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Jun 03 2026

STATE HEALTH PLANNING AND
DEVELOPMENT AGENCY

STATE HEALTH PLANNING AND DEVELOPMENT AGENCY

100 NORTH UNION STREET, SUITE 870
MONTGOMERY, ALABAMA 36104

Via Email Only

June 3, 2026

Ms. Laura D. Grill, CEO/President
East Alabama Health
2000 Pepperell Parkway
Opelika, Alabama 36801

RE: Voluntary Agreement of Extension
AL2026-025
East Alabama Medical Center

Dear Ms. Grill:

The June 17, 2026, Certificate of Need (CON) Review Board meeting has been cancelled. All projects originally scheduled for this public hearing date will be heard at the next regularly scheduled Certificate of Need Review Board public hearing currently scheduled for Wednesday, July 15, 2026.

Please confirm below the applicant's voluntary agreement to an extension of all relevant deadlines for the issuance of a final order in the above styled cases, including, as applicable, the time period for issuance of an order under ALA. CODE § 41-22-16 (1975 as amended) and the statutory review period under ALA. CODE § 22-21-275(3) (1975 as amended). The extension consented to herein shall extend for the period necessary for consideration of this application at the next meeting held by the CON Board where a quorum is present, and the effective date of a final written order pursuant thereto.

Please return this letter by email to shpda.online@shpda.alabama.gov immediately. As provided by ALA. ADMIN. CODE r. 410-1-7-.10(1), the Agency shall exercise its unilateral authority to extend the project review period in this case for thirty (30) days if a response is not received.

Sincerely,

Emily T. Marsal
Executive Director

ETM/mst

cc: Ms. Marcilla Gross, East Alabama Health

RE: AL2026-025

June 3, 2026

Page Two

East Alabama Medical Center agrees to a voluntary extension as described above.

By: Maicell C. Brown
Attorney of Record or Authorized

Date: 06/03/2026

STAFF REPORT

I. Summary of Project

A. Project Identification

1. Project Number: AL2026-025
 2. Applicant: East Alabama Medical Center
2000 Pepperell Parkway
Opelika, Alabama 36801
- Projected Start: Two (2) months after CON approval
- Projected Completion: Thirteen (13) months from start date

B. Ownership

East Alabama Medical Center (EAMC) is owned by The East Alabama Health Care Authority. A list of the eleven (11) governing board members is included on page 2 of the CON application.

C. Brief Description

The applicant proposes to expand and renovate the Spencer Cancer Center, an existing facility located in the city of Opelika, Lee County, Alabama. Upon completion, the newly renovated center will have 30,500 additional square feet for clinical space pertaining to patient care and physician offices, which includes a gynecological oncology and breast surgery suite, increased capacity in imaging, pharmacy, and laboratory services, as well as a second PET/CT scanner. It is noted this project does not include the addition of a third linear accelerator.

D. Costs

Total costs associated with this project are projected to be **\$43,761,830.00**

Total Cost of Construction	\$32,609,743.00
Total Cost of Purchase ¹	5,164,620.00
First Year Annual Operating Cost	<u>5,987,467.00</u>
Total Project Cost	<u>\$43,761,830.00</u>

E. Construction Costs/Renovation Costs

The cost per square foot is \$1,069.17, which is computed by dividing cost of construction (\$32,609,743.00) by 30,500 gross square feet.

According to the applicant, this project will add approximately 30,500 square feet to the Spencer Cancer Center, an existing medical facility located at 2501 Village Professional Drive in Opelika, Alabama. It is indicated the proposed expansion consists of two (2) floors that are approximately 15,250 square feet each. The first floor will incorporate two (2) clinical exam pods with support areas, a PET/CT scanner with adjacent support areas, as well as office space and mechanical space. The second floor will have a new, larger infusion pharmacy, five (5) new clinical exam pods, four (4) new infusion bays with adjacent nursing stations and support areas. The applicant notes this proposal will add twenty-three (23) new infusion chairs to the cancer center, for a total of fifty-two (52) infusion treatment bays.

¹On page 4 of the CON application, total cost of purchase involves the acquisition of major medical equipment (\$2,200,000.00) and "other equipment" (\$2,964,620.00).

According to the applicant, the alternative to the proposed project is to keep the existing footprint at Spencer Cancer Center. It is indicated the maximum capacity for patients and providers has currently been met and the only way to continue meeting the growing needs of the community is to expand square footage to take on additional imaging and diagnostics, provider-based care, and infusion treatment areas. It is noted the proposed two-story expansion will be an extension of the existing building.

The applicant asserts the expansion/renovation of the facility will foster cost containment to the point that it is a reasonable project at a reasonable cost per square foot and notes energy saving measures will be incorporated in coordination with the project. A schematic drawing of the proposed spaces is included in Appendix A of the application.

F. Funding of the Project

This project will be funded with \$5,987,467.00 from new earnings and revenues (*East Alabama Health Care Authority*) and \$37,774,363.00 from cash on hand (*East Alabama Health Care Authority*).

G. Charges

East Alabama Medical Center submitted sixty-two (62) *current* charges/procedures that are provided at the Spencer Cancer Center in Opelika, Alabama.

The applicant indicates there will be no changes in the current charge structure as a result of the proposed expansion. After completion of this project, it is anticipated that total operating costs for Spencer Cancer Center will increase by \$10,464,030.00 from fiscal year 2025 to fiscal year 2028, which will be the first full year of operation after the expansion is complete. It is noted of the \$10,464,030.00 in operating expenses, only \$5,987,467.00 of that amount can be attributed to new operating costs related to the expansion and the remaining balance of \$4,476,563.00 is attributed to expected patient volume at the facility based on its current size and capacity, as well as anticipated inflation costs.

H. Charity and Uncompensated Care Evaluation

East Alabama Medical Center reported as a gross percentage of revenue, Medicaid was 12.70% in 2023, 9.80% in 2024, 10.35% in 2025, and is projected to be 10.35% for years 2028 and 2029 after completion of the project. Medicare was 20.43% in 2023, 16.01% in 2024, 17.54% in 2025, and is projected to be 17.54% for years 2028 and 2029 following completion of the project.

As a percentage of gross revenue, Charity Care is included with *Self pay*, and is reported as 4.24% in 2023, 4.55% in 2024, 3.63% in 2025 and is projected to be 3.63% for years 2028 and 2029.

The applicant estimates uncompensated care for this proposed project to be \$443,201.00 in 2028 and \$487,521.00 in 2029 following completion of the project.

I. Medical Service Area

The primary service area for this project is Lee County, Alabama. It is indicated the areas surrounding Lee County, which includes Chambers, Macon, Randolph, Russell, and Tallapoosa counties, comprise the secondary service area. The applicant reports 89% of East Alabama Medical Center's patient origin is derived from the primary and secondary service areas. A map of the service area is included in Part Two (page 25) of the application.

J. Need for the Project

According to the applicant, East Alabama Medical Center seeks to expand and renovate Spencer Cancer Center, a pillar of patient care since the year 1992. It is asserted *Certificate of Need 1370-H* was issued on September 30, 1992 for an outpatient services center that includes the construction of a 47,690 square foot, two floor addition on the north side of the existing facility in the city of Opelika, Alabama (the facility will offer outpatient oncology services and nuclear medicine for radiation therapy). It is also noted *Certificate of Need 2780-H* was issued on March 30, 2017 to relocate the cancer center to a two-story, state-of-the-art freestanding building in Lee County, Alabama with two (2) linear accelerators. The applicant indicates EAMC is the largest provider/source of health care services in the primary and secondary service areas as well as the only provider of radiation therapy services and the only institutional provider of both radiation therapy and medical oncology services in Lee County.

The applicant states Lee County, Alabama, the primary service area, currently has approximately 190,821 residents and the secondary service area, which consists of five (5) counties, has a current population estimate of 176,323. It is reported according to the Center for Business and Economic Research (CBER), Lee County's population is projected to increase by 17.49% between the years 2025 and 2050 and the populace of the secondary service area is anticipated to grow 3.73% during this same period. The applicant notes the proposed expansion will continue to help meet the needs of EAMC's growing service areas.

According to the applicant, the proposed expansion is a continuation of East Alabama Medical Center's long-range plans for improving its services to patients and residents of the primary and secondary service areas. It is further stated the hospital is committed to providing quality care with appropriate facilities, technology, and equipment and this proposal will help individuals who need cancer treatment to continue to receive those services from EAMC through the Spencer Cancer Center.

II. Report of Staff Findings

A. Project History

This application was received February 23, 2026, with additional information received on March 12, 2026. The application was placed in the review cycle on March 20, 2026 and has not been previously reviewed by the Certificate of Need Review Board.

B. State Health Plan

The 2024-2027 Alabama State Health Plan, effective June 16, 2024, addresses Renovations in Rule 410-2-4-.13.

(1) Renovation is defined as a project for modernization, improvement, alteration and/or upgrading of an existing physical plant and/or equipment. Renovation does not include the modernization or construction of a non-clinical building, parking facility, or any other non-institutional health services capital item on the existing campus of a health care facility, provided that construction or modernization does not allow the health care facility to provide new institutional health services subject to review and not previously provided on a regular basis.

(2) Planning Policies

(a) The applicant must demonstrate that the proposed renovation is the most cost effective or otherwise most appropriate alternative to provide patients with needed health care services and/or facility improvements.

The applicant states prior to making a formal proposal for expansion, the cancer center adjusted to meet the needs of patients and staff by repurposing the cancer registry and manager office for referral intake staff, repurposed retail boutique space into an office for a genetic counselor, and added a sixth infusion bay in an existing treatment room. In addition, the Oncology Wellness Program moved to a conference room to make space for additional exam rooms and office space to accommodate new providers. It is noted these are only a few examples of accommodation that have been made throughout the facility.

The applicant asserts the alternative to the proposed expansion is to keep the existing footprint at Spencer Cancer Center, noting the maximum capacity for patients and providers has currently been met. It is reported the only way to continue meeting the growing needs of the community is to expand square footage to take on additional imaging and diagnostics, provider-based care, and infusion treatment areas.

(b) The applicant must provide evidence that the proposed square footage, construction cost per square foot, and cost of fixed equipment is appropriate and reasonable for the types and volumes of patients to be served.

The applicant states between the years 2019-2025, Spencer Cancer Center had a seventy-four percent (74%) increase in patient volume and successfully recruited a team of seven (7) new providers. This growing team includes two (2) gynecological surgical oncologists, two (2) breast surgeons, and two (2) nurse practitioners who need designated office and clinical space for a gynecological oncology suite. In addition to clinical space, the needs of this new group will contribute to the overall need for expanded services and additional staff members for the cancer center. It is noted that additional recruitment offers have been extended to potential providers.

(c) The applicant must demonstrate how the disruption of normal operations will be minimized during the period of construction.

According to the applicant, East Alabama Medical Center is the appropriate organization for this project as the hospital already provides cancer services at Spencer Cancer Center and is the only provider of these services in Lee County, Alabama. It is indicated this proposal is a natural expansion of EAMC's current services and allows the applicant to meet the needs of its patients and continue to improve the care that is provided.

(3) Needs Assessment

(a) 1. The service being provided by the applicant requires additional space or the facility requires renovation to meet minimum licensure and certification requirements.

It is indicated EAMC is the largest provider/source of health care services in the primary and secondary service areas and the only provider of both radiation therapy and medical oncology services to Lee County residents. In the last decade, the applicant reports that increased cancer patient volumes have led to the increased need for additional providers and staff, resulting in the need for additional office and clinical space. It is noted the proposed project affects the quality of care by making additional resources available to patients through expanded imaging and laboratory services, additional provider choice, and faster scheduling for treatments with expanded infusion capability.

(a) 2. There are operating problems which can best be corrected by renovation of the existing facility.

The applicant states leadership at Spencer Cancer Center has provided creative solutions to keep up with the growing demand for space in the facility, but this effort has quickly plateaued as the

space itself is finite. It is noted expanding the cancer center by fifty percent (50%) will account for space for the current needs as well as allowing space for continued growth.

C. Utilization

Historical Inpatient Occupancy Data for East Alabama Medical Center												
Occupancy	Number of Beds			Discharges			Total Patient Days			Percentage (%)		
	2023	2024	2025	2023	2024	2025	2023	2024	2025	2023	2024	2025
Medicine & Surgery	249	249	249	11,378	12,607	13,700	57,693	63,608	70,299	63.5%	69.8%	77.3%
Obstetrics	27	27	27	2,193	2,202	2,190	5,308	5,389	5,524	53.9%	54.5%	56.1%
Pediatrics	10	10	10	517	518	559	977	977	1,042	26.8%	26.7%	28.5%
Psychiatry	28	28	28	726	738	648	8,265	8,316	8,611	80.9%	81.1%	84.3%
Totals	314	314	314	14,814	16,065	17,097	72,243	78,290	85,476	63.0%	68.1%	74.6%

It is noted the total number of beds reported in the chart above is based on the Alabama Department of Public Health licensed beds. *CON 3000-H* was issued June 7, 2022 to add thirty (30) general acute care beds to EAMC and the license for these beds was issued with an effective date of December 3, 2025, which is in fiscal year 2026. Therefore, the thirty (30) additional beds are not included in the bed totals above.

Projected Inpatient Occupancy Data for East Alabama Medical Center								
Occupancy	Number of Beds		Discharges		Total Patient Days		Percentage (%)	
	2028	2029	2028	2029	2028	2029	2028	2029
Medicine & Surgery	279	279	15,862	16,655	81,418	85,489	79.7%	83.9%
Obstetrics	27	27	2,533	2,659	6,407	6,727	64.8%	68.3%
Pediatrics	10	10	647	680	1,157	1,215	31.6%	33.3%
Psychiatry	20	20	334	351	5,548	5,825	75.8%	79.8%
Inpatient Rehabilitation	17	17	329	347	3,787	3,976	60.9%	64.1%
Totals	353	353	19,705	20,692	98,317	103,232	76.1%	80.1%

The applicant states *CON 3055-PSYCH* was issued March 4, 2024 to add six (6) child/adolescent beds and six (6) adult psychiatric beds to the existing twenty-eight (28) bed inpatient psychiatric unit at EAMC (the CON also authorized the build of a forty (40) bed freestanding acute care psychiatric hospital). The new hospital opened in January 2026; therefore, the twenty-eight (28) psychiatric beds reported in historical data have been removed from the projected bed count above.

It is also noted *CON 3084-REHAB* was issued March 3, 2025 to transfer seventeen (17) inpatient physical rehabilitation beds from EAMC-Lanier to EAMC and *CON 3085-PSYCH* was issued March 3, 2025 to transfer twenty (20) geriatric psychiatric beds from EAMC-Lanier to EAMC, which are reflected in the chart above.

<u>Historical</u> Outpatient Occupancy Data for East Alabama Medical Center*						
	Number of Outpatient Visits			Percentage of Outpatient Visits		
	<u>2023</u>	<u>2024</u>	<u>2025</u>	<u>2023</u>	<u>2024</u>	<u>2025</u>
Clinical	67,855	78,411	82,475	33.9%	36.5%	36.6%
Diagnostic	110,017	117,196	124,106	54.9%	54.5%	55.1%
Rehabilitation	6,894	2,757	1,137	3.4%	1.3%	0.5%
Surgical	15,644	16,724	17,461	7.8%	7.8%	7.8%

*Please note the data reported in the chart above includes information pertaining to the Spencer Cancer Center.

<u>Projected</u> Outpatient Occupancy Data for East Alabama Medical Center*				
	Number of Outpatient Visits		Percentage of Outpatient Visits	
	<u>2028</u>	<u>2029</u>	<u>2028</u>	<u>2029</u>
Clinical	95,475	100,249	36.6%	36.6%
Diagnostic	143,558	150,851	55.1%	55.1%
Rehabilitation	1,317	1,383	0.5%	0.5%
Surgical	20,214	21,225	7.8%	7.8%

*Please note the data reported in the chart above includes information pertaining to the Spencer Cancer Center.

D. Population

According to the Center for Business and Economic Research at the University of Alabama (CBER), Lee County has an estimated population of 180,746 in 2025. By 2028, CBER estimates Lee County's population will be 188,130, which is an overall increase of 4.08%.

Lee County has an estimated population 65 and older of 26,082 in 2025. By 2028, CBER estimates Lee County's population 65 and older will be 29,679, an increase of 13.8%.

E. Community Reaction

Section 410-1-6-.06(1)(f) of the *Alabama Certificate of Need Program Rules and Regulations* authorizes consideration of community reaction to the facility or service in determining whether a need for the project exists.

Thirteen (13) letters were submitted in support of the CON application. There is no opposition.

F. Items for Special Attention

There are no open Certificate of Need (CON) projects in Lee County, Alabama, pertaining to oncology-radiation therapy services.

The following chart was provided by the applicant:

Population Projections for the Service Areas*								
	<u>2025</u>	<u>2030</u>	<u>2035</u>	<u>2040</u>	<u>2045</u>	<u>2050</u>	Change 2025-2050	
							Number	Percent
<i>Primary Service Area</i>								
Lee County	190,821	206,330	212,098	219,002	218,134	224,190	33,369	17.49%
<i>Secondary Service Area</i>								
Chambers County	34,695	34,793	35,189	35,493	35,731	35,891	1,196	3.45%
Macon County	18,465	17,728	17,635	17,424	17,692	17,407	-1,058	-5.73%
Randolph County	21,430	21,096	21,187	21,158	21,395	21,278	-152	-0.71%
Russell County	61,124	63,193	64,484	65,904	65,945	67,105	5,981	9.79%
Tallapoosa County	40,609	40,311	40,650	40,844	41,186	41,213	604	1.49%
SSA Total	176,323	177,121	179,145	180,823	181,949	182,894	6,571	3.73%
TOTAL	367,144	383,451	391,243	399,825	400,083	407,084	39,940	10.88%

*U.S. Census Bureau and Center for Business and Economic Research, The University of Alabama, October 2024.

The applicant provided the following items which may be of particular interest to the Board when examining this project:

1. Pharmacy and laboratory support the care provided to cancer patients and due to the key role these two support departments play in the treatment of cancer, the Spencer Cancer Center includes a satellite hospital pharmacy and lab within the facility.
2. Cancer services will be made available to the underserved community in the same manner as existing services offered by EAMC. Underserved groups include low-income persons, racial and ethnic minorities, women and persons with disabilities, as well as all patients that East Alabama Medical Center treats will have access to the services at the Spencer Cancer Center.
3. According to the American Cancer Society, 2,114,850 new cases of cancer are projected to occur in the United States in 2026. It is stated cancer is the second leading cause of death in Alabama and according to the Alabama Cancer Statistics report produced by the Alabama Statewide Cancer Registry, approximately 30,730 new cancers were expected to be diagnosed in 2023, which equates to slightly more than eighty-four (84) people per day. It is also noted Alabama's cancer incidence rate is 447.0, which is slightly higher than the 442.0 incidence rate for the United States.
4. EAMC and its affiliated entities provide many services to the community, such as staff from various departments participating in health fairs and screening events and giving presentations to a variety of groups, the *Diabetes and Nutrition Center* provides diabetes screenings and education year-round and offers programs for free test strips and monitors for underserved patients, *Spencer Cancer Center* offers free screenings and education, including free mammograms to underserved persons, at health fairs and events throughout the year, *Unity Wellness Center*, a Ryan White HIV clinic that provides free HIV prevention education and testing to the community at large and offers free or low-

- cost HIV primary care to patients residing in a five (5) county area, and *The East Alabama Medical Center Faith Community Nurse Program* provides outreach in the community, including an annual Hispanic health fair and other health fairs in low-income neighborhoods, as well as partnering with the Opelika Neighborhood Mobile Clinic.
5. In March of 2020, East Alabama Medical Center set up a free COVID-19 testing site which collected over 161,285 samples. To ensure that individuals had access to testing and monoclonal antibody infusions, the hospital set up and maintained a call center that answered over 192,625 calls. It is noted East Alabama Medical Center administered over 3,955 monoclonal antibody infusions and provided more than 90,000 COVID-19 vaccines free of charge.
 6. East Alabama Medical Center began an Internal Medicine Residency Program in 2021 and several members of the medical staff at the hospital are adjunct professors at the Auburn campus of Edward Via College of Osteopathic Medicine. EAMC also partners with several community colleges and state universities to provide training opportunities for nursing, pharmacy, radiology, and health administration students. These educational partnerships will continue with the renovation/expansion of the Spencer Cancer Center.

G. Issues

The Certificate of Need Review Board should determine if the application is consistent with the required findings. The following questions should be answered affirmatively to approve the proposed project.

- | | | |
|-----|----|---|
| Yes | No | 1. Is the application consistent with the latest approved revision of the appropriate <i>State Health Plan</i> effective at the time the State Health Planning and Development Agency received the application? |
| Yes | No | 2. Are less costly, more efficient, or more appropriate alternatives to such services not available, and has the development of such alternatives been studied and found not feasible? |
| Yes | No | 3. Are existing facilities providing services similar to those proposed being used in an appropriate and efficient manner consistent with community demands for services? |
| Yes | No | 4. In the case of new construction, have alternatives to new construction (e.g., modernization and sharing arrangements) been considered and implemented to the maximum extent feasible? |
| Yes | No | 5. Will patients experience serious problems in obtaining patient care of the type proposed in the absence of the proposed expansion/renovation of Spencer Cancer Center in Lee County, Alabama? |

**REQUEST TO SPEAK AT PUBLIC HEARING
DURING CON-REVIEW BOARD MEETING**

RECEIVED

Apr 17 2026

STATE HEALTH PLANNING AND
DEVELOPMENT AGENCY

PROJECT NO.: AL2026-025

CONTACT: Ms. Laura Grill
President/Chief Executive Officer
East Alabama Health
2000 Pepperell Parkway
Opelika, AL 36801
Telephone: (334) 528-1310

DATE REVIEW CYCLE BEGINS: March 20, 2026

DEADLINE DATE FOR APPLICANT: April 20, 2026

DEADLINE DATE FOR INTERESTED PARTIES OTHER THAN APPLICANT:
May 4, 2026

PERSONS SPEAKING FOR APPLICANT:

1. **NAME:** Laura Grill, President/Chief Executive Officer
 ADDRESS: East Alabama Health
 2000 Pepperell Parkway
 Opelika, Alabama 36801

2. **NAME:** Chris Clark, Chief Clinical Services Officer
 ADDRESS: East Alabama Health
 2000 Pepperell Parkway
 Opelika, Alabama 36801

3. **NAME:** Greg Nichols, Chief Facilities Officer/EAMC-Lanier Administrator
 ADDRESS: Esat Alabama Health
 2000 Pepperell Parkway
 Opelika, Alabama 36801

4. **NAME:** Roben Casey, Chief Legal & Governance Officer
 ADDRESS: East Alabama Health
 2000 Pepperell Parkway
 Opelika, Alabama 36801

5. **NAME:** Marcilla Gross, Chief Compliance & Regulatory Affairs Officer
 ADDRESS: East Alabama Health
 2000 Pepperell Parkway
 Opelika, Alabama 36801

6. **NAME:** Chris Waits, Executive Director Oncology
 ADDRESS: Spencer Cancer Center
 2501 Village Professional Drive
 Opelika, Alabama 36801

**REQUEST TO SPEAK AT PUBLIC HEARING
DURING CON-REVIEW BOARD MEETING**

PROJECT NO.: AL2026-025 **CONTACT:** Ms. Laura Grill
President/Chief Executive Officer
East Alabama Health
2000 Pepperell Parkway
Opelika, AL 36801
Telephone: (334) 528-1310

7. **NAME:** Brandon Johnson, M.D.
 ADDRESS: Spencer Cancer Center
 2501 Village Professional Drive
 Opelika, Alabama 36801



STATE HEALTH PLANNING AND DEVELOPMENT AGENCY

100 NORTH UNION STREET, SUITE 870
MONTGOMERY, ALABAMA 36104

MEMORANDUM

DATE: March 20, 2026
TO: Applicant and Interested Parties
FROM: Emily T. Marsal 
Executive Director
SUBJ: HOSPITAL

Project No. AL2026-025, East Alabama Medical Center, will be reviewed against the 2024-2027 *State Health Plan* effective June 14, 2024.

Individuals or entities seeking to be granted intervenor status should file a Notice of Intervention with the Agency pursuant to § 41-22-14 Code of Alabama, 1975 on or before the 45th day of the review cycle, May 4, 2026. The applicant or any intervenor of record may request that this matter be heard initially as a contested case hearing before an Administrative Law Judge (ALJ). Any such request must be received by the Agency by May 13, 2026. If no such request is received by the deadline, the application shall be heard before the CON Review Board at a public hearing. The applicant, any competing applicant or an intervenor of record may file a written request for reconsideration not more than 15 days subsequent to the date that any decision of the CON Review Board is deemed final. Any adverse decision of the CON Review Board (other than a case first heard as a contested case before an ALJ) may be appealed to an ALJ designated by the Governor for fair hearing which appeal shall be heard de novo as a contested case in accordance with §41-22-12 and §41-22-13, Code of Alabama, 1975. The fair hearing appeal proceedings shall be conducted pursuant to the requirements of the Alabama Administrative Procedure Act, Title 41 of Chapter 22.

Rule 410-1-3-.03 Ex Parte Contacts of the *Alabama Certificate of Need Program Rules and Regulations* provides that there shall be no ex parte contacts:

- (a) in the case of an application for Certificate of Need, between the applicant for the Certificate of Need, any person acting on behalf of the applicant, or any person opposed to the issuance of a Certificate of Need for the applicant and any member of the Certificate of Need Review Board who exercises any responsibility respecting the application after the application has been received by the agency and before a decision is made with respect to the application.

ETM/mst

**STATE OF ALABAMA
STATE HEALTH PLANNING AND DEVELOPMENT AGENCY
OFFICE OF HEALTH DEVELOPMENT**

REVIEW SCHEDULE

TO: 1. Project applicant
2. Persons directly affected

NOTICE: A complete application for review under the provisions of Sections 22-21-260 through 22-21-278, Code of Alabama, 1975. A brief description of the proposal and of the Review Schedule is set forth below:


Emily T. Marsal
Executive Director

March 20, 2026
Date

DESCRIPTION OF PROPOSED FACILITY AND/OR SERVICE			
1. PROJECT NUMBER AL2026-025	2. TYPE FACILITY HOSPITAL	3. ESTIMATED COST \$43,761,830.00	4. COUNTY Lee
5. NAME OF PROJECT: East Alabama Medical Center			
6. LOCATION OF PROJECT: Spencer Cancer Center 2501 Village Professional Drive Opelika, Alabama 36801			
7. BRIEF DESCRIPTION OF PROJECT (Change in bed capacity, service, equipment, service units proposed, etc.): The applicant proposes to expand and renovate the Spencer Cancer Center, an existing facility located in the city of Opelika, Lee County, Alabama. Upon completion, the newly renovated center will have 30,500 additional square feet for clinical space pertaining to patient care and physician offices, which includes a gynecological oncology and breast surgery suite, increased capacity in imaging, pharmacy, and laboratory services, as well as a second PET/CT scanner. It is noted this project does not include the addition of a third linear accelerator.			
8. REVIEW PERIOD BEGINS: (Day 1) March 20, 2026		9. DEADLINE DATE FOR ADDITIONAL INFORMATION FROM APPLICANT (30 TH DAY) April 20, 2026	
10. DEADLINE DATE FOR ANY INTERESTED PARTIES WISHING TO SUBMIT INFORMATION IN OPPOSITION OR SUPPORT OF THE PROPOSED PROJECT (45 TH DAY): May 4, 2026			
11. NOTIFICATION OF STAFF FINDINGS TO THE APPLICANT (50 TH DAY) May 8, 2026		12. DEADLINE DATE TO REQUEST CONTESTED CASE HEARING (55 TH DAY) May 13, 2026	
13. DEADLINE DATE FOR APPLICANT’S RESPONSE TO STAFF FINDINGS (65 TH DAY) May 26, 2026		14. PROPOSED DATE OF PUBLIC HEARING June 17, 2026	
15. PROPOSED DATE OF FINAL DECISION (DPA) (15 DAYS AFTER VOTE OF CONRB) July 2, 2026		16. DEADLINE DATE FOR APPEAL OF FINAL ORDER (36 DAYS AFTER VOTE OF CONRB) July 23, 2026	

**REQUEST TO SPEAK AT PUBLIC HEARING
DURING CON-REVIEW BOARD MEETING**

PROJECT NO: AL2026-025

CONTACT: Ms. Laura D. Grill, CEO/President
East Alabama Health
2000 Pepperell Parkway
Opelika, Alabama 36801
Telephone: (334) 528-1310

DATE REVIEW CYCLE BEGINS: March 20, 2026

DEADLINE DATE FOR APPLICANT: April 20, 2026

DEADLINE DATE FOR INTERESTED PARTIES OTHER THAN APPLICANT: May 4, 2026
Persons other than applicant, please give mailing address.

(For requirements of speakers, please see "Notice to Applicant and Interested Parties.")

PERSONS SPEAKING FOR APPLICANT: PERSONS SPEAKING IN OPPOSITION:

1. NAME: _____ ADDRESS: _____	1. NAME: _____ ADDRESS: _____
2. NAME: _____ ADDRESS: _____	2. NAME: _____ ADDRESS: _____
3. NAME: _____ ADDRESS: _____	3. NAME: _____ ADDRESS: _____
4. NAME: _____ ADDRESS: _____	4. NAME: _____ ADDRESS: _____
5. NAME: _____ ADDRESS: _____	5. NAME: _____ ADDRESS: _____

APPLICANT EXHIBITS:

1. _____	1. _____
2. _____	2. _____
3. _____	3. _____

OPPOSITION EXHIBITS:

Pursuant to SHPDA Rule 410-1-3-.09, all documents to be filed must be submitted electronically to
shpda.online@shpda.alabama.gov in text searchable, PDF format.

