to an overall decrease in the mortality rate of 20.4% for males since 1997 and 21.4% for females since 1998. The overall trends in both incidence and mortality show similar patterns to those observed in the United States[11]. It is possible that the recent decrease in mortality rates for males and females is due to improved and more aggressive treatment.

Figure 21: Incidence trends for non-Hodgkin's lymphoma by sex, Queensland, 1982-2004

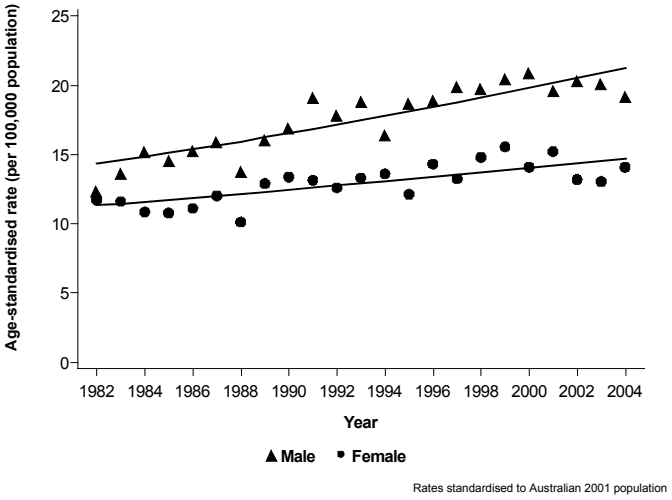
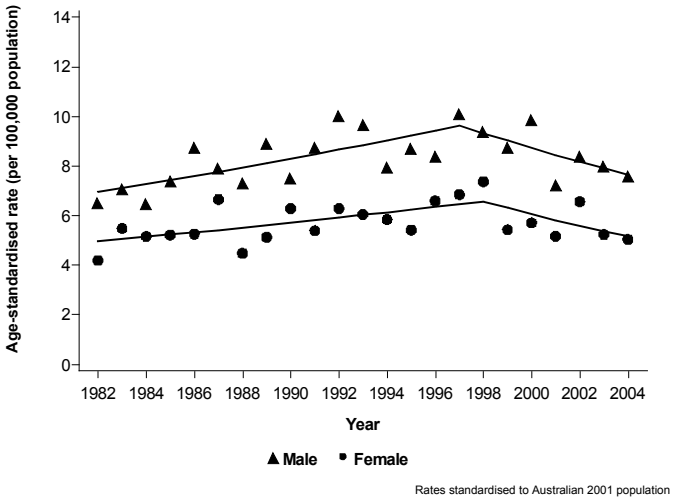


Figure 22: Mortality trends for non-Hodgkin's lymphoma by sex, Queensland, 1982-2004



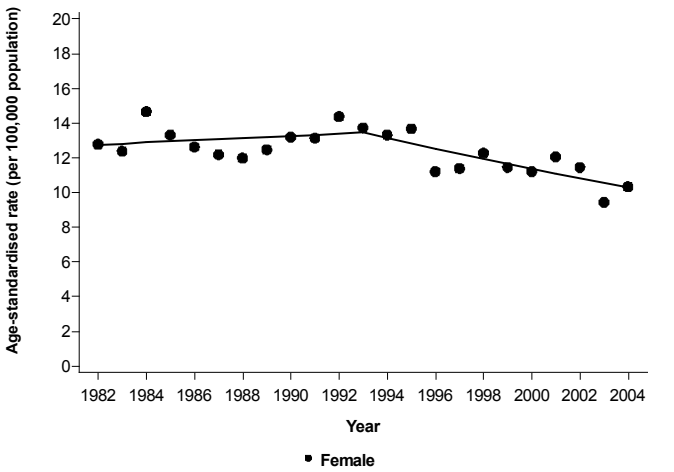
Rates standardised to Australian 2001 population

Despite ongoing international research, the causes of non-Hodgkin's lymphoma remain largely undefined[12]. Immunodeficiency status, both congenital and acquired (e.g, HIV), has been shown to raise the risk of developing non-Hodgkin's lymphoma, but this does not account for all of the increase in incidence rates. A number of potential environmental sources are also being investigated.

Ovarian cancer

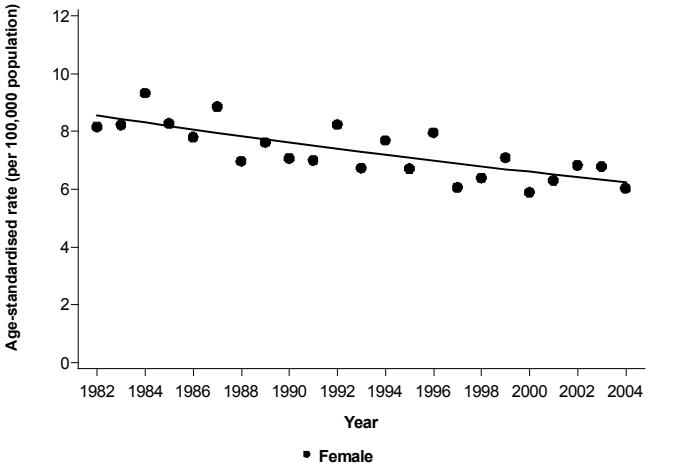
The incidence rate of ovarian cancer in Queensland increased at a rate of 0.5% per year over the period 1982 to 1993 but this increase was not statistically significant. This was followed by a decrease of 2.4% per year between 1993 and 2004 (Figure 23). The mortality rate from ovarian cancer has shown a continual decrease of 1.4% per year on average, corresponding to a total drop in the mortality rate of 26.9% between 1982 and 2004 (Figure 24).

Figure 23: Incidence trend for ovarian cancer, Queensland, 1982-2004



Rates standardised to Australian 2001 population

Figure 24: Mortality trend for ovarian cancer, Queensland, 1982-2004



Rates standardised to Australian 2001 population

Prostate cancer

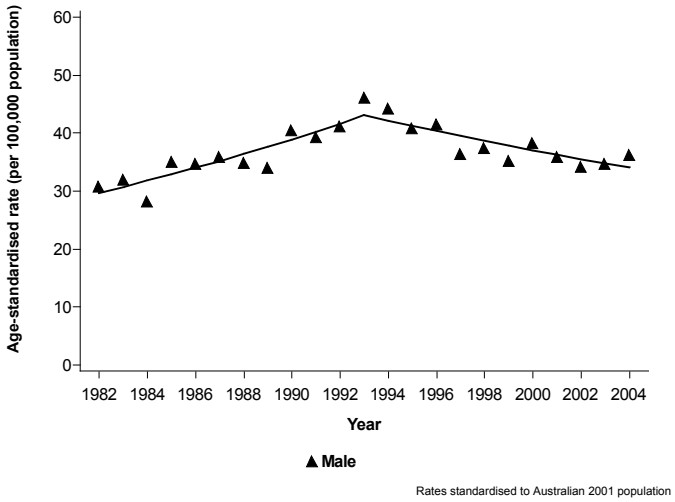
Prostate cancer is the leading registrable cancer amongst males[2]. The sharp increase in the incidence rate of prostate cancer in Queensland between 1988 and 1994 coincided with increases in the use of PSA and allied testing (Figure 25). The incidence rate then decreased between 1994 and 1997 which probably represents depletion of prevalent cases due to men having earlier PSA testing. Since 1997 there has been an increase of 4.3% per year.

Figure 25: Incidence trend for prostate cancer, Queensland, 1982-2004

Rates standardised to Australian 2001 population

The mortality rate from prostate cancer peaked in Queensland in 1993, and has been decreasing by 2.1% per year since then (Figure 26). The total drop in mortality rate for the eleven years to 2004 was 20.8%. It is not clearly understood why prostate cancer mortality rates have decreased. In particular, there is still no definitive evidence that PSA screening reduces mortality. Additionally, it is possible that the mortality reduction could be due to improved treatment of early-stage disease with surgery or radiotherapy, or better treatment of advanced prostate cancer with medical anti-androgenic therapies.