*If additional space is needed, please use a separate sheet.

**NOTICE
TO APPLICANT
AND
INTERESTED PARTIES**

THE APPLICANT

Under Rule 410-1-7-.06 *Alabama Certificate of Need Program Rules and Regulations*, notice of a CON application for substance abuse treatment facilities or psychiatric beds must be published in a newspaper of general circulation in the affected area once a week for two consecutive weeks. Proof of such publication must be filed with the agency no later than the 30th day of the review cycle. Where publication has occurred within the thirty-day deadline, but the newspaper failed to provide notarized proof of publication, counsel may provide copies of the actual publication along with a notarized certificate from counsel or an employee of the applicant, attesting to the newspaper and publication date. Failure to provide proof of publication by the 30th day of the review cycle will deem the application incomplete, and it will be dismissed from the review cycle. Publication of notice is not required for CON applications filed for other proposed services.

Once an application is deemed complete by the State Agency staff, the applicant will have thirty (30) days to submit a PDF copy of any additional information to shpda.online@shpda.alabama.gov. No additional data will be accepted or considered for inclusion in the application unless received on or before the thirtieth (30th) day of the review cycle.

Person(s) who desire to make presentations to the Certificate of Need Review Board must register to speak. If a list of speakers is not received from the applicant by the thirtieth (30th) day, only the applicant or his designee will be allowed to speak. Presentations to the Board will be limited to the materials filed as a matter of record with the State Agency by the thirtieth (30th) day. Visual aids such as graphs, charts, and related materials may be used in the presentation to the Board only if the content of such aids is included in the application materials by the thirtieth (30th) day of the review cycle.

AFFECTED PERSONS OTHER THAN THE APPLICANT

Rule 410-1-2-.18 of the *Alabama Certificate of Need Program Rules and Regulations* defines an “affected person” as “include[ing] at a minimum, the applicant, and health care facilities located in the area in which the project is to be located and which provides similar services to those proposed. Also included are those persons who have an active letter of intent on file to provide similar services in the same area.”

Affected person(s) other than the applicant who wish to submit written statements, either in opposition or support of the application, must electronically file their comments on or before the forty-fifth (45th) day of the review cycle. Affected person(s) other than the applicant who wish to make an oral presentation to the Board must electronically file their request on or before the forty-fifth (45th) day of the review cycle. They must submit a written summary statement and must limit their comments to the Board to the same. Visual aids such as graphs, charts and related materials may be used in the presentation to the Board only if the content of such aids is submitted on or before the forty-fifth (45th) day of the review cycle.

Affected person(s) other than the applicant will be required to file an electronic PDF copy of any materials filed of record with the State Agency. Any materials filed of record with the State Agency by an affected person other than the applicant, must be served on or provided to the applicant the same day said materials are filed with the agency by the person so filing them. If not, these materials may be excluded from the record.

Parties seeking formal intervenor status in SHPDA proceedings are required to meet the requirements of Ala. Code § 41-22-14 and Rule 410-1-9-.03 of the *Alabama Certificate of Need Program Rules and Regulations* (see below).

PERSONS OTHER THAN AFFECTED PERSONS

Person(s) other than affected persons must file their letter of support or opposition with the Agency on or before the forty-fifth (45th) day of the review cycle, but will not be required to file a copy of it with the applicant. These letters will be placed in a separate file for review by the members of the Certificate of Need Review Board.

ALL PERSONS

Rule 410-1-3-.08 Mode of Filing of the *Alabama Certificate of Need Program Rules and Regulations* provides that all official documents filed with this Agency must be timely filed by electronic mail, as required by Rule 410-1-3-.09, and must be sent to the Executive Secretary of the Agency at shpda.online@shpda.alabama.gov in order to be deemed officially filed.

Rule 410-1-9-.03 Intervention of the *Alabama Certificate of Need Program Rules and Regulations* requires an application for intervention must be filed on or before the forty-fifth (45th) day of the review period. The application to intervene shall be in writing and shall state the identity of the intervenor, the names of all persons who will testify on behalf of the intervenor, and a concise statement of the substance of the testimony to be offered.

Rule 410-1-7-.15 Fifty-Fifth (55th) Day of the Review Period of the *Alabama Certificate of Need Program Rules and Regulations* provides that “The applicant or any intervenor of record may request a contested case hearing, as described in Section 410-1-8-.02, on or before the fifty-fifth (55th) day of the review cycle.”

An entire copy of the Rules and Regulations is available upon request for a fee of \$40.

Revised: 3/15/2017

Filed Electronically at: shpda.online@shpda.alabama.gov

March 11, 2026

Ms. Emily T. Marsal
Executive Director
State Health Planning and Development Agency
100 North Union Street, Suite 870
Montgomery, Alabama 36104

Re: AL2026-025; East Alabama Medical Center

Dear Ms. Marsal:

East Alabama Medical Center ("EAMC") filed a certificate of need on February 23, 2026, proposing to expand and renovate the *Spencer Cancer Center*, an existing facility located in the city of Opelika, Lee County, Alabama. Upon completion, the newly renovated center will have 30,500 additional square feet for clinical space pertaining to patient care and physician offices, which includes a gynecological oncology and breast surgery suite, increased capacity in imaging, pharmacy, and laboratory services, as well as a second PET/CT scanner. The proposed project does not include the addition of a third linear accelerator.

The purpose of this correspondence is for EAMC to submit additional information that you requested for AL2026-025 per your letter dated March 10, 2026. The information that you requested is provided below.

Part One, (I), (F), Applicant Identification: On page 2 of the CON application, the applicant reports eleven (11) governing board members. Please clarify for the Agency whether these are members of the East Alabama Health Care Authority or East Alabama Medical Center.

The board members listed on page 2 of the CON application are the board members for The East Alabama Health Care Authority. The East Health Alabama Care Authority Board is responsible for all entities that fall under The East Alabama Health Care Authority including East Alabama Medical Center. Therefore, there is not a separate board for East Alabama Medical Center. A corrected page 2 is included with this correspondence noting this information.

Part One, (III), Executive Summary: On page 3 of the application, it is indicated that EAMC's cancer center has been a pillar of patient care since November of 1992; the center grew to include radiation oncology as well as medical oncology and extended its footprint to 21,240 square feet in the year 2006, and the 2016 construction project brought a two-story, state-of-the-art cancer center with two (2) linear accelerators. Please provide the Certificate of Need numbers pertaining to EAMC's cancer center in Lee County, Alabama.

CON 1370-H was issued to East Alabama Medical Center on September 30, 1992, for an outpatient services center which included the building of a 47,690 square foot, two-floor addition on the north side of the facility. The outpatient services center in this project included outpatient oncology services and nuclear medicine with space for radiation therapy.

CON 2780-H-MOD1 was issued March 30, 2017, for the relocation of the existing cancer center to a new freestanding cancer center, to replace one existing linear accelerator and to add a second linear accelerator at that location. This facility is located at 2501 Village Professional Drive, Opelika, Alabama.

Part Two, (I), (B), Project Narrative: The applicant provided population data for Lee County, the primary service area, as well as the secondary service area, which is comprised of five (5) counties that surround Lee County, Alabama. Please provide the Agency with population data regarding the senior demographic for the proposed medical service areas.

The population data regarding the senior demographic for the proposed medical service area is in the table below.

Population Projections for Service Area for 65 Years and Older

	2020	2025	Census 2030	2035	2040	Change 2020-2040 Number	Percent
Primary Service Area							
Lee County	21,095	26,082	30,877	34,466	37,539	16,444	77.95%
Secondary Service Area							
Chambers County	7,043	7,778	8,181	8,352	8,330	1,287	18.27%
Macon County	3,352	3,669	3,855	3,795	3,698	346	10.32%
Randolph County	4,847	5,393	5,820	6,016	6,032	1,185	24.45%
Russell County	8,959	10,124	11,062	11,348	11,416	2,457	27.42%
Tallapoosa County	8,694	9,556	9,991	10,037	9,889	1,195	13.75%
Secondary Service Area	32,895	36,520	38,909	39,548	39,365	6,470	19.67%
Total	53,990	62,602	69,786	74,014	76,904	22,914	42.44%

Source: U.S. Census Bureau and Center for Business and Economic Research, The University of Alabama

Part Five, (II), (B), Charge Information: The applicant neglected to discuss the impact of project cost on operational costs of the facility or service. Please submit a revised application page for this section of the application

After completion of this project, it is expected that total operating costs for the Spencer Caner Center will increase by \$10,464,030 from fiscal year 2025 to fiscal year 2028 which will be the first full year of operation after the expansion is complete. Of the \$10,464,030 in operating costs, only \$5,987,467 of that amount can be attributed to new operating costs related to the expansion. The remaining balance of \$4,476,563 is attributed to expected patient volume at the facility based on its current size and capacity as well as expected inflation costs.

Pages 11 through 13 of the application have been revised and are included with this correspondence noting this information per your request.

If you have any questions or need additional information, please contact me at (334) 528-5825.

Sincerely,



Marcilla C. Gross
Chief Compliance & Regulatory Affairs Officer

cc: Laura D. Grill, President/CEO

Enclosures

I. APPLICANT IDENTIFICATION (continued)**E. Type Ownership and Governing Body**

1. Individual () _____
2. Partnership () _____
3. Corporate (for profit) () _____
Name of Parent Corporation
4. Corporate (non-profit) () _____
Name of Parent Corporation
5. Public () _____
6. Other (specify) (X) Health Care Authority

F. Names and Titles of Governing Body Members and Owners of This Facility**GOVERNING BOARD MEMBERS FOR THE EAST ALABAMA HEALTH CARE AUTHORITY**

<u>C. Wayne Alderman, Ph.D., Chairman</u>	<u>Vertrina Grubbs</u>
<u>Dozier Smith T, Vice Chairman</u>	<u>Lee Johnson, M.D.</u>
<u>Stanley Tucker, Secretary</u>	<u>J. Stephen Lock, M.D.</u>
<u>John Abrams, M. D.</u>	<u>Haley Welsh</u>
<u>Robert Dumas</u>	<u>Mike Williams, M.D.</u>
<u>Valerie Gray</u>	

Note: The East Health Alabama Care Authority Board is responsible for all entities that fall under The East Alabama Health Care Authority including East Alabama Medical Center. Therefore, there is not a separate board for East Alabama Medical Center.

II. PROJECT DESCRIPTION

Project/Application Type (check all that apply)

- | | |
|---|---|
| ☐ New Facility
Type_____ | ☐ Major Medical Equipment
Type:_____ |
| ☐ New Service
Type_____ | ☐ Termination of Service or Facility |
| ☒ Construction/Expansion/Renovation | ☐ Other Capital Expenditure
Type_____ |
| ☐ Change in Service | |

PART FIVE: UTILIZATION DATA AND FINANCIAL INFORMATION

This part should be completed for projects which cost over \$500,000.00 or which propose a substantial change in service, or which would change the bed capacity of the facility in excess of ten percent (10%), or which propose a new facility. ESRD, home health, and projects that are under \$500,000.00 should omit this part and complete Part Four.

I. PERCENT OF GROSS REVENUE FOR EAST ALABAMA MEDICAL CENTER

Source of Payment	Historical			Projected	
	2023	2024	2025	2028	2029
ALL Kids	0.20%	0.51%	0.60%	0.60%	0.60%
Blue Cross/Blue Shield	26.24%	31.16%	26.59%	26.59%	26.59%
Champus/Tricare	0.80%	1.02%	0.90%	0.90%	0.90%
Charity Care (see note below)	Charity Care is included in Self pay percentage				
Medicaid	12.70%	9.80%	10.35%	10.35%	10.35%
Medicare	20.43%	16.01%	17.54%	17.54%	17.54%
Other commercial insurance	33.64%	34.61%	38.27%	38.27%	38.27%
Self-pay	4.24%	4.55%	3.63%	3.63%	3.63%
Other	1.54%	1.95%	1.90%	1.90%	1.90%
Workers' Compensation	0.21%	0.39%	0.22%	0.22%	0.22%
TOTAL	100.00%	100.00%	100.00%	100.00%	100.00%

Note: Refer to the Healthcare Financial Management Association (HFMA) Principles and Practices Board Statement Number 15, Section II.

II. CHARGE INFORMATION**A. List schedule of current charges related to this project.**

See below.

B. List schedule of proposed charges after completion of this project. Discuss the impact of project cost on operational costs and charges of the facility or service.

There will be no changes in the current charge structure as a result of the proposed expansion. Listed on page 12 are charges for the listed procedures that are provided at the Spencer Cancer Center.

After completion of this project, it is expected that total operating costs for the Spencer Cancer Center will increase by \$10,464,030 from fiscal year 2025 to fiscal year 2028 which will be the first full year of operation after the expansion is complete. Of the \$10,464,030 in operating costs, only \$5,987,467 of that amount can be attributed to new operating costs related to the expansion. The remaining balance of \$4,476,563 is attributed to expected patient volume at the facility based on its current size and capacity as well as expected inflation costs.

CPT CODE	DESCRIPTION	CHARGE
36593	DECLOT BY THROMBOLYTIC AGENT IMPLANT DEVICE-	\$ 631.00
96360	ONC IV INFUSION HYDRATION INITIAL 31 MIN-1 H	\$ 613.00
96361	ONC IV INFUSION HYDRATION EACH ADDITIONAL HO	\$ 159.00
96365	ONC IV INFUSION THERAPY-PROPHYLAXIS -DX 1ST	\$ 613.00
96366	ONC IV INFUSION THERAPY PROPHYLAXIS-DX EA HO	\$ 159.00
96367	ONC IV INFUSION THER PROPH ADDL SEQUENTIAL T	\$ 159.00
96368	ONC IV NFS THERAPY PROPHYLAXIS-DX CONCURRENT	\$ 613.00
96372	ONC THERAPEUTIC PROPHYLACTIC-DX INJECTION SU	\$ 131.00
96374	ONC THER PROPH-DX NJX IV PUSH SINGLE-1ST SBS	\$ 404.00
96375	ONC THER PROPH-DX NJX EA SEQL IV PUSH SBST-D	\$ 136.00
96376	ONC EACH ADDITIONAL SEQUENTIAL IV PUSH	\$ 136.00
96377	APPL ON-BODY INJECTOR FOR TIMED SUBQ INJ	\$ 89.00
96401	ONC CHEMOTX ADMN SUBQ-IM NON-HORMONAL ANTI-N	\$ 163.00
96402	ONC CHEMOTX ADMN SUBQ-IM HORMONAL ANTI-NEO	\$ 163.00
96409	ONC CHEMOTX ADMN IV PUSH TQ 1-1ST SBST-DRUG	\$ 608.00
96411	ONC CHEMOTX ADMN IV PUSH TQ EA SBST-DRUG	\$ 159.00
96413	ONC CHEMOTX ADMN IV NFS TQ UP 1 HR 1-1ST SBS	\$ 631.00
96415	ONC CHEMOTHERAPY ADMN IV INFUSION TQ EA HR	\$ 159.00
96416	ONC CHEMOTX ADMN TQ INIT PROLNG CHEMOTX NFUS	\$ 159.00
96417	ONC CHEMOTX ADMN IV NFS TQ EA SEQL NFS TO 1	\$ 613.00
96523	ONC IRRIGATION OF IMPLANTED VENOUS ACCESS DEVICE	\$ 127.00
96549	ONC UNLIS CHEMOTX PX	\$ 613.00
36592	COLLECT BLD VIA VENOUS IV CATH NOS	\$ 229.00
36415	COLLECT VENOUS BLD BY VENIPUNCTURE	\$ 20.00
70450	CT SCAN OF THE HEAD OR BRAIN PERFORMED WITHOUT CONTRAST	\$ 639.00
50391	INSTILL OF AGT IN RENAL PELVIS OR URETER	\$ 769.00
77295	RT 3D TREATMENT PLANNING	\$ 2,504.00
77316	RT BRACHYTHERAPY ISO PL SIMPLE	\$ 725.00
77318	RT BRACHYTHERAPY ISO PN COMP	\$ 1,026.00
77336	RT CONTINUING PHYSICS SUPPORT	\$ 523.00
71250	RT CT CHEST W-O CONTRAST	\$ 236.00
77014	RT CT GUIDANCE F-PLCMT RT FIELDS	\$ 188.00
77338	RT DESIGN MLC DEVICE FOR IMRT	\$ 1,309.00
77300	RT DOSIMETRY	\$ 387.00
77387	RT GUIDANCE FOR RAD TX DEL	\$ 294.00
77770	RT HDR RDNCL NTRSTL-ICAV BRCHTX 1 CH	\$ 1,402.00
77771	RT HDR RDNCL NTRSTL-ICAV BRCHTX 2-12	\$ 2,866.00
77301	RT IMRT PLAN	\$ 2,504.00
77386	RT IMRT TREATMENT COMPLEX	\$ 1,309.00
77385	RT IMRT TREATMENT SIMPLE	\$ 1,309.00
57156	RT INS VAG BRACHYTX DEVICE	\$ 2,006.00
57155	RT INSERTION TANDEM OVOIDS	\$ 9,591.00
77307	RT ISODOSE PLAN - INT	\$ 1,003.00
77306	RT ISODOSE PLAN - SIMPLE	\$ 974.00
77372	RT LINEAR ACC STEREOTACTIC SURGERY	\$ 15,367.00
79005	RT NUCLEAR RX ORAL ADMIN	\$ 632.00
77417	RT PORT FILM - EACH	\$ 116.00
99426	RT PRINCIPAL CARE MGMT SVC 1ST 30 STAFF CAL MO	\$ 210.00

CPT CODE	DESCRIPTION	CHARGE
77412	RT RADIATION TX DELIVERY COMPLEX	\$ 1,309.00
77407	RT RADIATION TX DELIVERY INTERM	\$ 468.00
77402	RT RADIATION TX DELIVERY SIMPLE	\$ 370.00
77293	RT RESPIRATOR MOTION MGMT SIMUL	\$ 965.00
77373	RT SBRT FRACTIONS 2-5	\$ 3,729.00
77290	RT SIMULATION COMPLETE	\$ 809.00
77280	RT SIMULATION SIMPLE	\$ 386.00
77331	RT SPECIAL DOSIMETRY	\$ 544.00
77370	RT SPECIAL PHYSICS CONSULT	\$ 495.00
77321	RT SPECIAL TELETHERAPY PORT PLA	\$ 791.00
77470	RT SPECIAL TMNT PROC	\$ 1,143.00
77790	RT SUPERVISION HANDLING	\$ 762.00
77332	RT TREATMENT DEVICES	\$ 405.00
77334	RT TREATMENT DEVICES COMPLEX	\$ 786.00



CON APPLICATION FOR SPENCER CANCER CENTER EXPANSION 2026

Spencer Cancer Center
EAST ALABAMA MEDICAL CENTER

East Alabama
Health 

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Feb 23 2026

STATE HEALTH PLANNING AND
DEVELOPMENT AGENCY

ALABAMA CERTIFICATE OF NEED APPLICATION

INSTRUCTIONS: Please submit an electronic pdf copy of this completed form and the appropriate attachments to the State of Alabama, State Health Planning and Development Agency, in accordance with ALA. ADMIN. CODE r. 410-1-7-.06 (Filing of a Certificate of Need Application) and 410-1-3-.09 (Electronic Filing). Electronic filings meeting the requirements of the aforementioned rules shall be considered provisionally received pending receipt of the required filing fee and shall be considered void should the proper filing fee not be received by the end of the next business day. Refer to ALA. ADMIN. CODE r. 410-1-7-.06 to determine the required filing fee.

Filing fees should be remitted to: State Health Planning and Development Agency, 100 North Union Street, Suite 870, Montgomery, Alabama 36104 or the fee may be submitted electronically via the payment portal available through the State Agency's website at www.shpda.alabama.gov.

PART ONE: APPLICANT IDENTIFICATION AND PROJECT DESCRIPTION

I. **APPLICANT IDENTIFICATION** (Check One) HOSPITAL (X) NURSING HOME (____)
OTHER (____) (Specify) _____

A. East Alabama Medical Center

Name of Applicant (in whose name the CON will be issued if approved)

<u>2000 Pepperell Parkway</u>	<u>Opelika</u>	<u>Lee</u>
Address	City	County

<u>Alabama</u>	<u>36801</u>	<u>(334) 749-3411</u>
State	Zip Code	Phone Number

B. Spencer Cancer Center

Name of Facility/Organization (if different from A)

<u>2501 Village Professional Drive</u>	<u>Opelika</u>	<u>Lee</u>
Address	City	County

<u>Alabama</u>	<u>36801</u>	<u>(334) 528-1070</u>
State	Zip Code	Phone Number

C. The East Alabama Health Care Authority

Name of Legal Owner (if different from A or B)

<u>2000 Pepperell Parkway</u>	<u>Opelika</u>	<u>Lee</u>
Address	City	County

<u>Alabama</u>	<u>36801</u>	<u>(334) 749-3411</u>
State	Zip Code	Phone Number

D. Laura D. Grill, CEO/President

Name and Title of Person Representing Proposal and with whom SHPDA should communicate

<u>2000 Pepperell Parkway</u>	<u>Opelika</u>	<u>Lee</u>
Address	City	County

<u>Alabama</u>	<u>36801</u>	<u>(334) 528-1310</u>
State	Zip Code	Phone Number

I. APPLICANT IDENTIFICATION (continued)

E. Type Ownership and Governing Body

- | | | | |
|----|------------------------|--------------|------------------------------|
| 1. | Individual | () | |
| 2. | Partnership | () | |
| 3. | Corporate (for profit) | () | _____ |
| | | | Name of Parent Corporation |
| 4. | Corporate (non-profit) | () | _____ |
| | | | Name of Parent Corporation |
| 5. | Public | () | |
| 6. | Other (specify) | (<u>X</u>) | <u>Health Care Authority</u> |

F. Names and Titles of Governing Body Members and Owners of This Facility

GOVERNING BOARD MEMBERS

<u>C. Wayne Alderman, Ph.D., Chairman</u>	<u>Vertrina Grubbs</u>
<u>Dozier Smith T, Vice Chairman</u>	<u>Lee Johnson, M.D.</u>
<u>Stanley Tucker, Secretary</u>	<u>J. Stephen Lock, M.D.</u>
<u>John Abrams, M. D.</u>	<u>Haley Welsh</u>
<u>Robert Dumas</u>	<u>Mike Williams, M.D.</u>
<u>Valerie Gray</u>	

II. PROJECT DESCRIPTION

Project/Application Type (check all that apply)

- | | |
|---|---|
| ☐ New Facility
Type_____ | ☐ Major Medical Equipment
Type:_____ |
| ☐ New Service
Type_____ | ☐ Termination of Service or Facility |
| ☒ Construction/Expansion/Renovation | ☐ Other Capital Expenditure
Type_____ |
| ☐ Change in Service | |

III. EXECUTIVE SUMMARY OF THE PROJECT (brief description)

East Alabama Medical Center (“EAMC”) which is located in Opelika, Lee County, AL, proposes an expansion of the existing Spencer Cancer Center, located at 2501 Village Professional Drive in Opelika. This expansion will add an additional 30,500 square feet to the current facility. The expansion will add clinical space for patient care and physician offices, including a gynecological oncology and breast surgery suite and increase capacity in imaging, pharmacy and lab services.

EAMC’s Cancer Center has been a pillar of patient care since November 1992. At the time of its opening, the department was only 7,240 square feet of designated space. In 2006, the Cancer Center grew to include both radiation oncology and medical oncology, extending its footprint to 21,240 square feet. This brought continued growth in patient volumes and led to the construction of the Spencer Cancer Center in 2016.

The 2016 construction project brought a two-story, state-of-the-art cancer center with two linear accelerators. As an operating department of the hospital, the Spencer Cancer Center services have met the needs of a vulnerable patient population with convenience of care in one central location. This includes imaging, provider appointments, personalized infusion treatments, labs, retail pharmacy and access to purchase durable medical equipment as needed. The Spencer Cancer Center also provides convenient parking and access to social services and support groups. The success of the Spencer Cancer Center not only expands EAMC’s patient reach but also makes physician recruitment for highly specialized areas of medicine possible.

Between 2019-2025, the Spencer Cancer Center had a 74% increase in patient volume and successfully recruited a team of seven (7) new providers and additional recruitment offers are currently extended. The growing team includes two (2) gynecological surgical oncologists, two (2) breast surgeons and two (2) nurse practitioners who need designated office and clinical space for a gynecological oncology suite. In addition to clinical space, the needs of this new group will contribute to the overall need for expanded services and additional staff members for the Spencer Cancer Center.

The proposed expansion addresses the need for additional diagnostic abilities through imaging and lab services. This will include the purchase of a second PET/CT scanner and a designated patient area to meet the increased demand for imaging services. Additionally, the expansion will renovate existing square footage to extend laboratory space at the Spencer Cancer Center in order to meet the increased demand for infusion lab services.

Next, the expansion proposal includes doubling the footprint of the compound pharmacy space to increase infusion hoods, from four (4) to eight (8) hood vents, which are used for compounding personalized treatments. This will increase capacity for making infusion treatments, and in turn, the need for additional infusion treatment areas. The proposal will add twenty-three (23) infusion bays, bringing the total from thirty (30) to fifty-two (52) infusion treatment bays.

IV. COST

A.	Construction (includes modernization expansion)	
1.	Predevelopment	\$ <u>65,000</u>
2.	Site Acquisition	<u> </u>
3.	Site Development	<u>1,500,000</u>
4.	Construction	<u> </u>
5.	Architect and Engineering Fees	<u>2,372,500</u>
6.	Renovation	<u>25,324,766</u>
7.	Interest during time period of construction	<u> </u>
8.	Attorney and consultant fees	<u> </u>
9.	Bond Issuance Costs	<u> </u>
10.	Other <u>Construction Contingency</u>	<u>2,532,477</u>
11.	Other <u>Landscaping, Signage, Sewer</u>	<u>815,000</u>
	<u>Impact Fees, & Low Voltage</u>	<u> </u>
	TOTAL COST OF CONSTRUCTION	\$ <u>32,609,743</u>
B.	Purchase	
1.	Facility	\$ <u> </u>
2.	Major Medical Equipment	<u>2,200,000</u>
3.	Other Equipment (FF&E)	<u>2,964,620</u>
	TOTAL COST OF PURCHASE	\$ <u>5,164,620</u>
C.	Lease	
1.	Facility Cost Per Year <u> </u> x <u> </u> Years =	\$ <u> </u>
2.	Equipment Cost per Month	<u> </u>
	<u> </u> x <u> </u> Months =	<u> </u>
3.	Land-only Lease Cost per Year	<u> </u>
	<u> </u> x <u> </u> Years	<u> </u>
	TOTAL COST OF LEASE(s)	\$ <u>0</u>
	(compute according to generally accepted accounting principles)	
	Cost if Purchased	\$ <u>n/a</u>
D.	Services	
1.	<u> </u> New Service	\$ <u> </u>
2.	<u> X </u> Expansion	\$ <u>5,987,467</u>
3.	<u> </u> Reduction or Termination	\$ <u> </u>
4.	<u> </u> Other	\$ <u> </u>
	FIRST YEAR NEW ANNUAL OPERATING COST	\$ <u>5,987,467</u>
E.	Total Cost of this Project (Total A through D)	
	(should equal V-C on page A-4)	\$ <u>43,761,830</u>

IV. COST (continued)

- F. Proposed Finance Charges
- | | | |
|----|---|----------|
| 1. | Total Amount to Be Financed | \$ _____ |
| 2. | Anticipated Interest Rates | _____ |
| 3. | Term of Loan | _____ |
| 4. | Method of Calculating Interest on Principal Payment | _____ |

V. ANTICIPATED SOURCE OF FUNDING

- | A. | Federal | Amount | Source |
|----|---------------------------------------|----------------------|---|
| 1. | Grants | \$ _____ | _____ |
| 2. | Loans | _____ | _____ |
| B. | Non-Federal | | |
| 1. | Commercial Loan | _____ | _____ |
| 2. | Tax-exempt Revenue Bonds | _____ | _____ |
| 3. | General Obligation Bonds | _____ | _____ |
| 4. | New Earning and Revenues | <u>5,987,467</u> | The East Alabama Health
Care Authority |
| 5. | Charitable Fund Raising | _____ | _____ |
| 6. | Cash on Hand | <u>37,774,363</u> | The East Alabama Health
Care Authority |
| 7. | Other | _____ | _____ |
| C. | TOTAL (should equal IV-E on page A-3) | \$ <u>43,761,830</u> | |

VI. TIMETABLE

- | | | |
|----|-------------------------------|------------------------------------|
| A. | Projected Start/Purchase Date | <u>2 months after CON approval</u> |
| B. | Projected Completion Date | <u>13 months from start date</u> |

PART TWO: PROJECT NARRATIVE

Note: In this part, please submit the information as an attachment. This will enhance the continuity of reading the application.

The applicant should address the items that are applicable to the project.

I. MEDICAL SERVICE AREA

- A. Identify the geographic (medical service) area by county (ies) or city, if appropriate, for the facility or project. Include an 8 ½ x 11" map indicating the service area and the location of the facility.
- B. What population group(s) will be served by the proposed project? Define age groups, location and characteristics of the population to be served.
- C. If medical service area is not specifically defined in the State Health Plan, explain statistical methodologies or market share studies based upon accepted demographic or statistical data available with assumptions clearly detailed. If Patient Origin Study data is used, explain whether institution or county based, etc.
- D. Are there any other factors affecting access to the project?

☐ Geographic ☐ Economic ☐ Emergency ☐ Medically Underserved

Please explain.