Figure 26: Mortality trend for prostate cancer, Queensland, 1982-2004



Stomach cancer

Incidence rate and mortality rate trends for stomach cancer continue to show significant decreases for both sexes. Specifically, incidence rates for both men and women in Queensland are decreasing by an average of 2.3% and 2.4% per year respectively (Figure 27). Mortality rates have been dropping more quickly, with an annual decline of 2.8% for males and 3.1% for females (Figure 28). This represents an overall reduction in the mortality rate of 45.5% and 49.8% for males and females in Queensland respectively in the period from 1982 to 2004.

Figure 27: Incidence trends for stomach cancer by sex, Queensland, 1982-2004

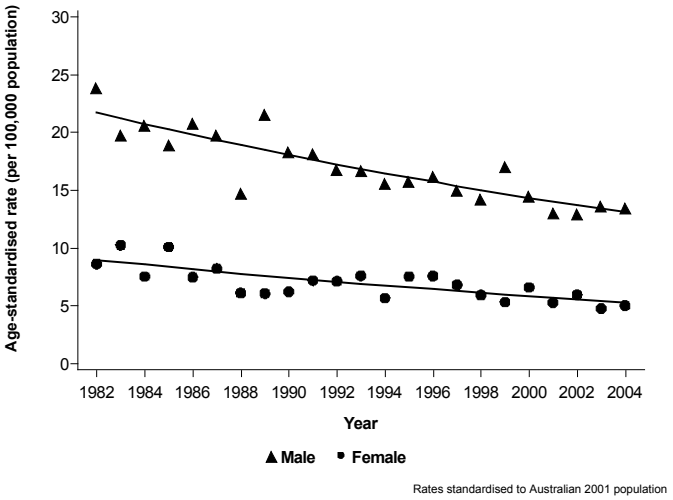
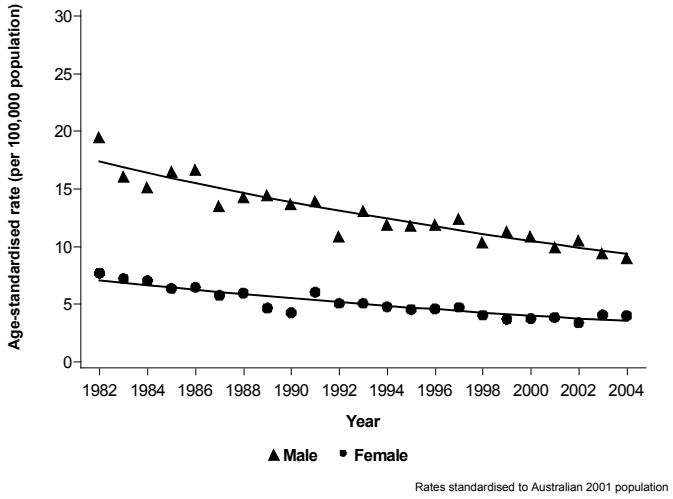


Figure 28: Mortality trends for stomach cancer by sex, Queensland, 1982-2004



Uterine cancer

The incidence rate for cancer of the uterus between 1982 and 2004 increased by an average of 1.3% per year (Figure 29). During the same period, the mortality rate increased by an average of 0.7% per year, although the change was not statistically significant (Figure 30). This corresponds to a total increase in mortality of 17.0%.

Figure 29: Incidence trends for uterine cancer by sex, Queensland, 1982-2004

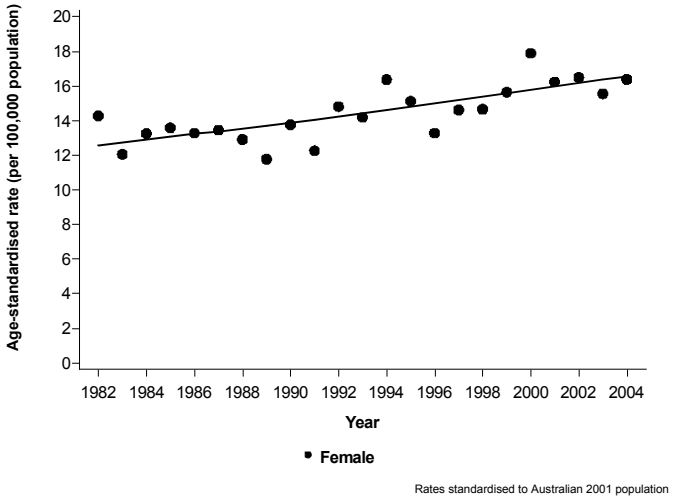
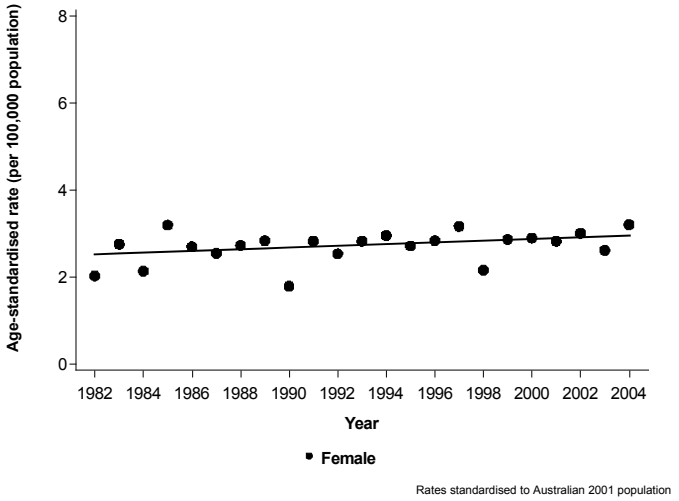


Figure 30: Mortality trends for uterine cancer by sex, Queensland, 1982-2004



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Appendix A

Joinpoint analysis

Joinpoint analysis is a statistical method that describes changing trends over successive segments of time and also determines the amount of increase or decrease within each time period. Joinpoint analysis chooses the best fitting point, called a joinpoint, at which the rate of increase or decrease changes significantly.

The analysis begins with the assumption of constant change over time (i.e., no joinpoint). Up to three joinpoints were tested in each model. The selected model is the simplest one (i.e. the least number of joinpoints) supported by the data.

Annual percent change (APC)

The APC is the average rate of change in the cancer trend per year, as determined by the selected joinpoint model. A negative APC describes a decreasing trend, and a positive APC describes an increasing trend. A trend is deemed to be statistically significant if the 95% confidence interval does not include zero.

Age-standardisation

All rates in this publication were age-standardised to the 2001 Australian estimated resident population.

Source of data

Queensland Cancer Registry 2006.

Appendix B

Cancer incidence trends, Queensland, 1982-2004

Site	ICD-O codes	Trend 1 Period	Trend 1 APC[1] (95% CI)	Trend 2 Period	Trend 2 APC[1] (95% CI)	Trend 3 Period	Trend 3 APC[1] (95% CI)
Females							
All sites	C00-C80	1982-2000	+1.28 (+1.11, +1.46)	2000-2004	-1.73 (-3.07, -0.38)		
Bladder	C67	1982-2004	+0.07 (-0.56, +0.70)				
Breast	C50	1982-2000	+2.11 (+1.77, +2.46)	2000-2004	-1.75 (-4.17, +0.73)		
Cervix	C53	1982-1993	-2.11 (-3.31, -0.89)	1993-2004	-5.43 (-6.67, -4.18)		
Colorectal	C18-C20,C218	1982-2004	+0.12 (-0.14, +0.39)				
Kidney	C64-C66,C68	1982-1995	+2.90 (+1.79, +4.02)	1995-2004	-0.88 (-2.29, +0.54)		
Lung	C33,C34	1982-2004	+2.52 (+2.08, +2.96)				
Melanoma	C44, M872-M879	1982-2004	+1.02 (+0.61, +1.43)				
Mesothelioma	M905	1995-2004	+9.66 (-0.18, +20.47)				
Non-Hodgkin's lymphoma	M959, M967-M972	1982-2004	+1.20 (+0.69, +1.72)				
Ovary	C56	1982-1993	+0.49 (-0.97, 1.98)	1993-2004	-2.41 (-3.67, -1.13)		
Stomach	C16	1982-2004	-2.37 (-3.21, -1.53)				
Uterus	C54	1982-2004	+1.26 (+0.78, +1.75)				
Males							
All sites	C00-C80	1982-1990	+0.80 (+0.13, +1.49)	1990-1993	+4.46 (-1.04, +10.27)	1993-2004	-0.48 (-0.79, -0.17)
Bladder	C67	1982-2004	+0.02 (-0.46, +0.50)				
Colorectal	C18-C20,C218	1982-2004	+0.70 (+0.36, +1.03)				
Kidney	C64-C66,C68	1982-1999	+2.42 (+1.67, +3.17)	1999-2004	-3.77 (-7.09, -0.33)		
Lung	C33,C34	1982-2004	-1.60 (-1.84, -1.37)				
Melanoma	C44, M872-M879	1982-2004	+2.10 (+1.53, +2.67)				
Mesothelioma	M905	1982-2004	+4.15 (+2.80, +5.51)				
Non-Hodgkin's lymphoma	M959, M967-M972	1982-2004	+1.82 (+1.36, +2.28)				
Prostate[2]	C61	1988-1994	+11.00 (+6.55, +15.64)	1994-1997	-12.75 (-25.90, +2.72)	1997-2004	+4.30 (+2.30,+6.34)
Stomach	C16	1982-2004	-2.28 (-2.79, -1.76)				