II. HEALTH CARE REQUIREMENTS OF THE MEDICAL SERVICE AREA

- A. What are the factors (inadequacies) in the existing health care delivery system which necessitate this project?
- B. How will the project correct the inadequacies?
- C. Why is your facility/organization the appropriate facility to provide the proposed project?
- D. Describe the need for the population served or to be served for the proposed project and address the appropriate sections of the State Health Plan and the Rules and Regulations under 410-1-6-.07. Provide information about the results of any local studies which reflect a need for the proposed project.
- E. If the application is for a specialized or limited-purpose facility or service, show the incidence of the particular health problem.
- F. Describe the relationship of this project to your long-range development plans if you have such plans.

III. RELATIONSHIP TO EXISTING OR APPROVED SERVICES AND FACILITIES

- A. Identify by name and location the existing or approved facilities or services in the medical service area similar to those proposed in this project.
- B. How will the proposed project affect existing or approved services and facilities in the medical service area?
- C. Will there be a detrimental effect on existing providers of the service? Discuss methodologies and assumptions.
- D. Describe any coordination agreements or contractual arrangements for shared services that are pertinent to the proposed project.
- E. List the new or existing ancillary and/or supporting services required for this project and briefly describe their relationship to the project.

IV. POTENTIAL LESS COSTLY OR MORE EFFECTIVE ALTERNATIVES

- A. What alternatives to the proposed project exist? Why was this proposal chosen?
- B. How will this project foster cost containment?
- C. How does the proposal affect the quality of care and continuity of care for the patients involved?

V. DESCRIBE COMMUNITY REACTION TO THE PROJECT (Attach endorsements if desired)

VI. NON-PATIENT CARE

If appropriate, describe any non-patient care objectives of the facility, i.e., professional training programs, access by health professional schools and behavioral research projects which are designed to meet a national need.

VII. MULTI-AREA PROVIDER

If the applicant holds itself as a multi-area provider, describe those factors that qualify it as such, including the percentage of admissions which resides outside the immediate health service area in which the facility is located.

VIII. HEALTH MAINTENANCE ORGANIZATION

If the proposal is by or on behalf of a health maintenance organization (HMO), address the rules regarding HMOs, and show that the HMO is federally qualified.

IX. ENERGY-SAVING MEASURES

Discuss as applicable the principal energy-saving measures included in this project.

X. OTHER FACTORS

Describe any other factor(s) that will assist in understanding and evaluating the proposed project, including the applicable criteria found at 410-1-6 of the Alabama Certificate of Need Program Rules and Regulations which are not included elsewhere in the application.

Complete the following if construction/renovation is involved in this project. Indicate N/A for any questions not applicable.

II. ATTACH SCHEMATICS AND THE FOLLOWING INFORMATION

This project will add approximately 30,500 square feet to the existing Spencer Cancer Center. The addition consists of two floors, approximately 15,250 square feet each. The first floor will incorporate two (2) clinical exam pods, with supporting areas. There will also be a PET/CT scanner with adjacent support areas as well as office space and mechanical space on the first floor. The second floor will provide a new larger infusion pharmacy, as well as five new clinical exam pods. Additionally, four (4) new infusion bays with adjacent nursing stations and supporting areas will be housed on the second-floor expansion, adding twenty-three (23) new infusion chairs to the Spencer Cancer Center.

H.	Cost per bed (if applicable)	N/A
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PART FOUR: UTILIZATION DATA AND FINANCIAL INFORMATION**NOT APPLICABLE**

This part should be completed for projects under \$500,000.00 and/or those projects for ESRD and home health. If this project is not one of the items listed above, please omit Part Four and complete Part Five. Indicate N/A for any questions not applicable.

I. UTILIZATION		CURRENT		PROJECTED	
Years:		20____	20____	20____	20____
A.	ESRD				
	# Patients	_____	_____	_____	_____
	# Procedures	_____	_____	_____	_____
B.	Home Health Agency				
	# Patients	_____	_____	_____	_____
	# of Visits	_____	_____	_____	_____
C.	New Equipment				
	# Patients	_____	_____	_____	_____
	# Procedures	_____	_____	_____	_____
D.	Other				
	# Patients	_____	_____	_____	_____
	# Procedures	_____	_____	_____	_____

II. PERCENT OF GROSS REVENUE

	Historical			Projected	
Source of Payment	20____	20____	20____	20____	20____
ALL Kids					
Blue Cross/Blue Shield					
Champus/Tricare					
Charity Care (see note below)					
Medicaid					
Medicare					
Other commercial insurance					
Self-pay					
Other					
Veterans Administration					
Workers' Compensation					
TOTAL	%	%	%	%	%

III. CHARGE INFORMATION

- A. List schedule of current charges related to this project.
- B. List schedule of proposed charges after completion of this project. Discuss the impact of project cost on operational costs and charges of the facility or service.

PART FIVE: UTILIZATION DATA AND FINANCIAL INFORMATION

This part should be completed for projects which cost over \$500,000.00 or which propose a substantial change in service, or which would change the bed capacity of the facility in excess of ten percent (10%), or which propose a new facility. ESRD, home health, and projects that are under \$500,000.00 should omit this part and complete Part Four.

I. PERCENT OF GROSS REVENUE FOR EAST ALABAMA MEDICAL CENTER

Source of Payment	Historical			Projected	
	2023	2024	2025	2028	2029
ALL Kids	0.20%	0.51%	0.60%	0.60%	0.60%
Blue Cross/Blue Shield	26.24%	31.16%	26.59%	26.59%	26.59%
Champus/Tricare	0.80%	1.02%	0.90%	0.90%	0.90%
Charity Care (see note below)	Charity Care is included in Self pay percentage				
Medicaid	12.70%	9.80%	10.35%	10.35%	10.35%
Medicare	20.43%	16.01%	17.54%	17.54%	17.54%
Other commercial insurance	33.64%	34.61%	38.27%	38.27%	38.27%
Self-pay	4.24%	4.55%	3.63%	3.63%	3.63%
Other	1.54%	1.95%	1.90%	1.90%	1.90%
Workers' Compensation	0.21%	0.39%	0.22%	0.22%	0.22%
TOTAL	100.00%	100.00%	100.00%	100.00%	100.00%

Note: Refer to the Healthcare Financial Management Association (HFMA) Principles and Practices Board Statement Number 15, Section II.

II. CHARGE INFORMATION

A. *List schedule of current charges related to this project.*

See below.

B. *List schedule of proposed charges after completion of this project. Discuss the impact of project cost on operational costs and charges of the facility or service.*

There will be no changes in the current charge structure as a result of the proposed expansion. Listed below are charges for the listed procedures that are provided at the Spencer Cancer Center.

CPT CODE	DESCRIPTION	CHARGE
36593	DECLOT BY THROMBOLYTIC AGENT IMPLANT DEVICE-	\$ 631.00
96360	ONC IV INFUSION HYDRATION INITIAL 31 MIN-1 H	\$ 613.00
96361	ONC IV INFUSION HYDRATION EACH ADDITIONAL HO	\$ 159.00
96365	ONC IV INFUSION THERAPY-PROPHYLAXIS -DX 1ST	\$ 613.00
96366	ONC IV INFUSION THERAPY PROPHYLAXIS-DX EA HO	\$ 159.00
96367	ONC IV INFUSION THER PROPH ADDL SEQUENTIAL T	\$ 159.00
96368	ONC IV NFS THERAPY PROPHYLAXIS-DX CONCURRENT	\$ 613.00
96372	ONC THERAPEUTIC PROPHYLACTIC-DX INJECTION SU	\$ 131.00

CPT CODE	DESCRIPTION	CHARGE
96374	ONC THER PROPH-DX NJX IV PUSH SINGLE-1ST SBS	\$ 404.00
96375	ONC THER PROPH-DX NJX EA SEQL IV PUSH SBST-D	\$ 136.00
96376	ONC EACH ADDITIONAL SEQUENTIAL IV PUSH	\$ 136.00
96377	APPL ON-BODY INJECTOR FOR TIMED SUBQ INJ	\$ 89.00
96401	ONC CHEMOTX ADMN SUBQ-IM NON-HORMONAL ANTI-N	\$ 163.00
96402	ONC CHEMOTX ADMN SUBQ-IM HORMONAL ANTI-NEO	\$ 163.00
96409	ONC CHEMOTX ADMN IV PUSH TQ 1-1ST SBST-DRUG	\$ 608.00
96411	ONC CHEMOTX ADMN IV PUSH TQ EA SBST-DRUG	\$ 159.00
96413	ONC CHEMOTX ADMN IV NFS TQ UP 1 HR 1-1ST SBS	\$ 631.00
96415	ONC CHEMOTHERAPY ADMN IV INFUSION TQ EA HR	\$ 159.00
96416	ONC CHEMOTX ADMN TQ INIT PROLNG CHEMOTX NFUS	\$ 159.00
96417	ONC CHEMOTX ADMN IV NFS TQ EA SEQL NFS TO 1	\$ 613.00
96523	ONC IRRIGATION OF IMPLANTED VENOUS ACCESS DEVICE	\$ 127.00
96549	ONC UNLIS CHEMOTX PX	\$ 613.00
36592	COLLECT BLD VIA VENOUS IV CATH NOS	\$ 229.00
36415	COLLECT VENOUS BLD BY VENIPUNCTURE	\$ 20.00
70450	CT SCAN OF THE HEAD OR BRAIN PERFORMED WITHOUT CONTRAST	\$ 639.00
50391	INSTILL OF AGT IN RENAL PELVIS OR URETER	\$ 769.00
77295	RT 3D TREATMENT PLANNING	\$ 2,504.00
77316	RT BRACHYTHERAPY ISO PL SIMPLE	\$ 725.00
77318	RT BRACHYTHERAPY ISO PN COMP	\$ 1,026.00
77336	RT CONTINUING PHYSICS SUPPORT	\$ 523.00
71250	RT CT CHEST W-O CONTRAST	\$ 236.00
77014	RT CT GUIDANCE F-PLCMT RT FIELDS	\$ 188.00
77338	RT DESIGN MLC DEVICE FOR IMRT	\$ 1,309.00
77300	RT DOSIMETRY	\$ 387.00
77387	RT GUIDANCE FOR RAD TX DEL	\$ 294.00
77770	RT HDR RDNCL NTRSTL-ICAV BRCHTX 1 CH	\$ 1,402.00
77771	RT HDR RDNCL NTRSTL-ICAV BRCHTX 2-12	\$ 2,866.00
77301	RT IMRT PLAN	\$ 2,504.00
77386	RT IMRT TREATMENT COMPLEX	\$ 1,309.00
77385	RT IMRT TREATMENT SIMPLE	\$ 1,309.00
57156	RT INS VAG BRACHYTX DEVICE	\$ 2,006.00
57155	RT INSERTION TANDEM OVOIDS	\$ 9,591.00
77307	RT ISODOSE PLAN - INT	\$ 1,003.00
77306	RT ISODOSE PLAN - SIMPLE	\$ 974.00
77372	RT LINEAR ACC STEREOTACTIC SURGERY	\$ 15,367.00
79005	RT NUCLEAR RX ORAL ADMIN	\$ 632.00
77417	RT PORT FILM - EACH	\$ 116.00
99426	RT PRINCIPAL CARE MGMT SVC 1ST 30 STAFF CAL MO	\$ 210.00
77412	RT RADIATION TX DELIVERY COMPLEX	\$ 1,309.00
77407	RT RADIATION TX DELIVERY INTERM	\$ 468.00
77402	RT RADIATION TX DELIVERY SIMPLE	\$ 370.00
77293	RT RESPIRATOR MOTION MGMT SIMUL	\$ 965.00
77373	RT SBRT FRACTIONS 2-5	\$ 3,729.00
77290	RT SIMULATION COMPLETE	\$ 809.00
77280	RT SIMULATION SIMPLE	\$ 386.00
77331	RT SPECIAL DOSIMETRY	\$ 544.00

CPT CODE	DESCRIPTION	CHARGE
77370	RT SPECIAL PHYSICS CONSULT	\$ 495.00
77321	RT SPECIAL TELETHERAPY PORT PLA	\$ 791.00
77470	RT SPECIAL TMNT PROC	\$ 1,143.00
77790	RT SUPERVISION HANDLING	\$ 762.00
77332	RT TREATMENT DEVICES	\$ 405.00
77334	RT TREATMENT DEVICES COMPLEX	\$ 786.00

III. INPATIENT UTILIZATION DATA

A. Historical Data

Give information for last three (3) years for which complete data is available.

OCCUPANCY DATA

Occupancy	Number of Beds			Discharges			Total Patient Days			Percentage (%)		
	2023	2024	2025	2023	2024	2025	2023	2024	2025	2023	2024	2025
Medicine & Surgery	249	249	249	11,378	12,607	13,700	57,693	63,608	70,299	63.5%	69.8%	77.3%
Obstetrics	27	27	27	2,193	2,202	2,190	5,308	5,389	5,524	53.9%	54.5%	56.1%
Pediatrics	10	10	10	517	518	559	977	977	1,042	26.8%	26.7%	28.5%
Psychiatry	28	28	28	726	738	648	8,265	8,316	8,611	80.9%	81.1%	84.3%
TOTALS	314	314	314	14,814	16,065	17,097	72,243	78,290	85,476	63.0%	68.1%	74.6%

Note: The total number of beds is based on Alabama Department of Public Health (“ADPH”) licensed beds. CON 3000-H was issued on June 7, 2022, to add thirty (30) general acute care beds to East Alabama Medical Center. The license for these additional beds was issued by ADPH with an effective date of December 3, 2025, which is in fiscal year 2026; therefore, these thirty (30) additional beds are not included in the bed totals above.

B. Projected Data

Give information to cover the first two (2) years of operation after completion of project.

OCCUPANCY DATA

Occupancy	Number of Beds		Discharges		Total Patient Days		Percentage (%)	
	2028	2029	2028	2029	2028	2029	2028	2029
Medicine & Surgery	279	279	15,862	16,655	81,418	85,489	79.7%	83.9%
Obstetrics	27	27	2,533	2,659	6,407	6,727	64.8%	68.3%
Pediatrics	10	10	647	680	1,157	1,215	31.6%	33.3%
Geriatric Psychiatry	20	20	334	351	5,548	5,825	75.8%	79.8%
Inpatient Rehabilitation	17	17	329	347	3,787	3,976	60.9%	64.1%
TOTALS	353	353	19,705	20,692	98,317	103,232	76.1%	80.1%

Note: CON 3055-PSYCH was issued on March 4, 2024, to add six (6) child/adolescent beds and six (6) adult psychiatric beds to the existing twenty-eight (28) bed inpatient psychiatric unit at East Alabama Medical Center. The CON also was for EAMC to build a forty (40) bed freestanding acute care psychiatric hospital. The freestanding acute care psychiatric hospital opened in January 2026; therefore, the twenty-eight (28) psychiatric beds reported in the historical data have been removed from the projected bed count.

CON 3084-REHAB was issued on March 3, 2025, to transfer seventeen (17) inpatient physical rehabilitation beds from EAMC-Lanier to EAMC. In addition, CON 3085-PSYCH was issued on March 3, 2025, to transfer twenty (20) geriatric inpatient psychiatric beds from EAMC-Lanier to EAMC.

IV. OUTPATIENT UTILIZATION DATA

A. HISTORICAL DATA

	<u>Number of Outpatient Visits</u>			<u>Percentage of Outpatient Visits</u>		
	2023	2024	2025	2023	2024	2025
Clinical	67,855	78,411	82,475	33.9%	36.5%	36.6%
Diagnostic	110,017	117,196	124,106	54.9%	54.5%	55.1%
Rehabilitation	6,894	2,757	1,137	3.4%	1.3%	0.5%
Surgical	15,644	16,724	17,461	7.8%	7.8%	7.8%

B. PROJECTED DATA

	<u>Number of Outpatient Visits</u>		<u>Percentage of Outpatient Visits</u>	
	2028	2029	2028	2029
Clinical	95,475	100,249	36.6%	36.6%
Diagnostic	143,668	150,851	55.1%	55.1%
Rehabilitation	1,317	1,383	0.5%	0.5%
Surgical	20,214	21,225	7.8%	7.8%

V. A. ORGANIZATION FINANCIAL INFORMATION – EAST ALABAMA HEALTH CARE AUTHORITY
(includes financials for EAMC, EAMC-Lanier and other entities owned by EAHCA)

STATEMENT OF INCOME AND EXPENSE	HISTORICAL DATA (Give information for last 3 years for which complete data are available)			PROJECTED DATA (First 2 years after completion of project)	
	2023 (Total)	2024 (Total)	2025 (Total)	2028 (Total)	2029 (Total)
Revenue from Services to Patients					
Inpatient Services					
Routine (nursing service areas)	128,930,071	172,574,485	176,389,433	258,655,063	284,426,466
Other	308,926,027	335,668,657	346,132,119	398,051,937	417,954,534
Outpatient Services	681,137,211	730,466,162	835,170,508	1,021,834,101	1,092,871,154
Emergency Services	70,222,624	76,572,904	81,355,564	93,558,900	98,236,846
Gross Patient Revenue	1,189,215,933	1,315,282,208	1,439,047,624	1,772,100,001	1,893,489,000
Deductions from Revenue					
Contractual Adjustments	647,244,103	719,014,818	766,232,537	937,293,000	1,003,702,000
Discount/Miscellaneous Allowances					
Total Deductions	647,244,103	719,014,818	766,232,537	937,293,000	1,003,702,000
NET PATIENT REVENUE (Gross patient revenue less deductions)	541,971,830	596,267,390	672,815,087	834,807,001	889,787,000
Other Operating Revenue	66,043,302	60,910,327	36,182,340	34,077,000	35,715,000
NET OPERATING REVENUE	608,015,132	657,177,717	708,997,427	868,884,001	925,502,000
OPERATING EXPENSES					
Salaries, Wages, and Benefits	259,954,444	289,610,136	302,092,020	367,331,000	381,677,000
Physician Salaries and Fees	15,253,524	17,268,765	17,207,515	24,037,000	25,083,000
Supplies and other	133,887,728	145,960,439	164,494,481	222,878,000	252,819,000
Uncompensated Care (less recoveries) per State Health Plan 410-2-2-.06(d)	84,860,226	95,991,962	99,539,371	121,920,000	130,399,000
Other Expenses	89,640,658	88,750,294	91,659,458	90,200,000	91,344,000
Total Operating Expenses	583,596,580	637,581,596	674,992,845	826,366,000	881,322,000
NON-OPERATING EXPENSES					
Taxes					
Depreciation	27,483,273	27,471,207	28,370,090	37,887,000	40,856,000
Interest (other than mortgage)	4,614,333	4,402,857	5,226,173	7,468,000	7,391,000
Existing Capital Expenditures					
Interest					
Total Non-Operating Expenses	32,097,606	31,874,064	33,596,263	45,355,000	48,247,000
TOTAL EXPENSES (Operating & Capital)	615,694,186	669,455,660	708,589,108	871,721,000	929,569,000
Operating Income (Loss)	(7,679,054)	(12,277,943)	408,319	(2,836,999)	(4,067,000)
Other Revenue (Expense) -- Net	45,168,169	38,541,563	37,217,599	32,988,000	35,366,000
NET INCOME (Loss)	37,489,115	26,263,620	37,625,918	30,151,001	31,299,000
Projected Capital Expenditure	N/A	N/A	N/A	N/A	N/A
Interest	N/A	N/A	N/A	N/A	N/A

ORGANIZATION FINANCIAL INFORMATION – EAST ALABAMA MEDICAL CENTER
(includes financials for EAMC and EAMC-Lanier)

STATEMENT OF INCOME AND EXPENSE	HISTORICAL DATA (Give information for last 3 years for which complete data are available)			PROJECTED DATA (First 2 years after completion of project)	
	2023 (Total)	2024 (Total)	2025 (Total)	2028 (Total)	2029 (Total)
Revenue from Services to Patients					
Inpatient Services					
Routine (nursing service areas)	128,930,071	173,755,933	191,131,526	210,244,679	231,269,147
Other	301,075,120	325,641,295	358,205,425	347,869,133	365,262,590
Outpatient Services	584,638,387	628,907,693	673,333,668	714,441,501	759,092,955
Emergency Services	70,222,624	76,572,904	81,355,564	93,558,900	98,236,846
Gross Patient Revenue	1,084,866,202	1,204,877,825	1,304,026,183	1,366,114,213	1,453,861,538
Deductions from Revenue					
Contractual Adjustments	588,178,563	643,212,092	707,533,301	728,759,300	787,060,044
Discount/Miscellaneous Allowances					
Total Deductions	588,178,563	643,212,092	707,533,301	728,759,300	787,060,044
NET PATIENT REVENUE (Gross patient revenue less deductions)	496,687,639	561,665,733	596,492,882	637,354,913	666,801,494
Other Operating Revenue	31,485,113	44,180,857	31,031,000	32,582,550	34,211,678
NET OPERATING REVENUE	528,172,752	605,846,590	627,523,882	669,937,463	701,013,172
OPERATING EXPENSES					
Salaries, Wages, and Benefits	208,319,862	235,327,831	247,094,223	259,448,934	272,421,380
Physician Salaries and Fees	14,720,490	15,472,960	16,246,608	17,058,938	17,911,885
Supplies and other	114,955,588	131,070,253	137,623,766	144,504,954	151,730,202
Uncompensated Care (less recoveries) per State Health Plan 410-2-2-.06(d)	77,569,896	89,086,774	93,541,113	98,218,168	103,129,077
Other Expenses	72,273,351	78,167,910	82,076,306	86,180,121	90,489,127
Total Operating Expenses	487,839,187	549,125,728	576,582,016	605,411,115	635,681,671
NON-OPERATING EXPENSES					
Taxes					
Depreciation	24,105,019	25,547,679	27,848,000	30,632,800	32,164,440
Interest (other than mortgage)	4,453,535	4,809,218	5,947,000	5,900,000	5,800,000
Existing Capital Expenditures					
Interest					
Total Non-Operating Expenses	28,558,554	30,356,897	33,795,000	36,532,800	37,964,440
TOTAL EXPENSES (Operating & Capital)	516,397,741	579,482,625	610,377,016	641,943,915	673,646,111
Operating Income (Loss)	11,775,011	26,363,965	17,146,866	27,993,548	27,367,061
Other Revenue (Expense) -- Net	39,050,648	25,207,619	35,000,000	28,000,000	29,000,000
NET INCOME (Loss)	50,825,659	51,571,584	52,146,866	55,993,548	56,367,061
Projected Capital Expenditure	N/A	N/A	N/A	N/A	N/A
Interest	N/A	N/A	N/A	N/A	N/A

B. PROJECT SPECIFIC FINANCIAL INFORMATION – SPENCER CANCER CENTER

STATEMENT OF INCOME AND EXPENSE	HISTORICAL DATA (Give information for last 3 years for which complete data are available)			PROJECTED DATA (First 2 years after completion of project)	
	2023 (Total)	2024 (Total)	2025 (Total)	2028 (Total)	2029 (Total)
Revenue from Services to Patients					
Inpatient Services					
Routine (nursing service areas)					
Other	1,000,252	1,078,194	1,186,013	1,304,615	1,435,076
Outpatient Services	133,733,097	143,981,082	158,379,190	190,055,028	228,066,034
Emergency Services	-	-	-	-	-
Gross Patient Revenue	134,733,349	145,059,276	159,565,203	191,359,643	229,501,110
Deductions from Revenue					
Contractual Adjustments	89,800,415	89,015,859	98,324,078	117,915,812	141,148,584
Discount/Miscellaneous Allowances	-	-	-	-	-
Total Deductions	89,800,415	89,015,859	98,324,078	117,915,812	141,148,584
NET PATIENT REVENUE(Gross patient revenue less deductions)	44,932,934	56,043,417	61,241,125	73,443,831	88,352,526
Other Operating Revenue	16,800	24,351	26,786	29,465	32,411
NET OPERATING REVENUE	44,949,734	56,067,768	61,267,911	73,473,296	88,384,937
OPERATING EXPENSES					
Salaries, Wages, and Benefits	10,818,142	13,000,504	14,300,554	17,160,665	20,592,798
Physician Salaries and Fees	50,833	50,249	55,274	60,801	66,881
Supplies and other	22,815,272	26,637,894	29,301,683	36,627,104	45,783,880
Uncompensated Care (less recoveries) per State Health Plan 410-2-2-.06(d)	326,306	366,282	402,910	443,201	487,521
Other Expenses	1,044,049	2,115,277	2,326,805	2,559,485	2,815,434
Total Operating Expenses	35,054,602	42,170,206	46,387,226	56,851,256	69,746,514
NON-OPERATING EXPENSES					
Taxes					
Depreciation	2,201,772	2,052,817	2,258,099	2,483,909	2,732,299
Interest (other than mortgage)	80	1,109	1,220	1,342	1,476
Existing Capital Expenditures					
Interest					
Total Non-Operating Expenses	2,201,852	2,053,926	2,259,319	2,485,251	2,733,775
TOTAL EXPENSES (Operating & Capital)	37,256,454	44,224,132	48,645,545	59,336,507	72,480,289
Operating Income (Loss)	7,693,280	11,843,636	12,622,366	14,136,789	15,904,648
Other Revenue (Expense) – Net					
NET INCOME (Loss)	7,693,280	11,843,636	12,622,366	14,136,789	15,904,648
Projected Capital Expenditure	N/A	N/A	N/A	N/A	N/A
Interest	N/A	N/A	N/A	N/A	N/A

VI. STATEMENT OF COMMUNITY PARTNERSHIP FOR EDUCATION AND REFERRALS

A. This section is declaration of those activities your organization performs out of inpatient and outpatient care in the community and for the underserved population. Please indicate historical and projected data by expenditures in the columns specified below.

Services and/or Programs	Historical Data (total dollars spent in last 3 years)			Projected Data (total dollars budgeted for next 2 years)	
	2023	2024	2025	2028	2029
Health Education (nutrition, fitness, etc.)	284,460	543,510	570,686	627,754	690,529
Community service workers (school nurses, etc.)	327,206	298,467	328,314	361,145	397,260
Health screenings	50,000	50,000	50,000	50,000	50,000
Other					
TOTAL	661,666	891,977	949,000	1,038,899	1,137,789

B. Please describe how the new services specified in this project application will be made available to and address the needs of the underserved community. If the project does not involve new services, please describe how the project will address the underserved population in your community.

Cancer services will be made available to the underserved community in the same manner as existing services offered by EAMC. The *Alabama Certificate of Need Program Rules and Regulations* in Section 410-1-6-.07, Access to the Facility or Service, provides examples of underserved groups to include low-income persons, racial and ethnic minorities, women and persons with disabilities. These identified groups, as well as all patients that EAMC treats will have access to the services provided at the Spencer Cancer Center.

Please briefly describe some of the current services or programs presented to the underserved in your community.

East Alabama Medical Center and its affiliated entities provide many services to the community, including those who are medically underserved. Staff from various departments participate in health fairs and screening events, and give presentations to a variety of groups, including elementary and high school students and teachers, civic groups and other community groups. The East Alabama Medical Center Faith Community Nurse Program provides outreach in the community including an annual Hispanic health fair as well as other health fairs in low-income neighborhoods, and they partner with the Opelika Neighborhood Mobile Clinic. This outreach is in addition to the health education and screenings they provide to members of the various congregations in which they serve. The Diabetes and Nutrition Center provides diabetes education year-round and offers programs for free test strips and blood glucose monitors for underserved patients. Assistance is also provided to attend the CDC National Diabetes Prevention Program that is currently available to the

community at large. EAMC's Spencer Cancer Center offers free screenings and education at health fairs and events throughout the year. Assistance is provided for uninsured individuals in accessing free mammograms. Patients who qualify for assistance with care receive aid in applying to the Alabama Breast and Cervical Cancer Medicaid program to cover their cancer treatment. To address the disproportionate number of African American women who experience health issues during pregnancy, often resulting in premature birth, EAMC partners with Alabama March of Dimes to provide intensive education, coaching, pre- and post-natal care to improve outcomes for both mother and baby. Unity Wellness Center, a Ryan White HIV Clinic, offers HIV prevention education and HIV testing to the community at large, and provides free or low-cost HIV primary health care to patients residing in a five-county area. Most recently, EAMC and the City of Opelika launched the Opelika Neighborhood Mobile Clinic in 2023, which provides health education, preventative and urgent care to underserved persons living in Opelika, Alabama.

EAMC also demonstrated its ability to provide care to the underserved community during the COVID-19 pandemic. In March 2020, EAMC set up a free COVID-19 testing site which collected over 161,285 samples. To ensure that individuals had access to COVID-19 testing and monoclonal antibody infusions, EAMC set up and maintained the EAMC Call Center, where staff responded to over 192,625 calls. EAMC administered more than 3,955 monoclonal antibody infusions to treat individuals with COVID-19. In addition, EAMC made the active decision to take care of its community with a COVID-19 vaccine clinic. Through that clinic, EAMC provided more than 90,000 COVID-19 vaccines free of charge.

PART SIX: ACKNOWLEDGEMENT AND CERTIFICATION BY THE APPLICANT

I. ACKNOWLEDGEMENT

In submitting this application, the applicant understands and acknowledges that:

- A. The rules, regulations and standards for health facilities and services promulgated by the SHPDA have been read, and the applicant will comply with same.
- B. The issuance of a certificate of need will depend on the approval of the CON Review Board, and no attempt to provide the service or incur an obligation will be made until a bona fide certificate of need is issued.
- C. The certificate of need will expire in twelve (12) months after date of issuance, unless an extension is granted pursuant to the applicable portions of the SHPDA rules and regulations.
- D. The certificate of need is not transferrable, and any action to transfer or assign the certificate will render it null and void.
- E. The applicant will notify the State Health Planning and Development Agency when a project is started, completed or abandoned.
- F. The applicant shall file a progress report on each active project every six (6) months until the project is completed.
- G. The applicant must comply with all state and local building codes, and failure to comply will render the certificate of need null and void.
- H. The applicants and their agents will construct and operate in compliance with appropriate state licensure rules, regulations, and standards.
- I. Projects are limited to the work identified in the Certificate of Need as issued.
- J. Any expenditure in excess of the amount approved on the Certificate of Need must be reported to the State Health Planning and Development Agency and may be subject to review.
- K. The applicant will comply with all state statutes for the protection of the environment.
- L. The applicant is not presently operating with a probational (except as may be converted by this application) or revoked license.

II. CERTIFICATION

The information contained in this application is true and correct to the best of my knowledge and belief.



Signature of Applicant

Laura D. Grill, President/CEO

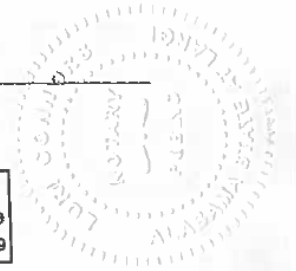
Applicant's Name and Title
(Type or Print)

23 day of February 2026



Notary Public (Affix seal on original)

LORI CONNORS
Notary Public, Alabama State at Large
My Commission Expires September 23, 2029



Author: Alva M. Lambert

Statutory Authority: §§ 22-21-267, -271, -275, Code of Alabama, 1975

History: Amended: March 19, 1996; July 25, 2002; Filed: July 22, 2013; effective August 26, 2013.

PART TWO: PROJECT NARRATIVE

I. MEDICAL SERVICE AREA

- A. *Identify the geographic (medical service) area by county (ies) or city, if appropriate, for the facility or project. Include an 8 ½ x 11" map indicating the service area and the location of the facility.*

The medical service area for East Alabama Medical Center (EAMC) consists of primary and secondary service areas which makes up approximately 89.0 percent of EAMC's patient origin. The primary medical service for EAMC is Lee County. The majority of patients at EAMC come from Lee County. The secondary medical service area is from surrounding counties. These counties consist of Macon, Chambers, Randolph, Russell, and Tallapoosa counties.

The following tables represent EAMC's geographical origin of patients for fiscal year 2024 and fiscal year 2025. Table 1 shows the percentage of patients that EAMC treated by county of residence and Table 2 shows the percentage of patients that EAMC's Cancer Center treated by county of residence.

Table 1 – EAMC's Patient Origin

	FY 2024	FY 2025
Primary Service Area		
Lee County	62.77%	62.60%
Secondary Service Area		
Chambers County	11.19%	11.43%
Macon County	5.77%	5.86%
Randolph County	1.67%	1.49%
Russell County	2.85%	2.67%
Tallapoosa County	5.35%	5.67%
Other Service Area	10.40%	10.28%
TOTAL	100.00%	100.00%

Table 2 – EAMC's Cancer Center's Patient Origin

	FY 2024	FY 2025
Primary Service Area		
Lee County	55.82%	55.88%
Secondary Service Area		
Chambers County	15.29%	14.67%
Macon County	5.45%	6.18%
Randolph County	2.28%	1.96%
Russell County	4.34%	3.46%
Tallapoosa County	6.47%	7.17%
Other Service Area	10.35%	10.68%
TOTAL	100.00%	100.00%

EAMC's service area map is located in Figure 1 on page 25.

B. What population group(s) will be served by the proposed project? Define age groups, location and characteristics of the population to be served.

All population groups will continue to be served as a result of this project. This project will benefit all patients who come to EAMC's Spencer Cancer Center for radiation therapy and medical oncology services regardless of their age.

As stated in the previous answer, EAMC has a primary and secondary service area. It is projected that EAMC's primary service area, Lee County, will have a population increase of 17.49% between 2025 and 2050 and its secondary service area will have a population increase of 3.73% during this same time period. This proposed project will continue to help meet the needs of EAMC's growing service area.

Table 3 – Population Projections for Service Area

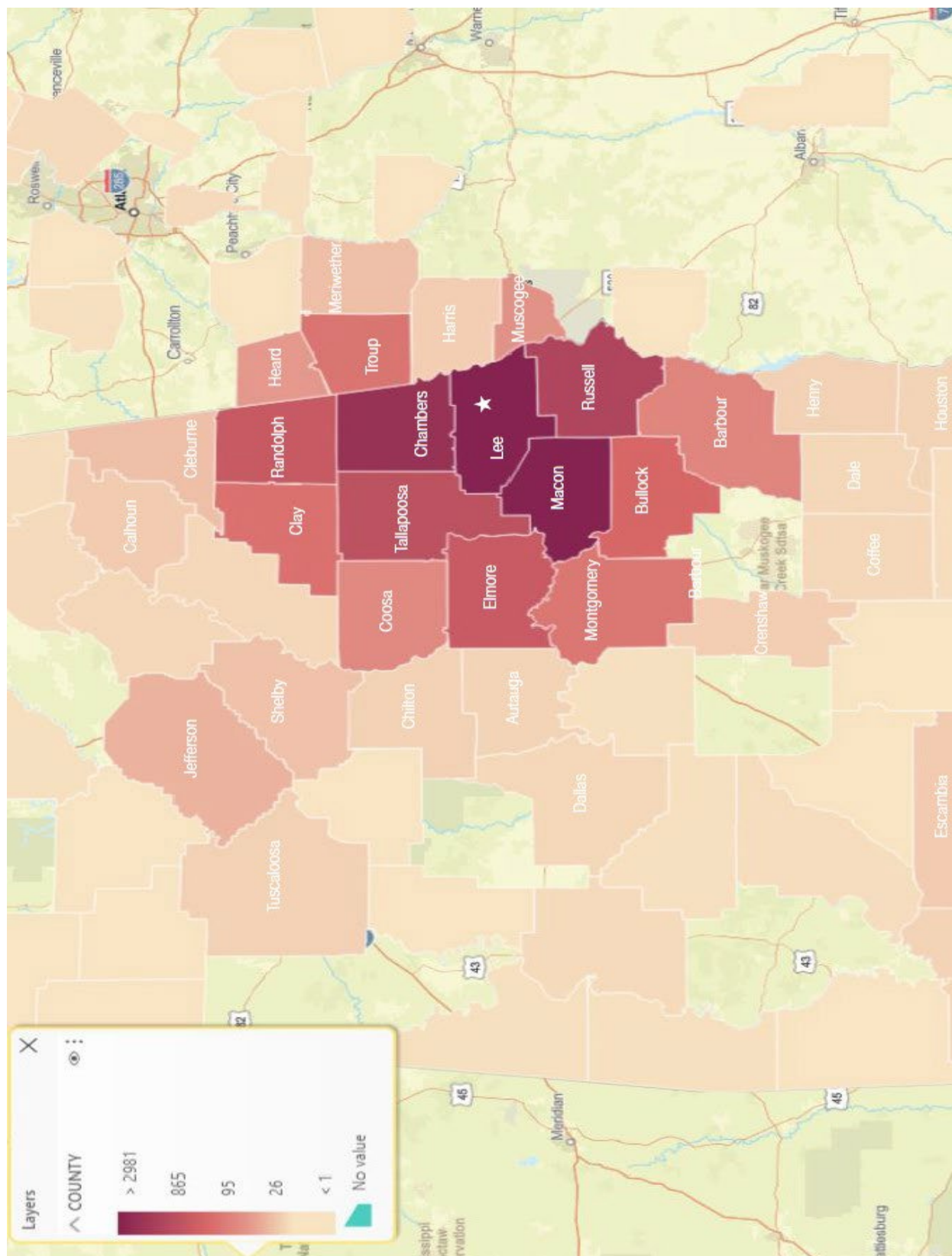
	Census						Change 2025-2050	
	2025	2030	2035	2040	2045	2050	Number	Percent
Primary Service Area								
Lee County	190,821	206,330	212,098	219,002	218,134	224,190	33,369	17.49%
Secondary Service Area								
Chambers County	34,695	34,793	35,189	35,493	35,731	35,891	1,196	3.45%
Macon County	18,465	17,728	17,635	17,424	17,692	17,407	-1,058	-5.73%
Randolph County	21,430	21,096	21,187	21,158	21,395	21,278	-152	-0.71%
Russell County	61,124	63,193	64,484	65,904	65,945	67,105	5,981	9.79%
Tallapoosa County	40,609	40,311	40,650	40,844	41,186	41,213	604	1.49%
Secondary Service Area	176,323	177,121	179,145	180,823	181,949	182,894	6,571	3.73%
Total	367,144	383,451	391,243	399,825	400,083	407,084	39,940	10.88%

Source: U.S. Census Bureau and Center for Business and Economic Research, The University of Alabama

C. If medical service area is not specifically defined in the State Health Plan, explain statistical methodologies or market share studies based upon accepted demographic or statistical data available with assumptions clearly detailed. If Patient Origin Study data is used, explain whether institution or county based, etc.

Section 410-2-3-.04(5)(a) of the *State Health Plan* states that “a megavoltage radiation therapy unit shall serve a population of at least 150,000 persons and perform 6,000 treatments/patients visits annually within three years after initiation”. EAMC is the only provider of radiation therapy services and is the only institutional provider of both radiation therapy and medical oncology services in Lee County. Lee County's current population estimate is 190,821 which is EAMC's primary service area while EAMC's secondary service area has a current population estimate of 176,323. EAMC's Spencer Cancer Center has been in operation since 1992 and meets the population requirement of the *State Health Plan* as well as the number of treatments annually to support its two existing linear accelerators. This expansion project does not include the addition of a third linear accelerator.

Figure 1 -- Service Area Map of East Alabama Medical Center



D. Are there any other factors affecting access to the project?

(X) Geographic () Economic () Emergency () Medically Underserved

Geographic: EAMC is the only provider of both radiation therapy and medical oncology services to residents of Lee County. In addition, EAMC is the largest provider/source of health care services in its primary and secondary service areas.

II. HEALTH CARE REQUIREMENTS OF THE MEDICAL SERVICE AREA

A. What are the factors (inadequacies) in the existing health care delivery system which necessitate this project?

In the last decade, increased cancer patient volumes have led to the increased need for additional providers and staff resulting in the need for additional office and clinical space. Prior to making a formal proposal for expansion, the Spencer Cancer Center adjusted to meet the needs of patients and staff by repurposing the cancer registry and manager office for referral intake staff, repurposing retail boutique space into an office for a genetic counselor and adding a sixth infusion bay in an existing treatment room. To accommodate new providers, the Oncology Wellness Program moved to a conference room to make space for additional exam rooms and office space for providers. These are only a few examples of accommodation that have been made throughout the facility.

The need for space also applies to the need for additional pharmacy, lab and imaging services. Without expansion, each of these ancillary services will be capped at their current capacity and unable to meet the growing demands of our community and staff.

B. How will the project correct the inadequacies?

Spencer Cancer Center leadership has provided creative solutions to keep up with the growing demand for space in the facility, but this effort has quickly plateaued as the space itself is finite. Expanding the facility by 50% will account for space for the current needs as well as allowing space for continued growth.

C. Why is your facility/organization the appropriate facility to provide the proposed project?

EAMC is the appropriate organization for this project because EAMC already provides cancer services at the Spencer Cancer Center and is the only provider of these services in Lee County. This project is a natural expansion of EAMC's current services and allows EAMC to meet the needs of its patients and continue to improve the services offered to its patients.

D. Describe the need for the population served or to be served for the proposed project and address the appropriate sections of the State Health Plan and the Rules and Regulations under 410-1-6-.07. Provide information about the results of any local studies which reflect a need for the proposed project.

This project is a continuation of The East Alabama Health Care Authority's long-range plans for improving its services to its customers and residents of its primary and secondary service areas. EAMC is committed to providing quality care with appropriate facilities, technology, and equipment. The project will help individuals who need cancer treatment services to continue to receive those services from EAMC through its Spencer Cancer Center.

E. If the application is for a specialized or limited-purpose facility or service, show the incidence of the particular health problem.

According to the American Cancer Society, it is estimated that 2,114,850 new cases of cancer will occur in the United States in 2026. It is estimated that Alabama will have 30,710 new cases of cancer in 2026.¹

Cancer is the second leading cause of death in Alabama. According to the Alabama Cancer Statistics report produced by the Alabama Statewide Cancer Registry, approximately 30,730 new cancers were expected to be diagnosed in 2023, which equates to slightly more than 84 people per day. It was expected that 10,640 individuals in Alabama would die of cancer in 2023. In addition, Alabama's cancer incidence rate is 447.0 which is slightly higher than the United States' incidence rate of 442.0.²

F. Describe the relationship of this project to your long-range development plans if you have such plans.

This project is a continuation of EAMC's long-range plans for improving its services to its customers. EAMC is committed to providing quality care with appropriate facilities, technology, and equipment. The project will help cancer center patients continue to receive quality care in a setting that meets their clinical needs.

¹ Cancer Facts & Figures 2026. American Cancer Society. ([Cancer Facts & Figures 2026](#))

² Alabama Cancer Statistics 2023. Alabama Department of Public Health and Alabama Statewide Cancer Registry. ([acs2023.pdf \(alabamapublichealth.gov\)](#)).

III. RELATIONSHIP TO EXISTING OR APPROVED SERVICES AND FACILITIES

A. Identify by name and location the existing or approved facilities or services in the medical service area similar to those proposed in this project.

EAMC is the only hospital in Lee County, its primary service area. There are no other institutional providers of cancer services, including both radiation therapy and medical oncology in the county.

B. How will the proposed project affect existing or approved services and facilities in the medical service area?

EAMC does not believe the expansion of the Spencer Cancer Center will have an effect on existing health care facilities in the medical service area. As stated above, there are no other providers of cancer services in the county.

C. Will there be a detrimental effect on existing providers of the service? Discuss methodologies and assumptions.

There should not be a detrimental effect since there are no other existing hospital or cancer center providers in Lee County.

D. Describe any coordination agreements or contractual arrangements for shared services that are pertinent to the proposed project.

Not applicable.

E. List the new or existing ancillary and/or supporting services required for this project and briefly describe their relationship to the project.

The pharmacy and laboratory support the care that is provided to cancer patients at the Spencer Cancer Center. Because of the key role that these two support departments have in the treatment of cancer patients, the Spencer Cancer Center includes a satellite hospital pharmacy and laboratory within the facility.

IV. POTENTIAL LESS COSTLY OR MORE EFFECTIVE ALTERNATIVES

A. What alternatives to the proposed project exist? Why was this proposal chosen?

The alternative to the proposed expansion is to keep the existing footprint at the Spener Cancer Center. Currently, the maximum capacity for patients and providers has been met. The only way to continue meeting the growing needs of the community is to expand square footage to take on additional imaging and diagnostics, provider-based care, and infusion treatment areas. This two-story expansion will be an extension of the current building.

B. How will this project foster cost containment?

This project will foster cost containment to the point that it is a reasonable project at a reasonable cost per square foot.

C. How does the proposal affect the quality of care and continuity of care for the patients involved?

This proposal affects the quality of care by making additional resources available to patients through expanded imaging and lab services, additional provider choice, and faster scheduling for treatments with expanded infusion capability.

This proposal supports continuity of care by building onto the current Spencer Cancer Center. When the Spencer Cancer Center was built, it was the intent of EAMC to be able to provide convenient access to care that included easier parking, dedicated meeting spaces for support groups, an onsite pharmacy dedicated to oncology, and retail durable equipment store for supplies that cancer patients would need. This expansion will increase patient access to all these services as well as additional providers.

V. DESCRIBE COMMUNITY REACTION TO THE PROJECT (Attach endorsements if desired)

Letters of support are provided in Attachment B on page 35. EAMC believes the community is supportive of this project.

VI. NON-PATIENT CARE

If appropriate, describe any non-patient care objectives of the facility, i.e., professional training programs, access by health professional schools and behavioral research projects which are designed to meet a national need.

EAMC started an Internal Medicine Residency Program in 2021 and several members of the medical staff at EAMC are adjunct professors at the Auburn campus of Edward Via College of

Osteopathic Medicine (“VCOM”). In addition, EAMC partners with several community colleges and state universities to provide training opportunities for nursing, pharmacy, radiology, and health administration students. These educational partnerships will continue with the renovation of the Spencer Cancer Center.

VII. MULTI-AREA PROVIDER

If the applicant holds itself as a multi-area provider, describe those factors that qualify it as such, including the percentage of admissions which resides outside the immediate health service area in which the facility is located.

Please see the answer to 1.A. on page 23.

VIII. HEALTH MAINTENANCE ORGANIZATION

If the proposal is by or on behalf of a health maintenance organization (HMO), address the rules regarding HMOs, and show that the HMO is federally qualified.

Not applicable.

IX. ENERGY-SAVING MEASURES

Discuss as applicable the principal energy-saving measures included in this project.

Energy saving measures will be incorporated in coordination with the renovation of the Spencer Cancer Center.

X. OTHER FACTORS

Describe any other factor(s) that will assist in understanding and evaluating the proposed project, including the applicable criteria found at 410-1-6 of the Alabama Certificate of Need Program Rules and Regulations which are not included elsewhere in the application.

Not applicable.

APPENDIX A

Schematic Drawings



APPENDIX B

Letters of Support



**ALABAMA
HOUSE OF REPRESENTATIVES**

11 SOUTH UNION STREET, MONTGOMERY, ALABAMA 36130

REP. JEREMY GRAY
DISTRICT 83
POST OFFICE BOX 55
OPELIKA, ALABAMA 36830

STATE HOUSE: 334-261-9505
CELL: 334-707-0879
EMAIL: jeremy.gray@alhouse.gov

January 6, 2026

Ms. Emily T. Marsal
Executive Director
State Health Planning and Development Agency
100 North Union Street, Suite 870
Montgomery, Alabama 36104

Re: Letter of Support for the Expansion of East Alabama Medical Center's Spencer Cancer Center

Dear Ms. Marsal:

I am writing to express my support for East Alabama Medical Center's ("EAMC") certificate of need application to expand its Spencer Cancer Center located at 2501 Village Professional Drive in Opelika. The expansion will include an additional 30,050 square feet to the current facility and allows for the addition of twenty-two (22) new infusion bays, space for an additional PET/CT, and clinic space for an additional gynecological oncologist, two breast surgeons, and additional medical oncologists. In addition to the expansion, this project involves renovating 2,255 square feet of existing space to provide increased capacity in the lab, pharmacy and walk-in clinic for infusion patients.

EAMC has continued to grow and meet the needs of its growing community since opening in 1952. This project is no exception. The Auburn/Opelika area has continued to grow and desires to have medical facilities that are comparable to any of the other major cities in Alabama. This project allows EAMC to continue to expand its existing services and meet the medical needs of the community.

It is essential that EAMC keep up with the increased demand for patient services. I strongly support EAMC's certificate of need application for the expansion of the Spencer Cancer Center.

Sincerely,

A handwritten signature in black ink, appearing to read "Jeremy Gray", is written over the word "Representative".

Representative Jeremy Gray



ALABAMA
HOUSE OF REPRESENTATIVES
11 SOUTH UNION STREET, MONTGOMERY ALABAMA 36130

REPRESENTATIVE JOE LOVVORN

DISTRICT 79

OFFICE:(334)261-0573

Joe.Lovvorn@alhouse.gov

HOUSE RULES COMMITTEE
CHAIRMAN

January 6, 2026

Ms. Emily T. Marsal
Executive Director
State Health Planning and Development Agency
100 North Union Street, Suite 870
Montgomery, Alabama 36104

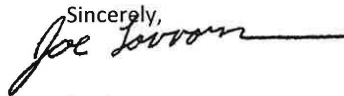
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Sincerely,
A handwritten signature in black ink that reads "Joe Lovvorn". The signature is written in a cursive, flowing style.

Joe Lovvorn



JAY HOVEY
ALABAMA STATE SENATE, DISTRICT 27

January 30, 2026

Ms. Emily T. Marsal
Executive Director
State Health Planning and Development Agency
100 North Union Street, Suite 870
Montgomery, Alabama 36104

Re: Letter of Support for the Expansion of East Alabama Medical Center's Spencer Cancer Center

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It is essential that EAMC keep up with the increased demand for patient services. I strongly support EAMC's certificate of need application for the expansion of the Spencer Cancer Center.

Sincerely,

A handwritten signature in black ink, appearing to read "J. Hovey", is written over a horizontal line.

Senator Jay Hovey

Alabama State House • 11 S. Union St., Suite 735 • Montgomery, AL 36130



ALABAMA

SENATOR RANDY PRICE
(334) 261-0856
randy.price@alisenate.gov

ALABAMA STATE SENATE ALABAMA STATE HOUSE

11 SOUTH UNION STREET, SUITE 729
MONTGOMERY, ALABAMA 36130-4600

January 6, 2026

COMMITTEES:

Tourism - Chairman
Education Policy
Agriculture, Conservation & Forestry
Banking & Insurance
Transportation & Energy
Confirmations
Finance & Taxation General Fund

Ms. Emily T. Marsal
Executive Director
State Health Planning and Development Agency
100 North Union Street, Suite 870
Montgomery, Alabama 36104

Re: Letter of Support for the Expansion of East Alabama Medical Center's Spencer
Cancer Center

Dear Ms. Marsal:

I am writing to express my support for East Alabama Medical Center's ("EAMC") certificate of need application to expand its Spencer Cancer Center located at 2501 Village Professional Drive in Opelika. The expansion will include an additional 30,050 square feet to the current facility and allows for the addition of twenty-two (22) new infusion bays, space for an additional PET/CT, and clinic space for an additional gynecological oncologist, two breast surgeons, and additional medical oncologists. In addition to the expansion, this project involves renovating 2,255 square feet of existing space to provide increased capacity in the lab, pharmacy and walk-in clinic for infusion patients.

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It is essential that EAMC keep up with the increased demand for patient services. I strongly support EAMC's certificate of need application for the expansion of the Spencer Cancer Center.

Sincerely,

A handwritten signature in black ink that reads "Randy Price".

Randy Price

RP/II



OFFICE OF THE MAYOR
204 South 7th Street • P.O. Box 390
Opelika, AL 36801-0390
(p) 334-705-5150
(f) 334-705-5153
www.opelika-al.gov

January 6, 2026

Ms. Emily T. Marsal
Executive Director
State Health Planning and Development Agency
100 North Union Street, Suite 870
Montgomery, Alabama 36104

Re: Letter of Support for the Expansion of East Alabama Medical Center's Spencer Cancer Center

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Sincerely,

A handwritten signature in blue ink, appearing to read "Eddie Smith".

Eddie Smith
Mayor

ES/bja



February 19, 2026

Ms. Emily T. Marsal
Executive Director
State Health Planning and Development Agency
100 North Union Street, Suite 870
Montgomery, Alabama 36104

Re: **Letter of Support for the Expansion of East Alabama Medical Center's Spencer Cancer Center**

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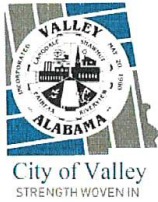
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Sincerely,

Ron Anders, Jr.
Mayor

CITY OF AUBURN



CITY OF VALLEY

February 2, 2026

Ms. Emily T. Marsal
Executive Director
State Health Planning and Development Agency
100 North Union Street, Suite 870
Montgomery, Alabama 36104

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Sincerely,


Leonard Riley
Mayor, City of Valley

January 6, 2026

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Executive Director
State Health Planning and Development Agency
100 North Union Street, Suite 870
Montgomery, Alabama 36104

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Sincerely,


Dr. Song Chu Ko

January 6, 2026

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Executive Director
State Health Planning and Development Agency
100 North Union Street, Suite 870
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Sincerely,

Dr. Caroline Heideman



January 6, 2026

Ms. Emily T. Marsal
Executive Director
State Health Planning and Development Agency
100 North Union Street, Suite 870
Montgomery, Alabama 36104

Re: Letter of Support for the Expansion of East Alabama Medical Center's Spencer Cancer Center

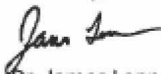
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Sincerely,



Dr. James Lennon

January 6, 2026

Ms. Emily T. Marsal
Executive Director
State Health Planning and Development Agency
100 North Union Street, Suite 870
Montgomery, Alabama 36104

Re: Letter of Support for the Expansion of East Alabama Medical Center's Spencer Cancer Center

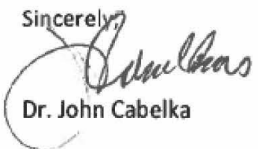
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Sincerely,


Dr. John Cabelka



January 6, 2026

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Sincerely,



Dr. Kerri Bevis

Spencer Cancer Center

EAST ALABAMA MEDICAL CENTER

East Alabama
Health 

January 7, 2026

Ms. Emily T. Marsal
Executive Director
State Health Planning and Development Agency
100 North Union Street, Suite 870
Montgomery, Alabama 36104

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I began working in the Oncology department here when it was a simple renovated administrative office that encompassed just a few small rooms. Now, 20 years later, we have outgrown a much larger/dedicated building. It is disappointing that cancer is so prevalent that a larger building is necessary, but it is vital to stay up to date and provide our patients with state of the art care and equipment. I strongly support EAMC's certificate of need application for the expansion of the Spencer Cancer Center.

Sincerely,



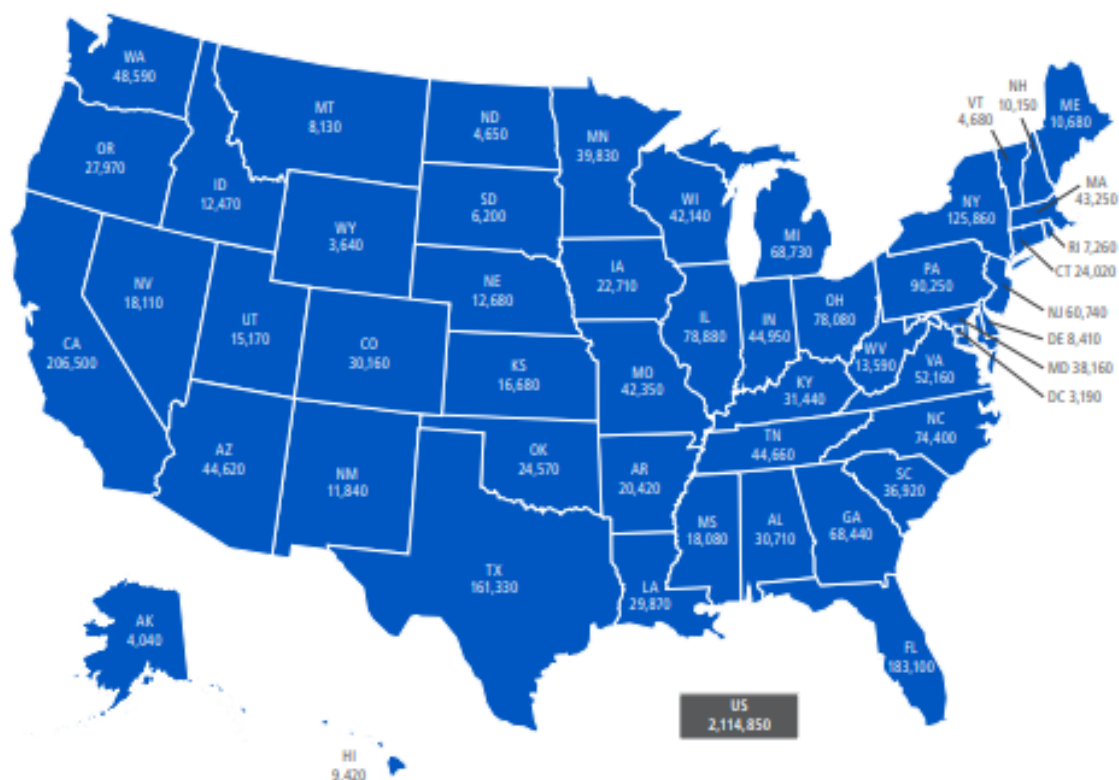
Brandon Johnson, M.D.
Hematology/Oncology

APPENDIX C

Referenced Materials in the Application



Cancer Facts & Figures 2026



Estimated number of new cases in 2026, excluding basal cell and squamous cell skin cancers and in situ carcinoma except urinary bladder. Estimates are model based projections and should be interpreted with caution.

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This publication summarizes current scientific information about cancer.

Except when specified, it does not represent the official policy of the American Cancer Society.

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at permissions@can.org for permission.

Basic Cancer Facts

What Is Cancer?

Cancer is a group of diseases characterized by the uncontrolled growth and spread of abnormal cells that can result in death if untreated. The cause of most cancers is unknown, but certain lifestyle factors and inherited genetic mutations can increase risk, either by acting alone or in combination, to initiate and/or promote cancer growth.

Can Cancer Be Prevented?

Excluding non-melanoma skin cancer, at least 40% of newly diagnosed cancers in US adults — about 850,000 cases in 2026 — are potentially avoidable, including the 19% of cancers associated with cigarette smoking, the 8% associated with excess body weight, and the 5% associated with alcohol consumption. See [Proportion and number of cancer cases and deaths attributable to potentially modifiable risk factors in the United States, 2019](#) for more information. Additionally, routine screening can prevent many colorectal cancers and most cervical cancers by detecting precancerous lesions that can be removed. Screening can also reduce the risk of death from these cancers, and those of the breast, lung, and prostate, through early detection when treatment is usually more successful. For detailed cancer screening guidelines, see page 44.

How Many People Alive Today Have Ever Had Cancer?

As of January 1, 2025, approximately 18.6 million Americans had a history of invasive cancer, most of whom were diagnosed many years ago; see [Cancer treatment and survivorship statistics, 2025](#) for more information.

How Many New Cases and Deaths Are Expected to Occur in 2026?

Excluding non-melanoma skin cancers, approximately 2.1 million new cancer cases are expected to be diagnosed in the US in 2026, and more than 626,000 people will die from the disease ([Table 1](#)), the equivalent of about 1,700 deaths per day. [Table 2](#) and [Table 3](#) provide

estimated new cancer cases and deaths, respectively, in 2026 by state.