1. Annual percentage change
2. The trend for prostate cancer incidence among males between 1982 and 1988 was -0.40 (-4.5, +4.0).

Appendix C

Cancer mortality trends, Queensland, 1982-2004

Site	ICD-O codes	Trend 1 Period	Trend 1 APC[1] (95% CI)	Trend 2 Period	Trend 2 APC[1] (95% CI)	Trend 3 Period	Trend 3 APC[1] (95% CI)
Females							
All sites	C00-C80	1982-1996	+0.32 (-0.03, +0.68)	1996-2004	-1.15 (-1.83, -0.47)		
Bladder	C67	1982-2004	+0.08 (-1.24, +1.43)				
Breast	C50	1982-1993	+0.58 (-0.23, +1.40)	1993-2004	-2.35 (-3.02, -1.68)		
Cervix	C53	1982-2004	-3.24 (-4.05, -2.42)				
Colorectal	C18-C20,C218	1982-2004	-1.32 (-1.65, -0.99)				
Kidney	C64-C66,C68	1982-1990	+4.34 (+1.14, +7.64)	1990-2004	-1.39 (-2.42, -0.35)		
Lung	C33,C34	1982-2004	+2.69 (+2.22, +3.17)				
Melanoma	C44, M872-M879	1982-2004	+0.10 (-0.72, +0.93)				
Mesothelioma	M905	1995-2004	+8.29 (+0.15, +17.09)				
Non-Hodgkin's lymphoma	M959, M967-M972	1982-1998	+1.78 (+0.46, +3.12)	1998-2004	-4.02 (-8.49, +0.67)		
Ovary	C56	1982-2004	-1.43 (-1.96, -0.89)				
Stomach	C16	1982-2004	-3.14 (-3.72, -2.55)				
Uterus	C54	1982-2004	+0.71 (-0.10, +1.53)				
Males							
All sites	C00-C80	1982-1994	+0.42 (+0.04, +0.79)	1994-2004	-1.44 (-1.84, -1.03)		
Bladder	C67	1982-2004	-0.66 (-1.41, +0.09)				
Colorectal	C18-C20,C218	1982-2004	-0.76 (-1.28,-0.24)				
Kidney	C64-C66,C68	1982-2004	0.00 (-0.73, +0.73)				
Lung	C33,C34	1982-2004	-1.54 (-1.80, -1.28)				
Melanoma	C44, M872-M879	1982-2004	+1.33 (+0.55, +2.11)				
Mesothelioma	M905	1982-2004	+4.97 (+3.88, +6.08)				
Non-Hodgkin's lymphoma	M959, M967-M972	1982-1997	+2.17 (+0.81, +3.56)	1997-2004	-3.26 (-6.40, -0.01)		
Prostate	C61	1982-1993	+3.43 (+2.14, +4.74)	1993-2004	-2.12 (-3.02, -1.22)		
Stomach	C16	1982-2004	-2.76 (-3.19, -2.33)				

1. Annual percentage change