How Much Progress Has Been Made Against Cancer?

Cancer mortality rates are the best measure of progress against cancer because they are less affected by changes in detection practices than incidence (new diagnoses) and survival rates. The age-adjusted cancer death rate rose during most of the 20th century because of the smoking epidemic but has dropped from its peak in 1991 by 34% as of 2023, averting approximately 4.8 million deaths. This progress, which mostly reflects declines in mortality for the four most common cancers — lung, colorectal, breast, and prostate ([Figure 1](#) and [Figure 2](#)), is the result of scientific discovery that translated into reductions in smoking, advances in treatment, and early detection. Over the past decade (2014-2023), the cancer death rate dropped by 1.5% per year on average. Future progress is threatened by reductions in federal funding for health care, cancer registries, and cancer research.

Do Cancer Incidence and Death Rates Vary Geographically?

Cancer rates vary substantially across states, with the largest differences for cancers that are most preventable, such as lung cancer. For example, male lung cancer incidence varies by 3- to 4-fold, from 21 per 100,000 men in Puerto Rico and 28 per 100,000 men in Utah to 96 per 100,000 men in Kentucky ([Table 4](#)). [Table 5](#) provides average annual death rates for selected cancers by state.

Who Is at Risk of Developing Cancer?

Everyone is at risk of developing cancer, although incidence increases greatly with age; 88% of people diagnosed with cancer in the US are 50 years or older, and 59% are 65 or older. In the US, an estimated 39 out of 100 men and women will develop cancer during their lifetime ([Table 6](#)). However, these probabilities are based on cancer occurrence in the population overall and may differ in individuals because of lifestyle exposures (e.g., smoking, excess body weight, alcohol use), family history, and/or genetic susceptibility.

What Percentage of People Survive Cancer?

The 5-year relative survival rate for all cancers combined has reached a milestone 70% for people diagnosed from 2015 to 2021, up from 49% in the mid-1970s (Table 7). Relative survival is a measure of life expectancy among people with cancer compared to that among the general population of the same age, race, and sex. Since the early 1960s, 5-year relative survival has increased from 39% to 71% among White people and from 27% to 66% among Black people because of advances in treatment and earlier diagnosis for some cancers. Survival varies greatly by cancer type, stage (Table 8), and age at diagnosis. See Sources of Statistics, page 43, for more information about relative survival.

How Is Cancer Staged?

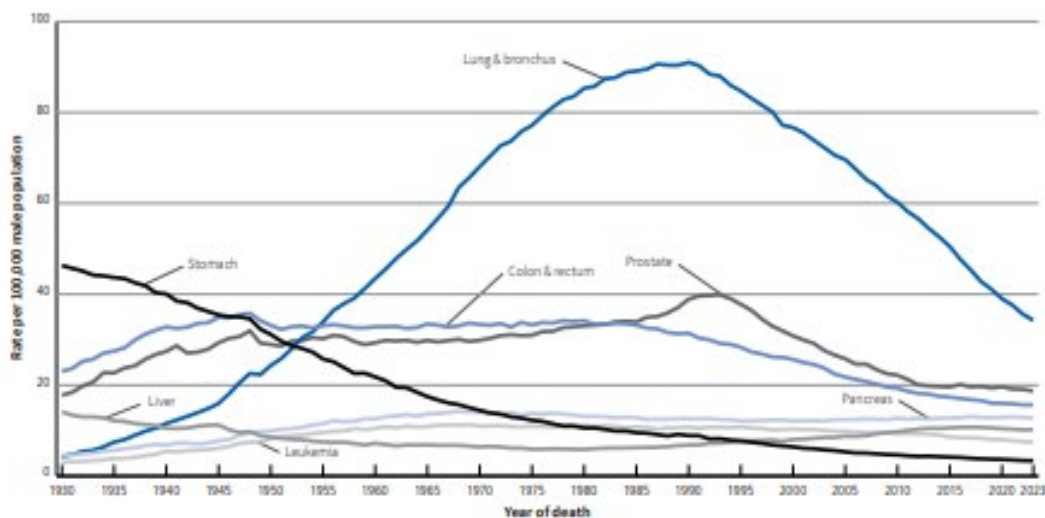
Stage describes the extent of cancer growth in the body, usually based on the size of the primary tumor and whether it has spread to nearby lymph nodes or other areas of the body. This report uses a summary

staging system that is standard in presenting population-based cancer registry data and is particularly useful for tracking trends. According to this system, if cancer is confined to the layer of cells where it began growing, the stage is in situ. If cancer cells have penetrated beyond the original layer of tissue, the cancer has become invasive and is categorized as local, regional, or distant based on the extent of spread. (For a more detailed description of these categories, see the footnotes in Table 8.) A different staging system is used by clinicians and for some cancers (e.g., leukemia and brain cancer). See cancer.org/cancer/diagnosis-staging/staging for more information on cancer staging.

What Are the Costs of Cancer?

The costs of cancer are estimated in several ways, including direct medical costs (total of all health care expenditures) and indirect costs, such as lost earnings from missed work due to illness or premature death. The National Cancer Institute estimated that cancer-related medical costs in the US were \$208.9 billion in 2020.

Figure 1. Trends in Age-adjusted Cancer Death Rates by Site, Males, US, 1930-2023



Rates are age adjusted to the 2000 US standard population. Due to historical improvements in classification, lung & bronchus includes pleura, trachea, mediastinum, and other respiratory organs; colon & rectum includes small intestine; and liver includes intrahepatic bile duct, gallbladder, and other biliary sites.
Data source: US Mortality Volumes 1930 to 1959, US Mortality Data 1960 to 2023, National Center for Health Statistics, Centers for Disease Control and Prevention.
©2026, American Cancer Society, Inc., Surveillance, Prevention, and Health Services Research

However, this is probably an underestimate because it did not account for the rising cost of treatment; the list price for many prescription medicines is more than \$100,000 annually. Cancer-related costs to patients are

estimated at \$21.1 billion per year, including \$16.2 billion in total out-of-pocket costs and \$4.9 billion in patient time costs (e.g., travel to/from treatment and waiting for and receiving care).

Selected Cancers

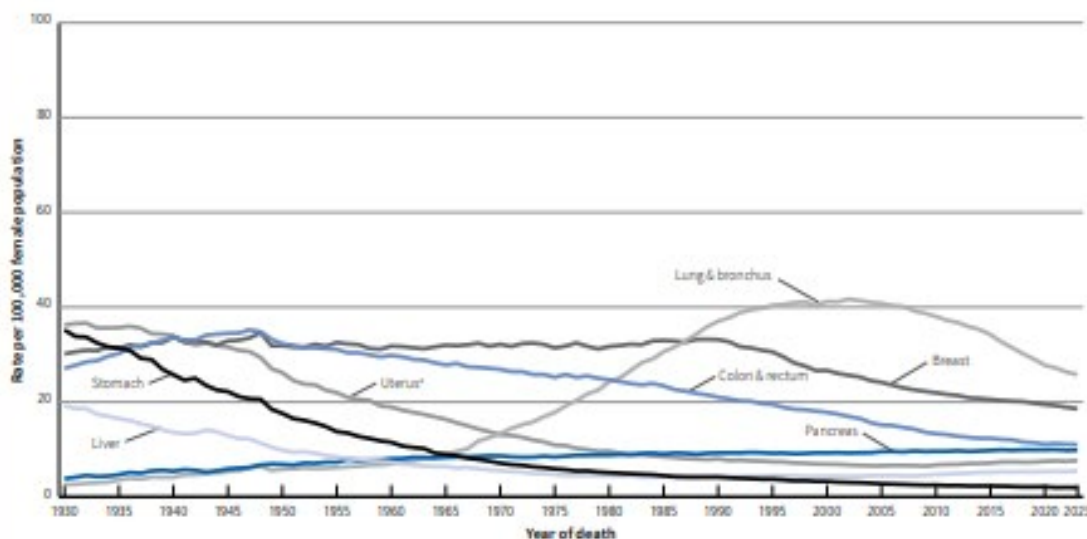
This section provides information on the occurrence, risk factors, symptoms, early detection, and treatment for the most common types of cancer and may have limited relevance for specific subtypes. Incidence trends are based on population-based registry data for cases diagnosed from 1998 through 2022 (covering 99% of the US population) that have been adjusted for delays in reporting. Data for 2020 were excluded from incidence trend analysis for improved accuracy based on guidance from the [National Cancer Institute](#). Mortality trends are based on the underlying cause of death reported on death certificates from 1975 through 2023. See Sources of Statistics, page 42, for more information on data sources and methods.

Breast

New cases and deaths: In the US in 2026, there will be an estimated 321,910 new cases of invasive breast cancer diagnosed in women and 2,670 cases in men, with an additional 60,730 cases of ductal carcinoma in situ (DCIS) diagnosed in women ([Table 1](#)). An estimated 42,670 breast cancer deaths (42,140 in women, 530 in men) will occur in 2026.

Incidence trends: The incidence of invasive female breast cancer has been increasing since the mid-2000s; from 2013 to 2022, the rate increased by 1% per year on average, with a steeper pace in women younger than 50 years (1.4% per year) than in those 50 and older (0.7%

Figure 2. Trends in Age-adjusted Cancer Death Rates by Site, Females, US, 1930-2023



Rates are age adjusted to the 2000 US standard population. Due to historical improvements in classification, lung & bronchus includes pleura, trachea, mediastinum, and other respiratory organs; colon & rectum includes small intestine; and liver includes intrahepatic bile duct, gallbladder, and other biliary sites. *Uterus includes uterine cervix and uterine corpus combined, and is not adjusted for hysterectomy prevalence.

Data source: US Mortality Volumes 1930 to 1959, US Mortality Data 1960 to 2023, National Center for Health Statistics, Centers for Disease Control and Prevention. ©2026, American Cancer Society, Inc., Surveillance, Prevention, and Health Services Research

Table 1. Estimated Number of New Cancer Cases and Deaths by Sex, US, 2026

	Estimated New Cases			Estimated Deaths		
	Both sexes	Male	Female	Both sexes	Male	Female
All sites	2,114,850	1,094,070	1,020,780	626,140	327,290	298,850
Oral cavity & pharynx	60,480	43,070	17,410	13,150	9,420	3,730
Tongue	20,420	14,250	6,170	3,560	2,460	1,100
Mouth	15,810	9,230	6,580	3,340	2,030	1,310
Pharynx	21,760	17,880	3,880	4,760	3,780	980
Other oral cavity	2,490	1,710	780	1,490	1,150	340
Digestive system	369,970	203,500	166,470	178,700	102,000	76,700
Esophagus	22,530	17,580	4,950	16,290	12,940	3,350
Stomach	31,510	17,900	13,610	10,740	6,360	4,380
Small intestine	14,450	7,470	6,980	2,170	1,250	920
Colon & rectum*	158,850	84,160	74,690	55,230	30,110	25,120
Colon	108,860	55,410	53,450			
Rectum	49,990	28,750	21,240			
Anus, anal canal, & anorectum	11,270	3,570	7,700	1,700	570	1,130
Liver & intrahepatic bile duct	42,340	27,790	14,550	30,980	19,650	11,330
Gallbladder & other biliary	12,640	5,950	6,690	4,590	1,960	2,630
Pancreas	67,530	35,190	32,340	52,740	27,230	25,510
Other digestive organs	8,850	3,890	4,960	4,260	1,930	2,330
Respiratory system	247,820	124,540	123,280	130,550	67,260	63,290
Larynx	12,290	9,730	2,560	3,960	3,180	780
Lung & bronchus	229,410	110,910	118,500	124,990	63,040	61,950
Other respiratory organs	6,120	3,900	2,220	1,600	1,040	560
Bones & joints	4,110	2,290	1,820	2,210	1,240	970
Soft tissue (including heart)	13,910	7,840	6,070	5,400	2,960	2,440
Skin (excluding basal & squamous)	119,750	70,590	49,160	14,570	9,850	4,720
Melanoma of the skin	112,000	65,400	46,600	8,510	5,500	3,010
Other nonepithelial skin	7,750	5,190	2,560	6,060	4,350	1,710
Breast	324,580	2,670	321,910	42,670	530	42,140
Genital system	463,560	345,900	117,660	71,970	37,400	34,570
Uterine cervix	13,490		13,490	4,200		4,200
Uterine corpus	68,270		68,270	14,450		14,450
Ovary	21,010		21,010	12,450		12,450
Vulva	7,130		7,130	1,750		1,750
Vagina & other genital, female	7,760		7,760	1,720		1,720
Prostate	333,830	333,830		36,320	36,320	
Testis	9,810	9,810		630	630	
Penis & other genital, male	2,260	2,260		450	450	
Urinary system	169,700	118,460	51,240	34,400	23,760	10,640
Urinary bladder	84,530	64,730	19,800	17,870	12,640	5,230
Kidney & renal pelvis	80,450	50,770	29,680	15,160	10,200	4,960
Ureter & other urinary organs	4,720	2,960	1,760	1,370	920	450
Eye & orbit	3,200	1,720	1,480	530	280	250
Brain & other nervous system	24,740	13,830	10,910	18,350	9,970	8,380
Endocrine system	53,200	16,630	36,570	3,500	1,700	1,800
Thyroid	45,240	13,240	32,000	2,320	1,100	1,220
Other endocrine	7,960	3,390	4,570	1,180	600	580
Lymphoma	88,240	48,660	39,580	21,070	12,390	8,680
Hodgkin lymphoma	8,920	4,890	4,030	1,100	680	420
Non-Hodgkin lymphoma	79,320	43,770	35,550	19,970	11,710	8,260
Myeloma	36,000	20,150	15,850	10,850	5,780	5,070
Leukemia	67,790	39,070	28,720	23,910	13,900	10,010
Acute lymphocytic leukemia	6,250	3,600	2,650	1,600	930	670
Chronic lymphocytic leukemia	22,760	13,810	8,950	4,350	2,720	1,630
Acute myeloid leukemia	22,720	12,160	10,560	11,500	6,520	4,980
Chronic myeloid leukemia	9,650	5,810	3,840	1,170	630	540
Other leukemia	6,410	3,690	2,720	5,290	3,100	2,190
Other & unspecified primary sites	67,800	35,150	32,650	54,310	28,850	25,460

Estimates are rounded to the nearest 10 and cases exclude basal cell and squamous cell skin cancer and in situ carcinoma except urinary bladder. About 60,730 cases of female breast ductal carcinoma in situ and 122,680 cases of melanoma in situ will be diagnosed in 2026. These are model-based estimates and should be interpreted with caution. *Deaths for colon and rectal cancers are combined because a large number of deaths from rectal cancer are misclassified as colon.

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Table 2. Estimated Number of New Cases for Selected Cancers by State, US, 2026

State	All sites	Female breast	Colon & rectum	Leukemia	Lung & bronchus	Melanoma of the skin	Non-Hodgkin lymphoma	Prostate	Urinary bladder	Uterine cervix	Uterine corpus
Alabama	30,710	4,900	2,690	870	3,960	1,450	960	5,400	1,210	250	910
Alaska	4,040	580	340	110	440	140	140	750	170	*	110
Arizona	44,620	7,090	3,330	1,450	4,350	3,890	1,690	5,540	1,970	280	1,430
Arkansas	20,420	2,720	1,620	600	2,710	1,050	670	3,150	780	150	520
California	206,500	34,170	16,650	6,380	16,670	12,170	8,310	32,610	7,370	1,490	7,390
Colorado	30,160	5,210	2,210	1,030	2,620	2,190	1,190	4,480	1,220	190	890
Connecticut	24,020	3,940	1,690	830	2,670	770	980	4,000	1,190	120	850
Delaware	8,410	1,240	520	200	950	450	290	1,410	350	*	260
Dist. of Columbia	3,190	590	230	80	330	90	100	450	100	*	110
Florida	183,100	24,700	12,850	7,060	18,570	10,530	7,600	26,970	7,630	1,200	5,490
Georgia	68,440	10,440	5,350	1,960	6,780	3,700	2,190	11,420	2,310	470	2,050
Hawaii	9,420	1,700	840	240	870	550	340	1,310	310	60	390
Idaho	12,470	1,890	900	490	1,090	1,080	490	2,030	580	70	310
Illinois	78,880	12,340	6,160	2,360	9,430	4,390	2,890	13,050	3,180	490	2,740
Indiana	44,950	6,530	3,510	1,410	6,230	2,330	1,630	6,440	1,890	290	1,420
Iowa	22,710	3,030	1,630	810	2,500	1,780	860	3,320	960	120	700
Kansas	16,680	2,620	1,410	520	2,090	860	670	2,650	620	100	540
Kentucky	31,440	4,280	2,660	990	5,060	1,610	1,150	4,290	1,310	210	940
Louisiana	29,870	4,250	2,500	870	3,390	1,310	1,020	5,440	1,030	200	710
Maine	10,680	1,600	730	380	1,460	410	440	1,820	640	*	390
Maryland	38,160	6,290	2,740	1,060	3,920	2,030	1,350	7,230	1,400	220	1,350
Massachusetts	43,250	7,340	2,910	1,410	5,390	1,370	1,760	7,310	1,990	180	1,520
Michigan	68,730	9,900	4,830	2,110	8,460	3,330	2,490	10,530	3,030	370	2,170
Minnesota	39,830	5,670	2,630	1,330	3,970	3,450	1,560	6,340	1,600	160	1,210
Mississippi	18,080	2,670	1,690	550	2,660	660	620	3,170	650	140	480
Missouri	42,350	6,300	3,100	1,350	5,780	2,310	1,530	5,530	1,590	250	1,230
Montana	8,130	1,150	550	250	760	620	280	1,260	370	*	200
Nebraska	12,680	1,770	950	380	1,320	840	450	2,030	480	60	390
Nevada	18,110	2,880	1,530	560	1,770	1,120	630	2,970	790	160	520
New Hampshire	10,150	1,560	670	350	1,330	470	450	1,760	540	*	350
New Jersey	60,740	9,510	4,540	2,090	5,640	2,570	2,500	11,480	2,650	360	2,260
New Mexico	11,840	1,910	940	400	920	750	430	2,140	450	100	420
New York	125,860	19,010	9,140	4,120	13,150	4,530	5,060	22,180	5,410	770	4,270
North Carolina	74,400	11,820	5,050	2,260	8,880	4,180	2,500	11,190	2,770	420	2,220
North Dakota	4,650	660	360	160	480	380	170	810	180	*	120
Ohio	78,080	11,400	5,830	2,170	10,120	4,600	2,810	11,670	3,390	490	2,590
Oklahoma	24,570	3,550	2,010	730	3,100	1,210	840	3,390	920	180	700
Oregon	27,970	4,290	1,890	840	2,970	1,660	1,120	3,630	1,270	140	890
Pennsylvania	90,250	13,720	6,520	2,910	10,710	3,890	3,410	13,470	4,160	510	3,300
Rhode Island	7,260	1,160	490	250	910	270	300	1,310	380	*	260
South Carolina	36,920	6,030	2,820	1,010	4,550	2,010	1,200	6,900	1,410	240	1,110
South Dakota	6,200	860	460	200	690	450	200	910	250	*	170
Tennessee	44,660	6,920	3,560	1,330	6,380	1,850	1,520	7,190	1,780	310	1,340
Texas	161,330	24,270	13,310	5,660	14,260	5,910	5,850	24,090	5,050	1,470	5,260
Utah	15,170	2,380	1,030	600	790	1,900	600	2,650	530	100	530
Vermont	4,680	710	310	160	590	250	200	850	230	*	170
Virginia	52,160	8,470	3,770	1,320	6,060	2,560	1,790	9,120	1,910	290	1,710
Washington	48,590	7,710	3,300	1,550	5,020	2,860	1,900	6,980	1,980	280	1,400
West Virginia	13,590	1,680	1,060	400	2,110	590	450	1,640	580	80	500
Wisconsin	42,140	6,030	2,680	1,550	4,220	2,340	1,620	7,050	1,790	180	1,390
Wyoming	3,640	500	270	100	330	270	120	500	170	*	110
United States	2,114,850	321,910	158,850	67,790	229,410	112,000	79,320	333,830	84,530	13,490	68,270

Estimates are rounded to the nearest 10 and exclude basal and squamous cell skin cancers and in situ carcinomas except urinary bladder. State estimates may not sum to US total due to rounding and exclusion of state estimates of fewer than 50 cases. These are model-based estimates and should be interpreted with caution. *Fewer than 50 cases.

Please note: Estimated cases for additional cancer sites by state can be found in Supplemental Data at cancer.org/statistics or via the American Cancer Society Cancer Statistics Center (cancerstatisticscenter.cancer.org).

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Table 3. Estimated Number of Deaths for Selected Cancers by State, US, 2026

State	All sites	Brain/ nervous system	Female breast	Colon & rectum	Leukemia	Liver*	Lung & bronchus	Non- Hodgkin lymphoma	Pancreas	Prostate	Uterine corpus
Alabama	10,670	320	730	970	360	550	2,370	280	760	560	180
Alaska	1,140	^k	60	90	^k	^k	210	^k	80	70	^k
Arizona	13,800	350	1,000	1,330	570	730	2,330	450	1,170	900	290
Arkansas	6,840	190	390	670	220	360	1,640	190	470	360	110
California	61,280	1,970	4,580	5,660	2,320	3,690	9,580	2,180	5,250	4,210	1,540
Colorado	8,740	310	710	790	390	450	1,340	290	750	670	190
Connecticut	6,760	230	420	490	270	340	1,240	220	600	430	200
Delaware	2,430	70	190	190	90	110	510	80	230	150	60
Dist. of Columbia	820	^k	80	80	30	40	150	^k	70	70	^k
Florida	50,010	1,470	3,360	4,240	2,000	2,200	9,990	1,560	4,280	2,970	1,100
Georgia	19,400	590	1,430	1,750	700	990	3,500	540	1,410	1,160	490
Hawaii	2,720	50	200	260	90	160	470	100	250	170	60
Idaho	3,510	130	250	310	150	190	580	90	300	240	70
Illinois	23,230	680	1,350	2,080	880	1,090	4,880	730	2,080	1,280	620
Indiana	14,230	390	900	1,260	520	560	3,430	450	1,090	740	300
Iowa	6,330	180	370	530	270	290	1,350	230	510	330	130
Kansas	5,700	190	370	510	250	250	1,250	220	450	290	110
Kentucky	10,510	270	640	970	370	500	2,870	310	760	450	180
Louisiana	9,360	250	560	870	330	580	2,080	260	750	450	160
Maine	3,560	100	200	260	120	130	800	120	280	220	80
Maryland	11,280	300	810	980	420	530	2,120	370	960	710	340
Massachusetts	12,470	410	710	840	460	650	2,510	410	1,200	710	310
Michigan	21,580	630	1,320	1,630	810	830	4,850	630	1,900	1,120	440
Minnesota	10,660	330	640	800	450	500	2,060	390	930	600	240
Mississippi	6,740	190	470	670	250	330	1,580	180	510	390	140
Missouri	13,470	380	970	1,280	490	650	3,320	420	1,060	720	280
Montana	2,310	90	140	200	80	120	420	70	190	160	^k
Nebraska	3,680	130	260	340	160	170	810	120	320	200	90
Nevada	5,840	150	430	580	170	320	1,050	170	490	400	120
New Hampshire	3,050	110	180	190	90	140	630	100	270	180	70
New Jersey	15,150	400	1,160	1,330	570	690	2,890	470	1,430	770	440
New Mexico	3,970	120	280	360	170	170	590	120	290	270	100
New York	31,140	850	1,920	2,680	1,190	1,310	5,850	980	2,930	1,650	900
North Carolina	21,770	570	1,460	1,900	780	920	5,040	630	1,840	1,230	510
North Dakota	1,320	^k	70	110	60	50	270	^k	120	70	^k
Ohio	24,590	640	1,580	2,020	950	1,050	5,550	790	2,130	1,350	560
Oklahoma	8,490	250	580	820	320	360	1,920	270	590	450	170
Oregon	8,840	270	580	670	350	450	1,610	310	710	590	270
Pennsylvania	27,630	820	1,770	2,240	1,060	1,260	5,870	900	2,420	1,440	560
Rhode Island	2,120	70	120	150	70	140	410	70	200	110	50
South Carolina	11,700	360	800	970	420	590	2,400	360	960	660	250
South Dakota	1,810	^k	90	150	80	50	380	60	160	100	^k
Tennessee	15,270	400	1,040	1,610	530	720	3,690	450	1,160	750	270
Texas	46,300	1,360	3,400	4,750	1,820	3,170	8,080	1,470	3,770	2,480	1,130
Utah	3,970	170	340	440	190	200	470	140	350	310	100
Vermont	1,520	50	90	130	50	50	300	50	130	100	^k
Virginia	16,550	500	1,150	1,490	650	780	3,300	500	1,320	1,020	380
Washington	14,160	390	960	1,160	540	730	2,570	510	1,220	980	310
West Virginia	4,710	120	290	420	180	190	1,330	150	330	240	80
Wisconsin	11,840	360	670	880	560	550	2,310	410	1,200	790	280
Wyoming	1,160	^k	80	130	^k	50	210	^k	110	70	^k
United States	626,140	18,350	42,140	55,290	23,910	30,980	124,990	19,970	52,740	36,320	14,450

Estimates are rounded to the nearest 10. State estimates may not sum to the US total due to rounding and exclusion of state estimates of fewer than 50 deaths. These are model-based estimates and should be interpreted with caution. *Includes intrahepatic bile duct. ^kfewer than 50 deaths.

Please note: Estimated deaths for additional cancer sites by state can be found in Supplemental Data at cancer.org/statistics or via the American Cancer Society Cancer Statistics Center (cancerstatisticscenter.cancer.org).

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Table 4. Incidence Rates for Selected Cancers by State, US, 2018-2022

State	All sites		Breast	Colon & rectum ^a		Liver & intrahepatic bile duct		Lung & bronchus		Prostate	Uterine cervix ^b	Uterine corpus ^b
	Male	Female	Female	Male	Female	Male	Female	Male	Female	Male	Female	Female
Alabama	481.4	403.6	128.6	44.5	33.5	13.1	4.9	71.3	47.3	115.0	14.5	40.4
Alaska	471.4	439.5	135.4	44.2	36.4	13.6	6.4	55.7	51.9	113.7	8.6	42.0
Arizona	432.6	394.6	122.7	36.2	27.2	12.3	4.7	44.9	39.1	88.2	8.7	38.0
Arkansas ^c	548.7	441.4	124.8	48.1	35.8	13.8	4.7	89.9	62.2	118.5	14.7	46.9
California	440.1	403.0	127.3	37.6	29.2	14.1	6.0	40.3	34.1	107.0	8.9	38.1
Colorado	419.4	396.1	135.0	33.2	26.3	10.4	4.3	38.3	36.8	105.5	7.5	34.8
Connecticut	530.1	466.8	148.6	37.5	29.2	12.6	4.7	57.5	53.1	144.3	6.7	40.5
Delaware	521.0	455.6	146.7	36.7	28.2	13.1	4.5	60.6	53.9	141.5	9.1	42.7
Dist. of Columbia	456.7	409.9	139.7	40.8	30.1	17.6	6.3	49.2	42.4	139.4	9.4	42.6
Florida	531.6	471.3	133.9	41.0	31.0	12.7	4.9	59.8	50.1	124.8	12.2	42.3
Georgia	538.3	435.7	135.2	44.5	33.0	13.1	5.0	66.4	47.9	144.2	11.0	45.1
Hawaii	431.7	399.4	139.2	42.9	30.6	13.6	5.6	43.0	34.4	105.4	7.9	43.2
Idaho	495.9	429.3	134.5	38.1	29.8	11.1	4.9	47.8	42.2	124.2	9.1	44.7
Illinois	512.7	451.1	136.4	43.8	32.0	12.2	5.2	64.2	54.4	129.1	8.9	43.4
Indiana ^d	532.7	456.8	130.9	45.4	33.8	13.1	5.0	79.8	62.0	121.9	11.7	48.2
Iowa	554.9	473.8	137.7	42.7	33.6	11.2	4.3	68.0	55.0	133.5	9.0	46.1
Kansas ^e	495.6	439.0	136.5	41.8	33.3	10.2	4.4	56.1	49.3	125.5	11.3	45.4
Kentucky	581.6	491.9	131.4	51.6	38.3	29.1	9.8	96.5	76.1	119.9	12.9	45.6
Louisiana	571.6	440.0	132.4	49.8	36.4	14.6	4.9	74.3	51.3	150.2	13.9	42.5
Maine	529.4	471.6	136.6	37.5	29.4	17.1	5.6	72.0	63.9	114.4	7.6	43.7
Maryland	498.6	433.2	140.0	37.8	30.3	11.0	4.4	53.2	46.9	145.4	7.6	40.4
Massachusetts	482.0	437.6	141.0	34.5	26.6	12.6	5.3	59.5	56.6	121.7	5.7	36.6
Michigan	495.0	432.5	132.4	38.4	30.5	13.9	4.9	64.7	55.9	122.6	8.4	44.5
Minnesota	533.1	471.6	143.0	38.6	30.2	10.4	4.7	58.7	52.2	123.8	6.7	43.0
Mississippi	559.3	430.4	127.0	53.7	37.7	12.0	5.1	87.2	56.1	145.5	14.6	48.0
Missouri	515.8	463.2	139.8	44.9	33.7	13.4	5.2	77.4	63.0	109.0	11.2	45.4
Montana	501.5	436.4	140.5	40.1	30.4	13.1	5.0	46.6	45.6	135.6	9.2	39.2
Nebraska	489.4	436.0	130.4	42.1	31.7	10.2	4.7	57.0	47.9	121.0	8.6	43.8
Nevada	420.4	382.5	113.3	38.5	30.1	8.3	4.3	45.5	42.9	101.3	10.9	38.4
New Hampshire	518.8	464.9	142.3	35.7	28.3	10.7	4.6	62.1	57.8	123.0	6.4	41.4
New Jersey	533.2	457.5	139.7	41.9	32.4	10.0	4.2	52.8	46.9	148.6	8.3	40.8
New Mexico	406.1	377.2	118.7	38.2	27.5	11.9	5.0	35.5	30.8	96.1	10.2	36.9
New York	513.6	448.4	136.5	39.3	29.7	15.6	6.0	56.9	50.0	138.5	8.2	40.3
North Carolina	543.8	458.2	147.8	39.6	30.0	12.4	4.8	72.6	55.2	138.7	9.5	45.0
North Dakota	500.8	439.8	132.4	43.5	32.8	14.2	5.0	59.0	51.5	125.9	6.8	39.4
Ohio	526.9	456.2	134.9	42.5	31.8	9.9	3.6	73.1	58.7	125.5	10.2	47.0
Oklahoma	502.0	437.1	128.0	45.6	33.4	11.7	4.6	70.9	57.5	111.7	14.6	46.8
Oregon	451.4	419.5	133.6	33.9	28.3	13.8	5.6	50.9	46.0	107.8	8.1	44.9
Pennsylvania	496.5	446.4	134.2	40.5	31.1	13.3	5.4	63.1	52.9	115.2	8.6	46.4
Rhode Island	497.6	451.4	142.3	33.6	27.6	12.7	4.7	64.7	57.6	127.0	7.8	39.6
South Carolina	488.2	417.8	137.3	40.3	29.4	13.4	5.4	67.5	50.5	119.5	10.8	42.0
South Dakota	514.5	453.8	134.8	42.0	34.5	12.1	4.6	57.9	52.4	136.7	7.1	42.6
Tennessee	513.0	431.1	128.1	42.9	32.2	10.1	4.0	77.2	59.6	120.4	10.7	46.0
Texas	491.3	415.8	127.6	44.4	31.1	13.1	4.9	53.6	40.2	118.6	13.0	42.3
Utah	467.2	398.5	123.5	31.2	24.5	19.5	7.2	27.5	23.2	129.8	8.0	44.4
Vermont	492.9	443.3	132.5	36.0	25.5	9.4	5.0	58.7	51.8	117.3	7.2	39.3
Virginia	454.3	403.5	132.7	36.8	28.3	8.7	3.7	58.4	46.3	116.6	7.8	39.3
Washington	470.8	437.1	139.7	36.5	28.7	11.3	4.5	50.9	47.5	108.2	8.3	40.3
West Virginia	539.6	493.9	130.0	48.2	37.7	12.6	5.6	83.9	72.0	108.4	13.4	59.3
Wisconsin	522.7	451.3	138.8	37.5	28.8	12.4	5.0	60.0	52.4	130.8	7.7	44.8
Wyoming	425.5	398.8	126.6	39.0	29.7	11.2	4.4	38.9	38.2	111.5	13.0	41.3
Puerto Rico^c	416.1	336.0	102.7	46.4	31.1	10.2	4.4	21.5	11.1	155.8	15.2	47.8
United States^f	497.9	436.0	133.5	40.5	30.7	13.1	5.2	59.0	48.8	122.3	9.7	42.3

Rates are per 100,000 persons, age adjusted to the 2000 US standard population using 19 age groups, and adjusted for delays in case reporting. ^aExcludes appendix.

^bAdjusted for hysterectomy prevalence. ^cFrom 2016 to 2020. ^dFrom 2017 to 2021. ^eNot adjusted for delays in case reporting. ^fExcludes Kansas and Puerto Rico.

Data source: North American Association of Central Cancer Registries, 2025.

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Table 5. Death Rates for Selected Cancers by State, US, 2019-2023

State	All sites		Breast	Colon & rectum		Liver & intrahepatic bile duct		Lung & bronchus		Pancreas		Prostate
	Male	Female	Female	Male	Female	Male	Female	Male	Female	Male	Female	Male
Alabama	194.4	133.2	20.4	17.6	12.0	10.5	4.4	50.8	30.0	13.1	9.9	19.9
Alaska	176.3	126.3	17.3	16.1	12.7	11.0	4.6	34.3	28.8	10.8	9.1	21.7
Arizona	151.6	116.6	18.7	14.6	10.3	8.7	4.5	27.9	22.5	11.7	9.1	17.7
Arkansas	205.8	140.4	20.1	18.9	12.7	11.4	4.9	55.0	36.2	13.0	9.5	20.0
California	153.9	116.3	18.7	14.1	10.2	10.4	5.1	26.4	19.6	11.9	9.3	20.3
Colorado	149.0	112.3	18.8	13.2	9.8	7.7	3.6	24.5	19.8	11.1	8.7	22.0
Connecticut	157.5	116.7	16.6	12.3	8.7	8.6	3.8	30.8	24.9	12.8	9.9	19.1
Delaware	184.7	134.4	22.0	14.8	10.2	10.1	3.4	41.2	30.0	14.8	11.3	20.0
Dist. of Columbia	162.8	134.6	23.2	16.1	11.6	12.2	5.1	29.9	23.5	13.2	11.0	27.5
Florida	161.4	120.0	18.7	14.3	10.0	8.7	3.8	35.9	26.3	12.6	9.3	16.7
Georgia	181.0	129.4	21.0	16.5	11.4	9.5	4.3	41.5	26.0	12.8	9.7	21.7
Hawaii	142.2	105.4	16.8	14.3	10.2	10.7	4.8	27.6	19.9	12.3	9.3	14.8
Idaho	161.7	120.3	19.0	14.4	10.6	7.7	3.9	28.4	22.8	12.4	9.4	21.7
Illinois	175.9	131.5	19.7	16.1	11.1	8.8	4.5	39.5	29.3	13.5	10.3	19.0
Indiana	197.5	142.6	20.3	17.7	12.5	8.8	4.1	49.9	35.3	14.2	10.9	20.6
Iowa	178.2	128.1	17.4	15.8	11.1	8.1	3.6	40.2	29.6	12.8	9.5	19.6
Kansas	179.5	132.9	19.7	16.5	11.6	8.4	4.1	41.8	30.7	13.8	9.6	18.0
Kentucky	215.5	154.6	21.7	19.9	13.6	10.3	4.0	59.7	42.9	13.3	10.2	18.4
Louisiana	201.0	138.3	21.8	18.6	12.8	13.4	5.1	50.6	31.2	14.2	11.3	19.4
Maine	190.5	135.3	17.2	14.3	10.9	7.6	2.9	42.8	34.8	14.0	9.5	21.4
Maryland	165.8	124.7	19.7	14.4	11.0	8.9	4.0	33.9	25.7	13.1	9.8	20.4
Massachusetts	162.4	118.2	15.2	11.8	8.6	9.2	3.8	32.9	27.3	13.6	10.1	18.3
Michigan	184.4	137.8	19.7	15.7	11.6	8.2	4.1	43.3	32.7	14.2	11.1	19.1
Minnesota	167.2	122.7	17.2	13.4	9.7	7.8	3.9	32.9	26.7	13.1	9.7	19.7
Mississippi	220.4	149.5	23.6	21.9	14.4	11.7	5.1	60.5	34.8	14.0	11.3	24.8
Missouri	193.0	139.5	20.2	17.0	11.8	9.6	4.4	49.2	35.5	13.9	10.3	19.2
Montana	165.1	122.8	18.1	14.4	10.5	7.7	4.1	29.1	25.1	12.1	9.4	22.0
Nebraska	173.8	130.4	20.1	17.6	11.9	6.8	3.4	36.6	27.5	13.8	10.2	19.2
Nevada	164.6	128.8	21.4	15.9	12.1	8.5	4.4	32.7	27.9	12.2	9.4	20.7
New Hampshire	173.3	124.7	17.9	12.5	9.4	7.7	3.4	34.7	29.8	13.3	10.4	19.8
New Jersey	148.7	117.7	18.9	13.7	10.2	7.8	3.8	29.4	23.1	12.8	9.9	16.1
New Mexico	152.7	114.7	19.3	14.8	9.9	11.2	5.1	24.4	18.2	11.0	8.9	19.7
New York	145.6	112.1	16.6	13.0	9.2	7.5	3.4	30.0	22.5	12.3	9.4	15.4
North Carolina	185.3	131.9	19.8	15.2	10.8	10.1	4.1	45.3	30.4	13.1	10.4	20.6
North Dakota	161.0	118.4	16.1	14.5	10.6	7.2	2.5	34.5	26.3	11.9	9.9	17.7
Ohio	192.3	137.4	20.1	16.6	11.3	8.9	4.0	46.6	32.7	14.1	10.6	19.5
Oklahoma	206.1	150.3	22.2	19.4	13.8	10.8	4.9	51.5	38.0	12.7	9.8	20.7
Oregon	172.9	131.0	19.3	14.3	10.3	10.0	4.4	32.8	28.3	12.8	10.2	21.4
Pennsylvania	180.6	131.3	19.2	15.5	10.9	9.3	4.1	39.7	28.6	13.9	10.4	18.5
Rhode Island	170.7	122.7	16.2	11.8	10.0	11.6	4.8	36.6	29.0	13.8	9.7	18.3
South Carolina	190.4	132.1	21.0	16.6	11.2	9.9	4.3	45.5	29.4	13.7	10.0	21.3
South Dakota	176.8	133.2	17.3	15.0	12.6	8.7	4.2	36.6	30.8	13.7	10.7	20.8
Tennessee	202.5	142.1	21.5	18.4	12.4	10.4	4.2	52.7	36.5	13.5	10.1	19.9
Texas	170.1	122.8	19.6	17.1	11.2	12.2	5.3	34.5	23.3	12.3	9.5	18.4
Utah	139.6	107.5	20.3	12.4	9.8	6.3	4.1	17.9	13.5	11.6	8.8	22.5
Vermont	179.5	128.6	16.7	16.2	10.1	7.7	3.6	35.4	28.6	12.5	11.5	21.7
Virginia	175.6	128.3	19.9	15.6	11.1	9.1	3.9	39.0	27.4	12.8	10.0	20.6
Washington	168.5	127.6	18.8	14.0	10.4	9.3	4.6	32.3	26.6	12.7	10.3	21.2
West Virginia	210.5	152.0	20.8	20.7	12.9	9.0	4.4	55.9	41.7	13.0	10.3	18.8
Wisconsin	177.0	128.0	17.4	13.6	10.0	8.2	3.9	36.1	28.5	14.2	10.8	21.7
Wyoming	161.6	130.2	19.6	16.9	12.2	7.4	4.0	29.9	26.4	13.2	10.3	19.3
Puerto Rico*	124.8	83.2	15.4	16.3	10.0	10.1	4.0	14.3	7.3	8.1	5.4	19.3
United States*	171.5	126.3	19.2	15.3	10.8	9.4	4.3	37.2	27.1	12.9	9.9	19.2

Rates are per 100,000 persons and age adjusted to the 2000 US standard population using 20 age groups. *From 2018 to 2022 and were obtained from statecancerprofiles.cancer.gov. *Excludes Puerto Rico.

Data source: National Center for Health Statistics, Centers for Disease Control and Prevention, 2025.

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Table 6. Probability (%) of Developing Invasive Cancer During Selected Age Intervals by Sex, US, 2019-2022*

Site	Sex	Birth to 49	50 to 64	65 to 84	85 and older	Birth to death
All sites ^b	Male	3.4 (1 in 29)	11.3 (1 in 9)	31.4 (1 in 3)	18.6 (1 in 5)	39.2 (1 in 3)
	Female	6.0 (1 in 17)	10.8 (1 in 9)	24.3 (1 in 4)	14.1 (1 in 7)	38.7 (1 in 3)
Breast	Female	2.2 (1 in 46)	4.0 (1 in 25)	7.3 (1 in 14)	2.6 (1 in 38)	13.0 (1 in 8)
Colon & rectum	Male	0.4 (1 in 223)	1.2 (1 in 83)	2.5 (1 in 40)	1.6 (1 in 62)	4.0 (1 in 25)
	Female	0.4 (1 in 237)	0.9 (1 in 115)	2.1 (1 in 48)	1.6 (1 in 63)	3.8 (1 in 26)
Kidney & renal pelvis	Male	0.3 (1 in 383)	0.7 (1 in 145)	1.5 (1 in 68)	0.6 (1 in 180)	2.2 (1 in 45)
	Female	0.2 (1 in 595)	0.3 (1 in 287)	0.8 (1 in 128)	0.3 (1 in 310)	1.3 (1 in 75)
Leukemia	Male	0.3 (1 in 376)	0.3 (1 in 309)	1.2 (1 in 84)	0.8 (1 in 120)	1.8 (1 in 56)
	Female	0.2 (1 in 479)	0.2 (1 in 448)	0.7 (1 in 136)	0.5 (1 in 195)	1.3 (1 in 77)
Lung & bronchus	Male	0.1 (1 in 922)	1.0 (1 in 96)	4.5 (1 in 22)	2.4 (1 in 42)	5.4 (1 in 19)
	Female	0.1 (1 in 831)	1.0 (1 in 97)	4.0 (1 in 25)	1.8 (1 in 56)	5.4 (1 in 19)
Melanoma of the skin ^c	Male	0.4 (1 in 248)	0.9 (1 in 116)	2.4 (1 in 41)	1.5 (1 in 68)	3.5 (1 in 28)
	Female	0.6 (1 in 158)	0.7 (1 in 145)	1.2 (1 in 83)	0.6 (1 in 171)	2.6 (1 in 39)
Non-Hodgkin lymphoma	Male	0.2 (1 in 402)	0.5 (1 in 209)	1.5 (1 in 66)	0.9 (1 in 109)	2.2 (1 in 46)
	Female	0.2 (1 in 538)	0.4 (1 in 271)	1.1 (1 in 87)	0.6 (1 in 159)	1.8 (1 in 55)
Prostate	Male	0.2 (1 in 480)	3.8 (1 in 26)	11.0 (1 in 9)	3.3 (1 in 30)	12.9 (1 in 8)
Thyroid	Male	0.2 (1 in 503)	0.2 (1 in 510)	0.3 (1 in 360)	0.1 (1 in 1,460)	0.6 (1 in 162)
	Female	0.8 (1 in 128)	0.5 (1 in 210)	0.4 (1 in 226)	0.1 (1 in 1,104)	1.7 (1 in 60)
Uterine cervix ^d	Female	0.3 (1 in 343)	0.2 (1 in 553)	0.2 (1 in 502)	0.1 (1 in 1,593)	0.6 (1 in 156)
Uterine corpus ^d	Female	0.3 (1 in 289)	1.1 (1 in 90)	1.8 (1 in 57)	0.4 (1 in 246)	3.1 (1 in 32)

Probability is for those who are free of cancer at the beginning of each age interval. The probability of developing additional cancers and the probability of cancer death can be found in Supplemental Data at cancer.org/statistics. *Excludes 2020. ^bExcludes basal and squamous cell skin cancers and in situ carcinoma except urinary bladder. ^cFor non-Hispanic White individuals only. ^dNot adjusted for hysterectomy prevalence.

Data source: DevCan: Probability of Developing or Dying of Cancer Software, Version 6.9.2. Statistical Research and Applications Branch, National Cancer Institute, 2025. surveillance.cancer.gov/devcan/.

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per year). The rising trend is at least partly attributed to factors like increased excess body weight, later age at first birth, and decreased number of childbirths, all of which are associated with increased risk. See [Breast Cancer Statistics 2024](#) for more information.

Mortality trends: The female breast cancer death rate peaked in 1989 and has declined through 2023 by a total of 44% because of earlier detection (through mammography and increased awareness) and improved treatment, translating to approximately 546,000 fewer breast cancer deaths than would have been expected if mortality had remained at its peak. This progress could be accelerated by eliminating wide socioeconomic and racial disparities in early detection and treatment; for example, the death rate has remained unchanged over these 3 decades among American Indian and Alaska Native women and is 37% higher in Black women than in White women, despite lower incidence ([Table 9](#)).

Risk factors: Increasing age and being born female are the strongest risk factors for breast cancer. Potentially modifiable factors associated with increased risk include having excess body weight or gaining weight during adulthood (postmenopausal breast cancer only), drinking alcohol, and being physically inactive. Breastfeeding for at least one year decreases risk. Non-modifiable factors that increase risk include a personal or family history of breast cancer, especially related to inherited genetic mutations in breast cancer susceptibility genes (e.g., *BRCA1* or *BRCA2*). *BRCA1* or *BRCA2* mutations are most common among people with a strong family history of breast, ovarian, prostate, pancreatic, and/or other cancers associated with these variants (cancer.gov/about-cancer/causes-prevention/genetics/brca-fact-sheet). Risk also increases with a history of certain benign breast conditions (e.g., atypical hyperplasia), DCIS or lobular carcinoma in situ (LCIS), high breast tissue density (the amount of glandular and connective tissue relative to fatty tissue measured on a mammogram), and high-dose radiation to the chest

before age 30 (e.g., for treatment of lymphoma).

Reproductive and hormonal factors that increase risk include menopausal hormone therapy use (combined estrogen and progestin), previously referred to as hormone replacement therapy (HRT); a long menstrual history (menstrual periods that start early and/or end late in life); not having children or having a first child after age 30; high natural levels of estrogen or testosterone; and recent use of hormonal contraceptives.

Prevention: In addition to reducing risk through previously mentioned lifestyle choices, some women at high risk because of a strong family history or inherited genetic mutations may consider medicines (e.g., tamoxifen, raloxifene, aromatase inhibitors) or surgery (prophylactic mastectomy; removal of the breasts).

Early detection: Early diagnosis lowers the risk of death from breast cancer and increases treatment options. Mammography is a low-dose x-ray procedure used to detect breast cancer before symptoms appear and is most effective when done regularly. However, like all screening tests, it is not perfect. Mammography can sometimes miss cancer (a false-negative result) or appear abnormal in the absence of cancer (a false-positive result); about 12% of women who are screened have results that require further evaluation, but only 5% of women with an abnormal mammogram have cancer. Other potential harms of screening include detection and treatment of breast cancers and in situ lesions (e.g., DCIS) that would never have progressed or caused harm over the woman's lifetime (i.e., overdiagnosis resulting in overtreatment). Although small radiation exposures from individual mammograms accumulate over time, they do not meaningfully increase breast cancer risk or outweigh the benefits of screening. See page 44 and cancer.org/health-care-professionals/american-cancer-society-prevention-early-detection-guidelines/breast-cancer-screening-guidelines.html for more information about the American Cancer Society breast cancer screening guidelines.

Signs and symptoms: The most common signs/symptoms of breast cancer are a lump or mass; changes to the breast, such as swelling, skin redness, or thickening; and nipple abnormalities, such as spontaneous discharge (especially if bloody), scaliness, or retraction (drawing back within itself).

Treatment: There are two general types of treatment for breast cancer – local therapy (surgical and radiation treatments to the breast and/or nearby lymph nodes and chest) and systemic therapy (such as hormone therapy, chemotherapy, immunotherapy, and targeted therapy). Treatment usually involves either breast-conserving surgery (i.e., lumpectomy, surgical removal of the tumor and a rim of surrounding normal tissue) combined with radiation or mastectomy (surgical removal of the entire breast). One or more underarm lymph nodes are usually removed and evaluated to determine whether the tumor has spread beyond the breast. For early-stage breast cancer (no spread to the skin, chest wall, or distant organs), breast-conserving surgery plus radiation therapy results in long-term survival that is equivalent to mastectomy. Women undergoing mastectomy may also need radiation if the tumor is large or there is lymph node involvement. Women undergoing mastectomy who elect to undergo breast reconstruction have several options, including the type of tissue or implant used to restore breast shape. Reconstruction may be performed at the time of mastectomy or later, but often requires more than one surgery. Depending on the cancer stage, subtype, and sometimes other test results, such as tumor gene expression profiling (e.g., Oncotype DX), treatment may also involve chemotherapy (before and/or after surgery), hormone (anti-estrogen) therapy, targeted therapy, and/or immunotherapy (e.g., immune checkpoint inhibitors).

Survival: The 5- and 10-year relative survival rates are 92% and 86%, respectively, for invasive female breast cancer, mostly because two-thirds of women are diagnosed with localized-stage disease, for which survival approaches 100%. Five-year survival ranges from 84% in Black women to 94% in White women, partly because Black women are least likely to be diagnosed with localized-stage disease and most likely to be diagnosed with aggressive breast cancer subtypes, although Black women have the lowest survival for most subtypes.

See [Breast Cancer Statistics 2024](#) for more information.

Table 7. Trends in 5-year Relative Survival Rates (%) by Race, US, 1975-2021

	All races & ethnicities			White			Black		
	1975-77	1995-97	2015-2021	1975-77	1995-97	2015-2021	1975-77	1995-97	2015-2021
All sites	49	63	70	50	64	71	39	54	66
Brain & other nervous system	23	32	33	22	31	30	25	30	37
Breast (female)	75	87	92	76	89	94	62	75	84
Colon & rectum	50	61	65	50	62	65	45	54	59
Colon*	51	61	63	51	62	65	45	54	57
Rectum	48	62	67	48	62	67	44	55	65
Esophagus	5	13	22	6	14	23	4	9	16
Hodgkin lymphoma	72	84	89	72	85	90	70	82	88
Kidney & renal pelvis	50	62	79	50	62	79	49	62	77
Larynx	66	66	62	67	68	63	58	52	56
Leukemia	34	48	68	35	50	69	33	42	62
Liver & intrahepatic bile duct	3	7	22	3	7	21	2	4	21
Lung & bronchus	12	15	28	12	15	28	11	13	25
Melanoma of the skin	82	91	95	82	91	95	57 ^a	76 ^a	70
Myeloma	25	32	62	24	32	62	29	32	63
Non-Hodgkin lymphoma	47	56	74	47	57	76	49	49	70
Oral cavity & pharynx	53	58	69	54	60	71	36	38	57
Ovary	36	43	52	35	43	51	42	36	44
Pancreas	3	4	13	3	4	13	2	4	12
Prostate	68	97	98	69	97	99	61	94	97
Stomach	15	22	38	14	20	38	16	22	40
Testis	83	96	95	83	96	96	73 ^{a,c}	86 ^a	88
Thyroid	92	95	98	92	96	99	90	95	97
Urinary bladder	72	80	79	73	81	80	50	63	68
Uterine cervix	69	73	68	70	74	68	65	66	59
Uterine corpus	87	84	81	88	86	85	60	62	63

Rates are adjusted for normal life expectancy and based on cases diagnosed in the SEER 9 areas (1975-1977 and 1995-1997), with follow-up through 2018 and SEER 21 areas, excluding Illinois (2015-2021), with follow-up through 2022. Rates for White and Black people diagnosed during 2015-2021 are exclusive of Hispanic ethnicity. *Excludes appendix. ^aThe standard error is between 5 and 10 percentage points. ^bFrom 1978 to 1980.

Data source: Surveillance, Epidemiology, and End Results Program, National Cancer Institute, 2025. Available from seer.cancer.gov/explorer/ except historical data and colon (excluding appendix), which were calculated using SEER*Stat software.

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Cancer in Children and Adolescents

New cases and deaths: In 2026, an estimated 9,680 children (ages 0 to 14 years) and 5,660 adolescents (ages 15-19 years) will be diagnosed with cancer, and 1,090 children and 730 adolescents will die from the disease. Cancer is the leading disease-related cause of death among both children and adolescents. Including benign and borderline malignant brain tumors, the most common cancers in children and adolescents are leukemia (28% and 13%, respectively), brain tumors (27% and 22%), and lymphoma (11% and 19%).

Incidence trends: After increasing since at least 1975, the overall incidence rate in children declined slightly from 2015 through 2022 by 0.6% per year, while rates in adolescents continued to slowly increase by 0.9% per year.

Mortality trends: Since 1970, the cancer death rate has declined by 69% in children and by 58% in adolescents, largely due to high participation in clinical trials for leukemia and other common cancers, especially among children, which has led to improvements in treatment. However, progress lags for some rare cancers, and many survivors experience lifelong side effects. Over the past decade, the cancer death rate decreased by 1.3% per year in children, but appears to have stabilized in adolescents.

Risk factors: Cancers that occur during childhood or adolescence have few established risk factors and are thought to mostly be due to genetic mutations present at birth. Cancer risk is increased in children and adolescents with certain genetic disorders (e.g., Down syndrome, Li-Fraumeni syndrome, and Beckwith-Wiedemann syndrome) or a family history of certain childhood cancers (e.g., hereditary retinoblastoma). In addition, exposure to ionizing radiation, such as for

cancer treatment, increases the risk of leukemia, brain tumors, and possibly other cancers. Prior chemotherapy also increases the risk of leukemia. Solid organ transplant recipients are at increased risk for non-Hodgkin lymphoma because drugs taken to prevent organ rejection suppress the immune system. Infection with the Epstein-Barr virus is associated with certain types of non-Hodgkin lymphoma, such as Burkitt lymphoma.

Signs and symptoms: Many early signs and symptoms of childhood and adolescent cancer are nonspecific and resemble common childhood conditions, which can delay diagnosis. Parents or other caregivers should ensure regular medical checkups and remain alert to unusual, persistent symptoms, including an unusual mass or swelling; unexplained paleness or loss of energy; a sudden increase in the tendency to bruise or bleed; persistent, localized pain or limping; prolonged, unexplained fever or illness; frequent headaches, often with vomiting; sudden eye or vision changes; and excessive, rapid weight loss.

Following are more specific symptoms for the major categories of pediatric cancer, according to the International Classification of Childhood Cancer (ICCC):

- Leukemia may lead to bone and joint pain, fatigue, weakness, pale skin, bleeding or bruising easily, fever, or infection.
- Brain and other central nervous system tumors may cause headaches, nausea, vomiting, blurred or double vision, seizures, dizziness, and difficulty walking or handling objects.
- Lymphoma often causes swollen lymph nodes, which can appear as a lump in the neck, armpit, or groin; other symptoms can include fatigue, abdominal swelling or pain, weight loss, sweating (especially at night), and fever.
- Neuroblastoma, a cancer of immature nerve cells that is most common in children under 5 years, can develop anywhere but often appears as a swelling in the abdomen, sometimes accompanied by loss of appetite.
- Wilms tumor, also called nephroblastoma, is a type of kidney cancer that may appear as swelling

or a lump in the abdomen, sometimes with blood in the urine.

- Rhabdomyosarcoma is a type of soft tissue cancer that occurs in muscle tissue, most often in the head or neck, genitourinary area, or extremities, and may cause pain and/or a mass or swelling at the tumor site.
- Retinoblastoma, a type of eye cancer that usually occurs in children under 5 years, may cause vision problems and is often recognized because the pupil appears white or pink instead of the normal red color in flash photographs or during an eye examination.
- Osteosarcoma, a type of bone cancer that most often occurs in adolescents, commonly appears as sporadic pain in the affected bone that may worsen at night or with activity and eventually progresses to local swelling.
- Ewing sarcoma, another cancer usually arising in the bone in adolescents, typically appears as pain or swelling at the tumor site.
- Gonadal germ cell tumors in girls occur in the ovaries and can be difficult to detect because symptoms, such as abdominal pain, often do not appear until the tumor is advanced; in boys, these tumors occur in the testes and are often visible and may cause pain at an early stage.

Treatment: Treatment is based on the type and stage of cancer and is typically coordinated by a team of experts, including pediatric oncologists and nurses, social workers, psychologists, and others trained to assist young patients and their families. Outcomes are generally most successful when treatment is at a pediatric cancer center, where health care professionals specialize in caring for children with cancer. Adolescents may be treated in the pediatric or adult oncology setting depending on cancer type and preference, although outcomes appear to be better in a pediatric setting for some cancers (e.g., acute lymphocytic leukemia). If the child or adolescent is eligible, participation in a clinical trial, which usually compares a new treatment with the best available standard treatment, should be considered.

Table 8. Five-year Relative Survival Rates (%) by Stage at Diagnosis, US, 2015-2021

	All stages	Local	Regional	Distant		All stages	Local	Regional	Distant
Breast (female)	92	>99	87	33	Non-Hodgkin lymphoma	74	87	78	67
Colon & rectum*	65	91	74	15	Oral cavity & pharynx	69	88	69	37
Colon†	63	91	74	13	Ovary	52	92	71	32
Rectum	67	90	74	18	Pancreas	13	44	17	3
Esophagus	22	49	28	5	Prostate	98	>99	>99	38
Kidney & renal pelvis	79	93	76	19	Stomach	38	77	37	8
Larynx	62	79	49	35	Thyroid	98	>99	98	50
Liver‡	22	38	13	3	Urinary bladder*	79	73	41	9
Lung & bronchus	28	65	37	10	Uterine cervix	68	91	62	20
Melanoma of the skin	95	>99	76	35	Uterine corpus	81	95	70	19

Rates are adjusted for normal life expectancy and based on cases diagnosed in the SEER 21 areas, excluding Illinois, with follow-up through 2022.

*Excludes appendix. †Includes intrahepatic bile duct. ‡Rate for in situ carcinoma is 98%. Stage classification based on Combined Summary Stage. **Local:** invasive cancer confined entirely to the organ of origin. **Regional:** cancer that 1) has extended beyond the limits of the organ of origin directly into surrounding organs or tissues; 2) involves regional lymph nodes; or 3) has both regional extension and involvement of regional lymph nodes. **Distant:** cancer that has spread to parts of the body remote from the primary tumor either by direct extension or by discontinuous metastasis to distant organs, tissues, or via the lymphatic system to distant lymph nodes.

Data source: Surveillance, Epidemiology, and End Results (SEER) Program, National Cancer Institute, 2025.

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Survival: The 5-year relative survival rate for all cancers combined during 2015 to 2021 was 85% among children and 88% among adolescents, excluding benign and borderline malignant brain tumors, for which it was 98%. However, rates vary considerably depending on cancer type, patient age, and other factors, and are less than 10% for some rare brain tumors (e.g., diffuse intrinsic pontine glioma). The overall survival rate among adolescents is heavily influenced by high survival for thyroid cancer (>99%) and Hodgkin lymphoma (98%), masking lower survival than children for several cancers, including lymphoid (acute lymphocytic) leukemia (77% versus 92%) and Ewing sarcoma (68% versus 80%). See cancerstatisticscenter.cancer.org for more information.

Some treatment-related side effects may persist, or even begin long after treatment ends, including new cancers and impaired organ function (e.g., memory, heart, and fertility problems). The burden of these and other chronic health conditions among childhood cancer survivors is nearly double that of the general population by age 50. The Children's Oncology Group has developed guidelines for screening for and managing late effects in survivors of childhood cancer. See childrensoncologygroup.org/survivorshipguidelines for more information.

Colon and Rectum

New cases and deaths: In 2026, an estimated 108,860 cases of colon cancer and 49,990 cases of rectal cancer will be diagnosed in the US, and 55,230 people will die from these cancers (Table 1). (Accurate mortality data for colon versus rectal cancer are unavailable because of high misclassification, in part due to widespread use of "colon cancer" to refer to colon and rectal cancer in educational messaging because of cultural reluctance to use the word "rectum.") Alaska Native people have the highest colorectal cancer incidence and mortality in the world, 2 to 3 times the rates in any other racial or ethnic group in the US.

Incidence trends: Overall, colorectal cancer incidence has declined since the mid-1980s due to changing patterns in risk factors and the widespread uptake of screening that began around 2000 among adults ages 50 and older. From 2013 through 2022, the rate decreased by about 1% per year. However, trends differ by age because the risk of disease is rising among generations born since 1950; the rate increased by 2.9% per year in people younger than 50 years and by 0.4% per year in adults 50-64 during this time.

Mortality trends: Colorectal cancer mortality rates have dropped by 56%, from 29.1 (per 100,000) in 1970 to 12.7 in 2023, due to reductions in incidence, earlier detection through screening, and improvements in treatment; during the past decade, the death rate

declined by about 1.5% per year in both men and women. Similar to incidence, however, this progress is confined to older adults; mortality rates in individuals younger than 55 years have increased by about 1% per year since the mid-2000s.

Risk factors: More than half (54%) of colorectal cancers in the US are attributable to potentially modifiable risk factors, including excess body weight, physical inactivity, long-term cigarette smoking, heavy alcohol consumption, and dietary factors, such as high consumption of red or processed meats, and/or low intake of calcium, whole-grain, and/or fiber-rich foods. Non-modifiable factors that increase risk include a personal or family history of colorectal cancer or adenomatous polyps, certain inherited genetic disorders (e.g., Lynch syndrome), a personal history of chronic inflammatory bowel disease (ulcerative colitis or Crohn's disease), and type 2 diabetes. Regular long-term use of nonsteroidal anti-inflammatory drugs, such as aspirin, reduces risk, but can lead to serious adverse health effects, primarily gastrointestinal bleeding.

Prevention and early detection: In addition to reducing risk through previously noted lifestyle choices, screening can prevent colorectal cancer through the detection and removal of precancerous growths (polyps), and can also detect cancer at an early stage, when treatment is usually more successful. Regular screening with a stool test that is done in the convenience of home or a visual exam, like colonoscopy, reduces risk of colorectal cancer incidence and death. Importantly, all non-colonoscopy tests with a positive finding must be followed by a colonoscopy to complete the screening process. The American Cancer Society and the US Preventive Services Task Force recommend that individuals at average risk begin screening at age 45. See page 44 or visit cancer.org/cancer/types/colon-rectal-cancer/detection-diagnosis-staging/acs-recommendations.html for more information about the American Cancer Society colorectal cancer screening guidelines. People at increased risk because of family history or other reasons should talk with their doctor about whether screening before age 45 is appropriate.

Signs and symptoms: The most common signs and symptoms of colorectal cancer include rectal bleeding,

blood in the stool, changes in bowel habits (e.g., constipation or diarrhea) or stool shape (e.g., narrower than usual), the feeling that the bowel is not completely empty, abdominal cramping or pain, decreased appetite, and weight loss. Sometimes, especially among younger adults, colorectal cancer causes unnoticed blood loss that results in anemia (low red blood cell count) that may be detected on a blood test and/or because of symptoms, such as weakness, fatigue, or shortness of breath. The most common signs and symptoms in younger individuals are bright red blood in the stool (hematochezia), abdominal pain, and altered bowel habits.

Treatment: Surgery is the most common treatment for both colon and rectal cancer that has not spread to distant sites. When cancer has penetrated the bowel wall deeply or spread to lymph nodes, people with colon cancer typically receive chemotherapy after surgery, whereas people with rectal cancer may receive chemotherapy before (neoadjuvant) and/or after surgery, alone or in combination with radiation. Select people with rectal cancer with a complete response to neoadjuvant treatment may be offered a non-operative (organ-sparing) approach. For both colon and rectal cancer that has spread to other parts of the body (metastatic colorectal cancer), treatments typically include chemotherapy and/or targeted therapy, but may also include surgery. Immunotherapy is an option that can be highly effective for a select group of advanced cancers.

Survival: The 5-year relative survival rate for colorectal cancer is 65% overall but drops to 15% for distant-stage disease (Table 8). Only 1 in 3 cases is diagnosed at a localized stage, for which 5-year survival is 91%, because screening prevents colorectal cancer more often than it detects early disease.

See Colorectal Cancer Statistics, 2023 for more information.

Kidney and Renal Pelvis

New cases and deaths: In 2026, an estimated 80,450 new cases of kidney (renal) cancer will be diagnosed in the US and 15,160 people will die from the disease (Table 1). Most kidney cancers are renal cell carcinomas; other types include cancer of the renal pelvis (5%), which behaves more like bladder cancer, and Wilms

Figure 3. Leading Sites of New Cancer Cases and Deaths – 2026 Estimates

	Male				Female		
Estimated New Cases	Prostate	333,830	31%	 	Breast	321,910	32%
	Lung & bronchus	110,910	10%		Lung & bronchus	118,500	12%
	Colon & rectum	84,160	8%		Colon & rectum	74,690	7%
	Melanoma of the skin	65,400	6%		Uterine corpus	68,270	7%
	Urinary bladder	64,730	6%		Melanoma of the skin	46,600	5%
	Kidney & renal pelvis	50,770	5%		Non-Hodgkin lymphoma	35,550	3%
	Non-Hodgkin lymphoma	43,770	4%		Pancreas	32,340	3%
	Oral cavity & pharynx	43,070	4%		Thyroid	32,000	3%
	Leukemia	39,070	4%		Kidney & renal pelvis	29,680	3%
	Pancreas	35,190	3%		Leukemia	28,720	3%
	All sites	1,094,070			All sites	1,020,780	
Estimated Deaths				 			
	Lung & bronchus	63,040	19%		Lung & bronchus	61,950	21%
	Prostate	36,320	11%		Breast	42,140	14%
	Colon & rectum	30,110	9%		Pancreas	25,510	9%
	Pancreas	27,230	8%		Colon & rectum	25,120	8%
	Liver & intrahepatic bile duct	19,650	6%		Uterine corpus	14,450	5%
	Leukemia	13,900	4%		Ovary	12,450	4%
	Esophagus	12,940	4%		Liver & intrahepatic bile duct	11,330	4%
	Urinary bladder	12,640	4%		Leukemia	10,010	3%
	Non-Hodgkin lymphoma	11,710	4%		Brain & other nervous system	8,380	3%
	Kidney & renal pelvis	10,200	3%		Non-Hodgkin lymphoma	8,260	3%
	All sites	327,290			All sites	298,850	

Estimates are rounded to the nearest 10 and exclude basal cell and squamous cell skin cancers and in situ carcinoma except urinary bladder. Rank is based on modeled projections and may differ from observed data.

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tumor (1%), a childhood cancer that usually develops before the age of 5. (See Cancer in Children and Adolescents on page 11.) Men are twice as likely as women to be diagnosed with kidney cancer.

Incidence trends: A long-term increase in kidney cancer incidence is partly attributed to incidental detection of asymptomatic tumors through increased use of medical imaging; however, rates appear to have stabilized since 2019.

Mortality trends: In contrast to incidence, the kidney cancer death rate has been declining since the early 2000s, by about 1% per year.

Risk factors: Cigarette smoking, excess body weight, and physical inactivity account for half of kidney cancer cases in the United States. Chronic high blood pressure, chronic renal failure, and occupational exposure to certain chemicals, such as trichloroethylene, also increase risk. A small proportion of kidney cancers are the result of rare hereditary conditions (e.g., von Hippel-Lindau disease).

Signs and symptoms: Signs and symptoms of kidney cancer can include blood in the urine, pain or a lump in the lower back or abdomen, fatigue, weight loss, fever, and anemia.

Treatment: Surgery is the primary treatment for most kidney cancers, although active surveillance (observation) may be an option for some small tumors. Patients who are not surgical candidates may be offered ablation therapy, a procedure that uses extreme heat or cold to destroy the tumor. Adjuvant treatment (after surgery) with an immunotherapy drug may be an option for certain patients at high risk for cancer recurrence. For metastatic disease, immunotherapy and targeted drug therapies are the main treatment options, sometimes along with removal of the kidney.

Survival: The 5-year relative survival rate is 79% for cancer that develops in the kidney, but just 52% for tumors in the renal pelvis, partly because they are less likely to be diagnosed at a localized stage.

Leukemia

New cases and deaths: In 2026, an estimated 67,790 new cases of leukemia will be diagnosed in the US and 23,910 people will die from the disease (Table 1).

Leukemia is a cancer of the bone marrow and blood that is classified into four main groups based on cell type and rate of growth: acute lymphoblastic leukemia (ALL), acute myeloid leukemia (AML), chronic myeloid leukemia (CML), and chronic lymphocytic leukemia (CLL). Although CLL is included with leukemia in this report to enable description of trends over time, it is now recognized to be the same cancer as small lymphocytic lymphoma (SLL), a type of non-Hodgkin lymphoma with a slightly different presentation. These cancers are collectively referred to as CLL/SLL.

The most common types of leukemia are CLL (38%) and AML (31%) among adults (20 years and older) and ALL (76%) and AML (16%) among children and adolescents (ages 0 to 19 years). (See Cancer in Children and Adolescents on page 11.)

Incidence trends: From 2013 to 2022, the leukemia incidence rate increased in children by 0.6% per year, in adolescents by 1% per year, and in adults ages 20 and older by 0.3% per year, although trends vary by subtype.

Mortality trends: In contrast to incidence, leukemia mortality has declined since the mid-1970s in children and adolescents and since the mid-1990s in adults; from 2014 to 2023, the death rate decreased by about 2% per year in all three age groups, but with variation by subtype.

Risk factors: The risk of leukemia is higher among individuals exposed to high-level ionizing radiation, most commonly from prior cancer treatment. Some types of chemotherapy also increase risk. In addition, risk is higher in people with certain genetic abnormalities or inherited syndromes (e.g., Li-Fraumeni or Down syndrome) and in workers exposed to certain chemicals, such as benzene (e.g., during oil refining or rubber manufacturing). Cigarette smoking increases the risk of AML in adults, and there is growing evidence that parental smoking before and after childbirth may increase risk of childhood leukemia.

Signs and symptoms: Signs and symptoms of leukemia, which can appear suddenly for acute subtypes, may include fatigue, pale or lighter-colored skin, weight loss, repeated infections, fever, night sweats, bruising or bleeding easily, bone or joint pain, and swelling. Chronic leukemias typically progress slowly with few symptoms during early stages and are sometimes diagnosed because of abnormal blood cell counts.

Treatment: Chemotherapy, sometimes in combination with targeted drugs, is used to treat most acute leukemias. Several targeted therapies are effective for treating CML because they attack cells with the Philadelphia chromosome, which is the genetic abnormality that is the hallmark of the disease. Some of these drugs are also used to treat a type of ALL with a similar genetic defect. People with CLL that is not progressing or causing symptoms may not require treatment initially but should be closely monitored. More aggressive CLL is typically treated with targeted drugs and/or chemotherapy. Certain types of leukemia may be treated with high-dose chemotherapy followed by stem cell transplantation under appropriate conditions. Newer treatments that boost the body's immune system, such as chimeric antigen receptor (CAR) T-cell therapy, have shown much promise, even against some hard-to-treat leukemias.

Survival: Five-year relative survival is 68% for leukemia overall, but ranges from 71% for AML to 90% for ALL and 91% for CML among youth (ages 0 to 19 years) and from 30% for AML and 49% for ALL to 70% for CML and 89% for CLL among adults (20 years and older). Age-related differences partly reflect wide variation in cancer biology in children versus adults.

Liver

New cases and deaths: In 2026, an estimated 42,340 new cases of liver cancer will be diagnosed in the US and 30,980 people will die from the disease (Table 1). The most common types of liver cancer are hepatocellular carcinoma (HCC, 69%) and cholangiocarcinoma (intrahepatic bile duct cancer, 22%). Liver cancer incidence in men is 2.5 times that in women.

Incidence trends: Liver cancer incidence tripled over the past four decades and continues to increase by nearly 2% per year in women but has stabilized in men.

Mortality trends: Mirroring incidence, death rates continued to increase in women by 1% per year from 2014 to 2023 but began a downturn in men, decreasing by 1% per year from 2017 to 2023.

Risk factors: About 75% of liver cancers in the US are caused by potentially modifiable risk factors, such as excess body weight, chronic infection with hepatitis C virus (HCV) and/or hepatitis B virus (HBV), smoking, and heavy alcohol consumption (3 or more drinks per day). Risk is also increased in people with type 2 diabetes and nonalcoholic fatty liver disease and those who have chronic exposure to food contaminated with aflatoxin (toxins produced by fungi that grow on improperly stored nuts and grains). Low-dose aspirin is associated with reduced risk, although potential harmful side effects outweigh the benefits for most people.

Prevention: A vaccine that protects against HBV infection has long been recommended for infants and unvaccinated children, and 91% of adolescents were vaccinated in 2023. However, because most adults are unvaccinated, the Centers for Disease Control and Prevention (CDC) recommends a one-time HBV screening of adults 18 years and older, screening women during every pregnancy, and vaccination of all adults ages 19–59 years and high-risk adults >60 (e.g., those with a history of sexually transmitted infections, multiple sex partners, or HCV infection). Regular testing is also recommended for people at high risk. See [cdc.gov/hepatitis-b/hcp/diagnosis-testing/index.html](https://www.cdc.gov/hepatitis-b/hcp/diagnosis-testing/index.html) for more information about people at increased risk. There are similar screening and testing recommendations for HCV infection, for which there is no vaccine. Antiviral therapy can usually reduce the risk of cancer among people infected with HBV or HCV. Visit [cdc.gov/hepatitis](https://www.cdc.gov/hepatitis) for more information about viral hepatitis.

Early detection: Although screening for liver cancer is not recommended for most people, many professional societies recommend testing individuals at high risk (e.g., those with cirrhosis) with ultrasound, computerized tomography (CT), and/or blood tests.

Signs and symptoms: Symptoms, which do not usually appear until the cancer is advanced, can include abdominal pain and/or swelling, weight loss, nausea, loss of appetite, jaundice (a yellowish discoloration of

the skin and white areas of the eyes), and fever. Enlargement of the liver is a common physical sign.

Treatment: Early-stage liver cancer can sometimes be treated successfully with surgery to remove part of the liver (although few patients have enough healthy liver for this option) or liver transplantation. Other local treatments include tumor ablation (destruction), embolization (blocking blood flow), or radiation therapy. Some patients diagnosed at an advanced stage may be offered targeted drug therapies and/or immunotherapy.

Survival: The 5-year relative survival rate for liver cancer is 22%, up from 3% four decades ago (Table 7). Even for the 42% of people diagnosed with localized-stage disease, 5-year survival is only 38% (Table 8).

Lung and Bronchus

New cases and deaths: In 2026, an estimated 229,410 new cases of lung cancer will be diagnosed in the US and 124,990 people will die from the disease (Table 1). Most lung cancers are classified as either non-small cell lung cancer (NSCLC, 77%) or small cell lung cancer (SCLC, 13%).

Incidence trends: Lung cancer incidence has been declining since the mid-1980s in men, but only since the mid-2000s in women because of sex differences in historical patterns of smoking uptake and cessation; from 2013 to 2022, the rate declined by 3.0% per year in men and by 1.3% per year in women.

Mortality trends: Lung cancer mortality rates have declined by 62% since 1990 in men and by 38% since 2002 in women due to reductions in smoking along with recent advances in treatment for NSCLC and earlier detection. From 2014 to 2023, the death rate decreased by 4.7% per year in men and 3.5% per year in women.

Risk factors: Cigarette smoking is by far the most important risk factor, causing an estimated 86% of all lung cancers in the US, according to a recent study by American Cancer Society researchers (doi.org/10.3322/caac.21858). Risk increases with both quantity and duration of smoking. Cigar and pipe smoking also increases risk. (See Tobacco Use section, page 30, for more information.) Exposure to radon gas, which is released from soil and can accumulate in indoor air, is

the second-leading cause of lung cancer in the US. Other risk factors include exposure to secondhand smoke (2.7% of lung cancers, the equivalent of about 6,200 new cases in 2026), asbestos (particularly among people who smoke), and certain metals (chromium, cadmium, and arsenic), as well as some organic chemicals, radiation, air pollution, and diesel exhaust. Specific occupational exposures that increase risk include rubber manufacturing, paving, roofing, painting, and chimney sweeping.

Early detection: Screening with low-dose spiral computed tomography (LDCT) has been shown to reduce lung cancer mortality in people at high risk. The American Cancer Society recommends annual LDCT for generally healthy adults ages 50 to 80 years with a minimum 20 pack-year smoking history, regardless of the number of years since quitting for people who previously smoked. For more information about American Cancer Society lung cancer screening recommendations, see page 44.

Signs and symptoms: Symptoms usually do not appear until the cancer is advanced and include persistent cough, blood-streaked sputum, chest pain, a hoarse voice, worsening shortness of breath, and recurrent pneumonia or bronchitis.

Treatment: Treatment is based on the cancer subtype, as well as its stage and molecular characteristics. For early-stage NSCLC, surgery is the standard treatment for otherwise healthy individuals, sometimes with chemotherapy, targeted drugs, immunotherapy, and/or radiation therapy. Advanced-stage NSCLC is usually treated with chemotherapy, targeted drugs, and/or immunotherapy. Early-stage SCLC is usually treated with chemotherapy combined with radiation, followed by immunotherapy. Radiation to the brain (prophylactic cranial irradiation) is sometimes given in early-stage SCLC to reduce the risk of brain metastases. People with advanced SCLC are usually treated with chemotherapy and immunotherapy.

Survival: The 5-year relative survival rate for lung cancer is 28% overall, but 65% for the 28% of people who are diagnosed at a localized stage (Table 8).

Lymphoma

New cases and deaths: In 2026, an estimated 88,240 new cases of lymphoma will be diagnosed in the US and 21,070 people will die from the disease (Table 1). These cancers begin in immune system cells and can occur almost anywhere in the body. Lymphomas are broadly grouped as Hodgkin lymphoma (8,920 cases and 1,100 deaths in 2026) or non-Hodgkin lymphoma (NHL; 79,320 cases and 19,970 deaths in 2026), and are further classified based on characteristics such as cell-surface markers and anatomic site. (Although chronic lymphocytic leukemia is now recognized to be the same cancer as small lymphocytic lymphoma, a type of non-Hodgkin lymphoma, it is included with leukemia in this report to enable description of trends over time.)

Incidence trends: During 2013 to 2022, incidence rates declined by 0.6%-0.7% per year for both Hodgkin and non-Hodgkin lymphoma.

Mortality trends: The death rate has been declining since at least 1975 for Hodgkin lymphoma and since 1997 for NHL due to reductions in incidence, advances in treatment, and improved survival for human immunodeficiency virus (HIV)-associated lymphoma. From 2014 to 2023, the death rate decreased by about 2% per year for both Hodgkin and non-Hodgkin lymphoma.

Risk factors: Typical of most cancers, the overall risk of NHL increases with age. In contrast, Hodgkin lymphoma incidence peaks during adolescence/early adulthood and then again in later life. Most known risk factors for lymphoma are associated with severely altered immune function. For example, risk is elevated in people who receive immunosuppressants to prevent organ transplant rejection and those with certain autoimmune disorders (e.g., Sjögren syndrome, systemic lupus, and rheumatoid arthritis). Certain infectious agents (e.g., Epstein-Barr virus) increase the risk of some lymphoma subtypes directly, whereas others increase risk indirectly by weakening (e.g., HIV) or continuously activating the immune system (e.g., *Helicobacter pylori* and hepatitis C virus). Family history of lymphoma also increases risk.

Signs and symptoms: The most common symptoms of lymphoma are caused by swollen lymph nodes and

include lumps in the neck, underarm, or groin; chest pain; shortness of breath; abdominal fullness; and loss of appetite. Other symptoms can include itching, night sweats, fatigue, unexplained weight loss, and intermittent fever.

Treatment: NHL is usually treated with chemotherapy, although targeted drugs, immunotherapy, and/or radiation might also be part of treatment for some stages and subtypes. If NHL persists or recurs after standard treatment, stem cell transplantation may be an option. Newer therapies that help the body's immune system recognize and attack lymphoma cells (e.g., CAR T-cell therapy) have shown promising results for some hard-to-treat or recurrent lymphomas.

Hodgkin lymphoma is usually treated with chemotherapy and/or radiation therapy, depending on disease stage and cell type. If these treatments are ineffective, options may include stem cell transplantation and/or immunotherapy.

Survival: Overall, 5-year relative survival is 89% for Hodgkin lymphoma and 74% for NHL (Table 7), but varies widely by cancer subtype, stage, and age at diagnosis.

Oral Cavity and Pharynx

New cases and deaths: In 2026, an estimated 60,480 new cases of cancer of the oral cavity (mouth) and pharynx (throat) will be diagnosed in the US and 13,150 people will die from the disease (Table 1). Incidence rates are almost 3 times higher in men than in women. The distribution of oral cavity cancers has shifted because of changing patterns in risk factors (e.g., less smoking), with the proportion of cases occurring on the tongue or tonsils doubling from 1 in 4 during the late 1970s to 1 in 2 during 2018 to 2022.

Incidence trends: Incidence rates increased by 0.7% per year during 2013 to 2022, mostly driven by cancers associated with human papillomavirus (HPV) that occur in the oropharynx (the part of the throat behind the oral cavity that includes the back one-third of the tongue, soft palate, and tonsils), which increased by about 2% per year versus a decrease of 1% per year for other oral sites.

Mortality trends: After decades of decline, the mortality rate for cancers of the oral cavity and pharynx combined increased by 0.8% per year from 2009 through 2023, driven by an increase of about 2% per year in deaths from cancers of the tongue, tonsil, and oropharynx, most of which are associated with HPV.

Risk factors: Known risk factors include any form of tobacco use and alcohol consumption, with a 30-fold increased risk for individuals who both smoke and drink heavily. HPV infection of the mouth and throat, believed to be transmitted through sexual contact, also increases risk.

Prevention: In 2020, the FDA added oral cancer prevention as an indication for the HPV vaccine in addition to cervical cancer. Unfortunately, up-to-date immunization rates remain low in adolescents ages 13 to 17 years at 63% in 2024 (64% of females and 62% of males), although 79% of girls and 77% of boys have received at least one dose.

Signs and symptoms: Symptoms may include a sore in the throat or mouth that bleeds easily and does not heal; a persistent red or white patch, lump, or thickening in the throat or mouth; ear pain; a neck mass; or coughing up blood. Difficulty chewing, swallowing, or moving the tongue or jaw are often later symptoms.

Treatment: Treatment largely depends on the stage and location of the tumor and whether it tests positive for HPV (oropharyngeal cancer), but other factors can also be important. Surgery and/or radiation therapy are standard treatments; chemotherapy is often added for high-risk or advanced disease. Chemotherapy or targeted drug therapy may be combined with radiation as the initial treatment in some cases. Immunotherapy with or without chemotherapy is a newer option for advanced or recurrent cancer.

Survival: The 5-year relative survival rate for cancers of the oral cavity and pharynx is 69% overall but is much lower in Black people (57%) than in White people (71%, Table 7). Although this may partly reflect more HPV-associated cancers (which have better outcomes) in White people, the survival disparity persists regardless of tumor HPV status.

Ovary

New cases and deaths: In 2026, an estimated 21,010 new cases of ovarian cancer will be diagnosed in the US and 12,450 women will die from the disease (Table 1). Approximately 9 in 10 cases are epithelial ovarian cancer, most of which are high-grade serous tumors that are thought to originate in the fallopian tubes.

Incidence trends: Ovarian cancer incidence has declined over the past several decades, in part likely due to increased use of oral contraceptives (which decreases risk) and decreased use of menopausal hormone therapy (which increases risk). Although rates continue to decrease in women 65 years and older, they have stabilized in women younger than 65 years.

Mortality trends: Ovarian cancer mortality has decreased by 45% since 1976, with most of the progress occurring since the mid-2000s; from 2003 through 2023, the death rate declined by 2%-3% per year, reflecting both reduced incidence and improved treatment.

Risk factors: Other than age, the most important risk factor is a family history of breast or ovarian cancer, some of which is linked to genetic predisposition (e.g., BRCA1/2 mutations or Lynch syndrome), although these only account for 25% of cases. Other medical conditions and characteristics associated with increased risk include a personal history of breast cancer, endometriosis, or pelvic inflammatory disease, and taller adult height. Modifiable factors associated with increased risk include the use of estrogen-only menopausal hormone therapy, excess body weight (more rare subtypes), and cigarette smoking (mucinous, a rare subtype). Factors associated with lower risk include pregnancy/higher number of children, later age at menarche, earlier age at menopause, fallopian tube ligation or removal (salpingectomy), and use of hormonal contraceptives. Accumulating evidence suggests that frequent aspirin use is also associated with reduced risk, although it can cause serious adverse health effects. In 2024, talc was classified as "probably carcinogenic to humans" (Group 2A) by the International Agency for Research on Cancer based on "limited" evidence that it increases the risk of ovarian cancer; however, contamination of talc-

containing products with asbestos remains a major concern in this association.

Prevention: Some women at high risk because of a strong family history or inherited genetic mutations may consider preventive surgery to remove both ovaries and fallopian tubes (prophylactic bilateral salpingo-oophorectomy), which greatly reduces risk. Women at average risk who undergo pelvic surgery for other reasons (e.g., hysterectomy) may choose to reduce ovarian cancer risk by having their fallopian tubes removed (opportunistic salpingectomy).

Early detection: Currently, there are no recommended screening tests for ovarian cancer. Women who are at high risk because of inherited genetic mutations may be offered a thorough pelvic exam in combination with transvaginal ultrasound and a blood test for the CA125 tumor marker; however, this strategy has not been shown to reduce ovarian cancer mortality and is associated with serious harms, including surgery in many cases when no cancer is present (false-positive). The US Preventive Services Task Force recommends against screening asymptomatic average-risk women for ovarian cancer.

Signs and symptoms: Early ovarian cancer usually causes no obvious specific symptoms. However, some women experience persistent, nonspecific symptoms, such as back pain, bloating, pelvic or abdominal pain, difficulty eating or feeling full quickly, or urinary urgency or frequency in the months before diagnosis. Women who experience such symptoms daily for more than a few weeks should seek prompt medical evaluation. The most common sign of ovarian cancer is swelling of the abdomen caused by fluid accumulation (ascites) when the disease is advanced.

Treatment: Treatment includes surgery, and often chemotherapy and targeted therapy. Surgery usually involves the removal of both ovaries and fallopian tubes (bilateral salpingo-oophorectomy), the uterus (hysterectomy), and the omentum (fatty tissue attached to some of the organs in the abdomen), along with biopsies of the peritoneum (lining of the abdominal cavity). Additional abdominal organs may be removed in women with advanced disease, whereas only the

involved ovary and fallopian tube may be removed in younger women with very early-stage tumors who want to preserve fertility. The goals of surgery are to remove as much of the tumor as possible, referred to as debulking, and accurately stage the cancer. Some women with advanced disease may benefit from chemotherapy administered directly into the abdomen (intraperitoneal). Targeted drugs can sometimes be used after other treatments to slow growth of advanced cancers or as maintenance treatment to keep the cancer from recurring after chemotherapy.

Survival: Ovarian cancer is the most fatal gynecologic cancer; the 5-year relative survival rate is 52% overall, but ranges from 44% among Black women to 60% among Asian American/Pacific Islander women. For the 23% of women who are diagnosed with localized disease, the 5-year survival rate is 92% (Table 8), prompting continued efforts to develop an effective early-detection strategy.

Pancreas

New cases and deaths: In 2026, an estimated 67,530 new cases of pancreatic cancer will be diagnosed in the US and 52,740 people will die from the disease (Table 1). Most cases develop in the exocrine tissue of the pancreas, which makes enzymes to digest food. Endocrine tumors, commonly referred to as pancreatic neuroendocrine tumors (NETs), develop in hormone-producing cells and have a younger median age at diagnosis and usually much better prognosis.

Incidence trends: The incidence rate for pancreatic cancer has increased by about 1% per year since the late 1990s.

Mortality trends: The death rate for pancreatic cancer increased slowly by 0.3% per year since the mid-1990s, but appears to have stabilized in recent years.

Risk factors: People who smoke have about twice the risk of pancreatic cancer as those who have never smoked, and the use of smokeless tobacco also increases risk. Other risk factors include type 2 diabetes, excess body weight, a family history of pancreatic cancer, and a personal history of chronic pancreatitis, often caused by heavy alcohol

consumption, which may also increase risk. Risk is also elevated among people with certain genetic syndromes (e.g., Lynch syndrome) and inherited mutations (e.g., in *BRCA1* or *BRCA2* genes).

Early detection: Studies suggest that individuals at high risk for pancreatic cancer because of genetic predisposition or a strong family history can benefit from annual surveillance with endoscopic ultrasound and/or magnetic resonance imaging (MRI). The US Preventive Services Task Force recommends against screening asymptomatic average-risk individuals for pancreatic cancer.

Signs and symptoms: Signs and symptoms of pancreatic cancer, which usually do not appear until the disease is advanced, can include weight loss, abdominal pain that may radiate to the back, jaundice (yellowing of the skin and whites of the eyes), nausea, and vomiting.

Treatment: Surgery, radiation therapy, and chemotherapy are treatment options that may extend survival and/or relieve symptoms but seldom produce a cure. Fewer than 20% of patients are candidates for surgery because the cancer has usually spread beyond the pancreas at diagnosis. For those who do undergo surgery, postoperative treatment with chemotherapy (and sometimes radiation) may lower the risk of recurrence and might help people live longer. For advanced disease, chemotherapy, sometimes along with a targeted therapy drug, may be used; a small number of patients are eligible for immunotherapy.

Survival: The 5-year relative survival rate for pancreatic cancer is 13% overall, but just 8% for people diagnosed with exocrine tumors (92% of diagnoses) versus 72% for NETs. Even for the 17% of people diagnosed with localized pancreatic cancer, the 5-year survival rate is only 44% (Table 8).

Prostate

New cases and deaths: In 2026, an estimated 333,830 new cases of prostate cancer will be diagnosed in the US and 36,320 men will die from the disease (Figure 3). The incidence of prostate cancer is nearly 70% higher in Black men than in White men (Table 9).

Incidence trends: Historically, prostate cancer incidence rates largely reflected trends in localized-stage disease detected through screening with the prostate-specific antigen (PSA) test. However, PSA testing declined from 2008 to 2013 following the US Preventive Services Task Force recommendation against screening and has remained stable over the past decade while overall prostate cancer incidence rates increased by 3% per year from 2014 to 2022, with the steepest rise for advanced-stage disease.

Mortality trends: The prostate cancer death rate has declined by half, from a peak of 39.9 per 100,000 men in 1993 to 18.7 per 100,000 men in 2023, because of earlier detection through PSA testing and advances in treatment. However, the pace of decrease has slowed from 3.5% per year during 1993 to 2012 to 0.6% per year through 2023, perhaps in part reflecting the increase in advanced-stage diagnoses.

Risk factors: The only well-established risk factors for prostate cancer are increasing age, African ancestry, a family history of the disease, and certain inherited genetic conditions (e.g., Lynch syndrome and *BRCA1* and *BRCA2* mutations). Black men in the US and the Caribbean have the highest documented prostate cancer incidence rates in the world. Smoking and excess body weight may increase the risk of aggressive and/or fatal disease.

Early detection: No major medical organization presently endorses routine screening for men at average risk because of concerns about overdiagnosis (detecting disease that would never have caused symptoms or harm), especially given the potential for serious side effects associated with prostate cancer treatment. The American Cancer Society and the US Preventive Services Task Force recommend “shared decision-making,” whereby health care providers educate men about the benefits and harms of PSA screening and encourage personal choice. The American Cancer Society recommends that these conversations begin at age 50 for men at average risk of prostate cancer, at age 45 for Black men and those with a close relative diagnosed with prostate cancer before the age of 65, and at age 40 for men at even higher risk because of a stronger family history (several close relatives diagnosed at an early age)

or *BRCA* mutation. See page 44 for more information about the American Cancer Society prostate cancer screening guidelines.

Signs and symptoms: Early-stage prostate cancer usually causes no symptoms. More advanced disease shares symptoms with benign prostate conditions, including weak or interrupted urine flow; difficulty starting or stopping urination; frequent urination, especially at night; blood in the urine; or pain or burning with urination. Late-stage prostate cancer commonly spreads to the bones, which can cause pain in the hips, spine, ribs, or other areas.

Treatment: Recent changes in the grading system for prostate cancer, as well as newer genomic and imaging tests, have improved tumor characterization and disease management. Careful monitoring of disease (called active surveillance) instead of immediate treatment is appropriate for many patients, especially men who are diagnosed at an early stage, have less aggressive tumors, and are older. The main treatment options for early-stage disease include surgery, external beam radiation, and radioactive seed implants (brachytherapy). Focal therapies, in which only part of the prostate is treated, are also being studied. Hormone therapy may be used along with surgery or radiation in locally advanced cases. Treatment often reduces a man's quality of life due to temporary or long-term side effects or complications, such as urinary and erectile difficulties.

The main treatment options for late-stage prostate cancer include hormone therapy, chemotherapy, and/or radiation therapy. Hormone treatment may control advanced prostate cancer for long periods of time by shrinking the size or limiting the growth of the cancer, thus helping to relieve pain and other symptoms. In cases where prostate cancer has spread extensively or is no longer responding to hormone therapy, chemotherapy may be used. If the cancer has spread to the bones and is causing pain, a therapy called radium-223 may be offered. Targeted drugs (PARP inhibitors) can be used along with hormone therapy for men whose cancers have *BRCA* or other DNA repair gene mutations, and other types of drugs can be used to treat prostate cancer that has spread to the bones.

Survival: The 5-year relative survival rate approaches 100% for the overwhelming majority (84%) of men diagnosed with localized- or regional-stage prostate cancer but drops to 38% for those diagnosed with distant-stage disease (Table 8). The 10-year survival rate for all stages combined is 98%.

Skin

New cases and deaths: Skin cancer is the most commonly diagnosed cancer in the US. More than 5 million cases of the most common types – basal cell carcinoma and squamous cell carcinoma (i.e., keratinocyte carcinoma or KC) – are diagnosed each year, although the actual number is unknown because these cases are not required to be reported to cancer registries. Invasive melanoma accounts for only 1% of all skin cancer cases but the majority of deaths. In 2026, an estimated 112,000 new cases of invasive and 122,680 cases of in situ melanoma will be diagnosed in the US, while 8,510 people will die from the disease (Table 1). Incidence rates are higher in women than in men before age 50 years but much higher in men among older adults, reflecting age-related differences in occupational and recreational exposure to ultraviolet (UV) radiation in children and adults, including use of indoor tanning, as well as changes in detection practices.

Incidence trends: Incidence of invasive melanoma of the skin has increased steeply since the 1970s, although contemporary trends vary by age and sex. Over the past decade, rates among individuals younger than 50 years declined by about 1% per year in men and have stabilized in women, whereas rates in adults ages 50 and older continue to increase by 1.4% per year in men and 2.8% per year in women.

Mortality trends: Melanoma mortality decreased over the past decade by about 2% per year in women and 3% per year in men, largely because of major advances in the treatment of advanced disease.

Risk factors: Excess exposure to UV radiation from sunlight or indoor tanning increases risk for most types of skin cancer, especially among people with light skin color. A personal history of the disease and advanced age also increase risk. The risk of squamous cell carcinoma (SCC) is increased with a history of

actinic keratosis, which is a common skin precancer caused by chronic sun exposure. A weakened immune system increases risk of SCC and melanoma, with transplant patients at particular risk of aggressive SCC. Additional melanoma risk factors include a strong family history of the disease and the presence of atypical, large, or numerous (more than 50) moles.

Prevention: All people are at risk of developing skin cancer, regardless of race or ethnicity. Most skin cancer cases and deaths are caused by exposure to UV radiation and thus are potentially preventable. Exposure to intense UV radiation can be minimized by wearing protective clothing (e.g., long sleeves, a wide-brimmed hat, etc.) and sunglasses that block UV rays; avoiding the sun at peak hours; applying broad-spectrum sunscreen that has a sun protection factor (SPF) of at least 30; seeking shade; and not sunbathing or tanning indoors. Children and adolescents should be especially protected from excessive UV radiation exposure because severe sunburn and other intense exposure early in life may particularly increase melanoma risk. Communities can help prevent skin cancer through educational interventions in schools and by providing shade at schools, recreational sites, and occupational and other public settings. Additionally, for people at elevated risk, such as those with a high incidence of actinic keratosis or genetic susceptibility, there are new medicines available to help reduce skin cancer risk.

Early detection: The best way to detect skin cancer early is to be aware of new or changing skin spots or growths, particularly those that look unusual. Any new lesions or a progressive change in a lesion's appearance (size, shape, color, new bleeding, etc.) should be evaluated promptly by a clinician. Periodic skin examination, preferably monthly and with the help of a partner for areas that are hard to see, may help identify changes.

Signs and symptoms: Warning signs of all skin cancers include changes in the size, shape, or color of a mole or other skin lesion; the appearance of a new skin growth; or a sore that does not heal. Changes that progress over a month or more should be evaluated by a clinician. Basal cell carcinoma may appear as a growth that is flat, or as a small, raised pink or red translucent, shiny area that

may bleed following minor injury. Squamous cell carcinoma may appear as a growing lump, often with a rough surface, or as a flat, reddish patch that grows slowly. The ABCDE rule outlines warning signs of the most common type of melanoma: A is for asymmetry (one half of the mole does not match the other half); B is for border irregularity (the edges are ragged, notched, or blurred); C is for color (the pigmentation is not uniform); D is for diameter greater than 6 millimeters (about the size of a pencil eraser); and E is for evolution, meaning a change in the mole's appearance over time. Not all melanomas have these signs, so be alert for any new or changing skin growths or spots.

Treatment: Most cases of KC are cured by removing the lesion through minor surgery or other techniques (e.g., freezing). Radiation therapy and/or certain topical medications may also be used. For more advanced cancers (which are uncommon), immunotherapy or targeted drugs might be options. For melanoma, the primary tumor and surrounding normal tissue are surgically removed, and sometimes a nearby lymph node is biopsied to determine stage; if this node contains cancer, more extensive surgery may be needed. Melanomas with deep invasion or that have spread to lymph nodes may be treated with surgery, immunotherapy, targeted drug therapy, and/or radiation therapy. The treatment of advanced melanoma has changed greatly in recent years with the development of several immunotherapy and targeted drugs that can often be very effective. Traditional chemotherapy may be used but is usually much less effective than newer treatments.

Survival: Almost all cases of KC can be cured, especially if detected and treated early. Although melanoma is also highly curable when detected in its earliest stages, it is more likely than KC to spread to other parts of the body. The 5-year relative survival rate for melanoma overall is 95%, ranging from >99% for cases diagnosed at a localized stage to 35% for distant-stage disease (Table 8), up from 15% in the mid-2000s due to treatment breakthroughs.

Thyroid

New cases and deaths: In 2026, there will be an estimated 45,240 new cases of thyroid cancer diagnosed in the US and 2,320 people will die from the disease (Table 1). The incidence rate is almost 3 times higher in women than in men.

Incidence trends: Thyroid cancer incidence rates increased by 7% per year during the 2000s, largely because of incidental findings on imaging tests, but decreased by 1.4% per year from 2013 to 2022 after more conservative diagnostic criteria were implemented to reduce overdiagnosis.

Mortality trends: The mortality rate for thyroid cancer has remained stable at about 0.5 deaths per 100,000 since the mid-2000s.

Risk factors: Risk factors for thyroid cancer include being female; having a history of goiter (enlarged thyroid) or thyroid nodules; family history of thyroid cancer; radiation exposure early in life (e.g., during cancer treatment); excess body weight; and certain rare genetic syndromes, such as familial adenomatous polyposis (FAP). People who test positive for a mutation in the *RET* gene, which causes a hereditary form of thyroid cancer (familial medullary thyroid carcinoma), can lower their risk of disease by having the thyroid gland surgically removed.

Signs and symptoms: The most common symptom of thyroid cancer is a lump in the front of the neck that is noticed by a patient or felt by a clinician during an exam. Other symptoms can include a tight or full feeling in the neck, difficulty breathing or swallowing, hoarseness, swollen lymph nodes, and pain in the throat or neck that does not go away. Many thyroid cancers are diagnosed incidentally in people without symptoms when an abnormality is seen on an imaging test done for another reason.

Treatment: Most thyroid cancers are highly curable, but about 3% (medullary and anaplastic thyroid cancers) are more aggressive and likely to spread to other organs. Treatment depends on the patient's age, tumor size and cell type, and extent of disease. If the cancer has not spread to other parts of the body, surgery is usually

offered, such as a thyroid lobectomy (partial removal of thyroid) or total thyroidectomy, sometimes with removal of nearby lymph nodes. Radioactive iodine (I-131) treatment may be recommended after thyroidectomy for larger papillary or follicular tumors or when cancer has spread outside the thyroid to destroy any remaining thyroid tissue. Thyroid hormone replacement therapy is given after thyroidectomy to replace hormones normally made by the thyroid gland, and to lower the likelihood of recurrence by preventing the pituitary gland from producing excess thyroid-stimulating hormone. For some types of advanced thyroid cancer, targeted drugs or chemotherapy can be used to help shrink or slow tumor growth.

Survival: The 5-year relative survival rate for thyroid cancer overall is 98% (Table 8) because two-thirds of cases are diagnosed at a local stage and treatment is usually successful for the more common tumor types. Survival drops to 93% for medullary thyroid cancer and 10% for anaplastic cancer, a rare but highly aggressive subtype.

Urinary Bladder

New cases and deaths: In 2026, an estimated 84,530 new cases of bladder cancer will be diagnosed in the US and 17,870 people will die from the disease (Table 1). Bladder is the only cancer for which in situ disease (diagnosed before it has spread beyond the layer of cells where it developed) is included in the case estimate because of its high likelihood of progression and recurrence. The incidence of bladder cancer is 4 times higher in men than in women.

Incidence trends: Bladder cancer incidence decreased by about 1% per year in both men and women from 2013 through 2022.

Mortality trends: Bladder cancer mortality rates were stable from the 1990s until 2016 but have since declined by 1.4% per year.

Risk factors: Smoking is the most well-established risk factor for bladder cancer, accounting for half of all cases in the US (Figure 4). Risk is also increased among workers in the dye, rubber, leather, and aluminum industries; painters and firefighters; people who live in communities with high levels of arsenic in the

drinking water; and people with certain bladder birth defects or long-term urinary catheters.

Early detection: There is currently no screening method recommended for people at average risk. People at increased risk may be screened by examination of the bladder wall with a cystoscope (slender tube fitted with a camera lens and light that is inserted through the urethra), microscopic examination of cells from urine or bladder tissue, or biomarker tests.

Signs and symptoms: Bladder cancer is usually detected because of blood in the urine or other symptoms, including increased frequency or urgency of urination, or pain or irritation during urination.

Treatment: Surgery, alone or in combination with other treatments, is used in more than 90% of cases. Early-stage cancers may be treated by removing the tumor and then administering immunotherapy (BCG, or bacillus Calmette-Guérin) or chemotherapy drugs directly into the bladder (intravesical therapy). More advanced cancers may require removal of the entire bladder (cystectomy). Systemic treatments such as chemotherapy and immunotherapy might be given before or after surgery, especially in people with higher risk for recurrence. Distant-stage cancers are usually treated with immunotherapy combined with a targeted drug. Other treatment options include immunotherapy and/or chemotherapy. Timely follow-up care after treatment is extremely important for people who still have their bladder because of the high likelihood of cancer recurrence or a subsequent bladder cancer. Approximately 7 in 10 people living with metastatic bladder cancer were originally diagnosed with early-stage disease.

Survival: The 5-year relative survival rate for bladder cancer is 79%, largely because half of cases are diagnosed in situ (still within the layer of cells where it originated), for which 5-year survival is 98% (Table 8).

Uterine Cervix

New cases and deaths: In 2026, an estimated 13,490 cases of invasive cervical cancer will be diagnosed in the US and about 4,200 women will die from the disease (Table 1).

Incidence trends: Cervical cancer incidence rates were stable from 2013 to 2022 after decreasing by more than half from the mid-1970s to the mid-2000s because of widespread screening uptake. However, the rate in women 20-24 years has decreased by 11% per year since 2012, likely reflecting the first signs of cancer prevention from the human papillomavirus (HPV) vaccine.

Mortality trends: Cervical cancer mortality rates have also dropped by more than half since the mid-1970s because of prevention and early detection through screening, although the decline has slowed to 0.7% per year since 2003. The death rate in Black women and Native American women is 55% and 80% higher, respectively, than in White women (Table 9).

Risk factors: Almost all cervical cancers are caused by persistent infection with certain types of HPV. HPV infections are common in healthy people and usually resolve before becoming chronic, only rarely causing cancer. Individuals are at increased risk for HPV infection if they began having sex at an early age or if they or their partners have had many sexual partners, although infection can occur with only one sexual partner and in the absence of penetrative sex. Several factors increase the risk of both persistent HPV infection and progression to cancer, including a suppressed immune system, a high number of childbirths, and cigarette smoking. Long-term use of oral contraceptives is also associated with increased risk that gradually declines after cessation.

Prevention: The HPV vaccine protects against 90% of cervical cancers, as well as several other cancers and diseases, and evidence of reductions in the risk of cervical cancer among vaccinated women is rapidly accumulating. The American Cancer Society recommends routine HPV vaccination between ages 9 and 12, with catch-up vaccination for all persons through age 26 who are not adequately vaccinated. Unfortunately, the immunization rate remains low in the US compared to many other countries, with 64% of girls and 62% of boys ages 13 to 17 years up to date (receipt of 3 doses or 2 doses if the first is at age <15 years) with the series in 2024. See [cdc.gov/vaccines/vpd/hpv/hcp/recommendations.html](https://www.cdc.gov/vaccines/vpd/hpv/hcp/recommendations.html) for current CDC recommendations. HPV vaccination cannot protect

against established infections or all types of HPV, which is why it is important for all people with a cervix, including those who have been vaccinated, to follow cervical cancer screening guidelines.

Cervical cancer can also be prevented through screening, which usually detects precancerous lesions that can be treated. Cancer can usually be prevented through regular screening because most cervical precancers develop slowly. The HPV test detects the viral infection that precedes cancer occurrence and is more effective than the Pap test at preventing cervical cancer.

Early detection: Although the primary purpose of screening is to prevent cervical cancer, screening can also detect invasive cancer early, when treatment is usually less intensive and more likely to be successful. Half of those diagnosed with cervical cancer have never been screened, and most others are not up-to-date. The American Cancer Society guidelines indicate that the preferred method of cervical cancer screening is with a primary HPV test every 5 years for individuals ages 25 through 65 who have a cervix and are at average risk of cervical cancer; only certain HPV tests are approved by the FDA for use as a primary test. If a primary HPV test is unavailable, co-testing (HPV testing in combination with a Pap test) every 5 years or screening with a Pap test alone every 3 years is acceptable. Individuals ages 65 and older can stop screening if they have a 10-year history of regular screening with normal results and do not have a history of cervical precancer (cervical intraepithelial neoplasia) or a more serious diagnosis within the past 25 years. See page 44 for more information about the American Cancer Society cervical cancer screening guidelines.

Signs and symptoms: Preinvasive cervical lesions usually cause no symptoms. Once abnormal cells become cancerous and invade nearby tissue, the most common symptom is abnormal vaginal bleeding, which may start and stop between regular menstrual periods or cause menstrual bleeding to last longer or be heavier than usual. Bleeding may also occur after sexual intercourse, douching, a pelvic exam, or menopause. Increased vaginal discharge and pain during intercourse may also be signs.

Treatment: Precancerous cervical lesions may be treated with a loop electrosurgical excision procedure (LEEP), which removes abnormal tissue with a wire loop heated by electric current; cryotherapy (the destruction of cells by extreme cold); laser ablation (destruction of tissue using a laser beam); or conization (the removal of a cone-shaped piece of tissue containing the abnormal tissue). Early-stage invasive cervical cancers are generally treated with surgery and/or radiation, sometimes combined with chemotherapy. Minimally invasive surgery (laparoscopy) is not often used because it is associated with worse survival than open surgery. Chemotherapy, typically along with immunotherapy and/or a targeted therapy drug, is often used to treat advanced disease.

Survival: The 5-year relative survival rate for cervical cancer is 68% overall, but as low as 59% in Black women (Table 7) and 48% in women 65 years and older. For the 16% of women diagnosed with distant-stage disease, the 5-year relative survival rate is only 20%.

Uterine Corpus

New cases and deaths: In 2026, an estimated 68,270 cases of cancer of the uterine corpus (body of the uterus) will be diagnosed in the US and 14,450 women will die from the disease (Figure 3). Cancer of the uterine corpus is often referred to as endometrial cancer because more than 90% of cases occur in the endometrium (inner lining of the uterus).

Incidence trends: Incidence increased by 1.4% per year from the mid-2000s to 2019 but appears to have stabilized in recent years overall and in White women. However, rates in women of all other racial and ethnic groups continued to increase by 1.8% to 2.6% per year from 2013 to 2022.

Mortality trends: Cancer of the uterine corpus is one of the few cancers with increasing mortality; from 2014 to 2023, the death rate rose by 1.6% per year.

Risk factors: According to American Cancer Society research, an estimated 60% of uterine corpus cancers are attributable to excess body weight and insufficient physical activity and are thus potentially preventable. Overall excess body weight and abdominal fatness each substantially increase the risk of uterine cancer, partly

by increasing the amount of circulating estrogen, which is a strong risk factor. Other factors that increase estrogen exposure or contribute to a hormonal imbalance include the use of estrogen-only menopausal hormone therapy, late menopause, and a history of polycystic ovary syndrome. Medical conditions that increase risk include Lynch syndrome, type 2 diabetes, and tamoxifen use to treat/prevent breast cancer. Progestin-containing IUDs dramatically protect the endometrium in tamoxifen users and are associated with reduced uterine corpus cancer risk. Pregnancy, use of hormonal contraceptives, and continuous estrogen-plus-progestin menopausal hormone therapy are also associated with reduced risk.

Early detection: There are no recommended screening tests for women at average risk; however, most cases (68%) are diagnosed at an early stage because of irregular or postmenopausal bleeding. Women of every age are encouraged to report any unexpected bleeding or spotting to a clinician. The American Cancer Society recommends that women with known or suspected Lynch syndrome be offered annual screening with endometrial biopsy and/or transvaginal ultrasound beginning at age 35.

Signs and symptoms: The most common symptom is abnormal uterine bleeding or spotting, especially in postmenopausal women. Pain during urination or intercourse, pain in the pelvic area, and non-bloody vaginal discharge can also be symptoms.

Treatment: Early-stage uterine corpus cancers are treated with surgery (hysterectomy often with bilateral salpingo-oophorectomy) and may not require chemotherapy or radiation. Adjuvant chemotherapy and/or radiation are often used for advanced-stage or high-grade diseases. Hormone therapy, targeted therapy, and immunotherapy may also be options.

Survival: The 5-year relative survival rate for uterine corpus cancer is 81% overall, but ranges from 85% for White women to only 63% for Black women, one of the largest racial disparities in cancer (Table 7). This is partly because Black women are much less likely to be diagnosed with localized-stage disease (56% versus 71%) and more likely to have aggressive subtypes, although neither fully explains the survival gap.

Cancer Disparities

A critical component of the American Cancer Society's mission is the elimination of cancer disparities. Cancer disparities occur when health care access and quality of cancer prevention, screening, and treatment differ based on non-medical factors like skin color, sexual orientation, and social determinants of health. The social determinants of health refer to the conditions in which people are born, live, grow, and age. Inequalities in access to safe places to live and affordable, healthy food stem from long-standing policies that favor one group over others. These inequalities limit opportunities for education, wealth accumulation, and other avenues for advancement and create barriers to health.¹ Although race and ethnicity are social constructs that aggregate heterogeneous population groups, they are useful for examining the influence of injustice and discrimination on health disparities. This chapter highlights specific racial and ethnic disparities in cancer incidence and mortality shown in [Table 9](#).

African American and Black people

- Black men (along with American Indian/Alaska Native men) have the highest overall cancer mortality rate (204 deaths per 100,000), 14% higher than White men (178 deaths per 100,000).
- Prostate cancer mortality in Black men is approximately 2 to 4 times that of men in other racial and ethnic groups ([Table 9](#)).
- Breast cancer mortality in Black women is 37% higher than White women despite lower incidence, a disparity that has remained fairly consistent since the mid-2000s. See [Breast Cancer Statistics 2024](#) for more information about this disparity.

See [Cancer Statistics for African American and Black People, 2025](#) for more information.

American Indian and Alaska Native (AIAN) people

- AIAN people have the highest cancer incidence and mortality of any population group in [Table 9](#), partly because of the high rates in women.

- Incidence and mortality in AIAN people are approximately twice that in White people for cancers of the kidney, liver, stomach, and cervix, and 45% higher for colorectal cancer.
- High rates of colorectal cancer are partly driven by the extraordinary burden among Alaska Native people, who have the highest incidence and mortality in the world.²

See [Cancer Statistics for American Indian and Alaska Native Individuals, 2022](#) for more information.

Asian American, Native Hawaiian, and Other Pacific Islander (AANHPI) people

- Although AANHPI people have the lowest incidence and mortality for the most common cancers, rates are 30% higher for stomach cancer and double for liver cancer compared to those in White people ([Table 9](#)), with an even larger disparity for Native Hawaiian and other Pacific Islander people specifically.³
- Additionally, rates in [Table 9](#) mask large disparities within this heterogeneous population. For example, death rates for uterine corpus (endometrial) cancer among Native Hawaiian and other Pacific Islander women are about 3 times those of White women.³

See [Cancer Facts & Figures for Asian American, Native Hawaiian, & Other Pacific Islander People 2024-2026](#) for more information.

Hispanic and Latino people

- Compared to (non-Hispanic) White people, Hispanic people have lower incidence for the most common cancers, but approximately 40% higher incidence of cervical cancer and almost 2 times higher incidence of stomach and liver cancers, all of which are largely preventable.
- Like other broadly defined groups, rates for the aggregated Hispanic population mask substantial heterogeneity by country of origin and nativity. For example, overall cancer mortality

Table 9. Incidence and Mortality Rates for Selected Cancers by Race and Ethnicity, US

Incidence, 2018-2022	All races & ethnicities	White	Black	American Indian/ Alaska Native*	Asian American/ Pacific Islander	Hispanic/ Latino
All sites	460.6	482.2	467.7	497.8	311.2	369.8
Male	497.9	518.0	541.1	518.7	304.4	383.5
Female	436.0	458.4	418.2	488.8	321.5	368.3
Breast (female)	133.5	139.5	133.2	125.2	112.5	106.6
Colon & rectum^b	35.3	35.2	40.4	51.1	28.5	32.7
Male	40.5	40.2	48.1	58.5	33.5	38.4
Female	30.7	30.7	34.7	44.9	24.3	27.9
Kidney & renal pelvis	18.0	18.2	19.5	34.1	8.4	18.6
Male	24.3	24.7	26.7	45.1	11.8	24.1
Female	12.4	12.3	13.9	24.8	5.6	13.9
Liver & intrahepatic bile duct	8.9	7.7	10.1	18.7	11.4	14.1
Male	13.1	11.3	16.0	25.2	17.2	20.1
Female	5.2	4.4	5.5	13.2	6.7	8.9
Lung & bronchus	53.2	57.8	54.8	63.0	33.2	28.3
Male	59.0	62.6	68.6	66.8	39.7	33.0
Female	48.8	54.3	45.2	60.5	28.2	24.9
Prostate	122.3	118.4	198.9	100.6	66.6	95.5
Stomach	6.6	5.3	10.1	10.5	9.0	9.6
Male	8.5	7.2	12.9	13.6	11.6	11.4
Female	5.0	3.7	8.2	8.0	7.0	8.2
Uterine cervix^c	9.7	9.0	12.1	16.1	6.7	12.2
Uterine corpus^c	42.3	42.2	52.6	49.5	26.6	37.8
Mortality, 2019-2023						
All sites	145.4	151.2	166.5	176.0	93.1	106.0
Male	171.5	178.0	203.6	200.6	107.1	124.4
Female	126.3	131.2	143.7	159.9	83.1	93.2
Breast (female)	19.2	19.3	26.5	20.9	11.8	13.6
Colon & rectum	12.9	12.9	16.6	18.6	9.2	10.6
Male	15.3	15.2	21.0	21.9	10.9	13.2
Female	10.8	10.9	13.4	16.0	7.8	8.6
Kidney & renal pelvis	3.4	3.6	3.3	6.4	1.6	3.2
Male	5.1	5.3	4.9	9.3	2.4	4.7
Female	2.1	2.2	2.1	4.1	1.0	2.1
Liver & intrahepatic bile duct	6.6	6.0	7.7	12.5	8.0	8.9
Male	9.4	8.5	12.0	17.1	11.4	12.2
Female	4.3	3.9	4.6	8.8	5.2	6.1
Lung & bronchus	31.5	34.5	33.1	38.7	18.6	14.2
Male	37.2	39.6	44.5	43.2	23.4	18.7
Female	27.1	30.5	25.3	35.6	15.0	10.9
Prostate	19.2	18.4	36.9	20.5	8.8	15.4
Stomach	2.7	2.0	4.5	5.0	4.1	4.5
Male	3.5	2.8	6.4	6.6	5.2	5.4
Female	2.0	1.4	3.2	3.9	3.3	3.7
Uterine cervix^c	3.0	2.9	5.0	5.1	1.9	3.2
Uterine corpus^c	8.8	8.1	18.4	9.7	4.7	6.7

Rates are per 100,000 persons and age adjusted to the 2000 US standard population. Incidence is adjusted for delays in case reporting. All race groups are exclusive of Hispanic ethnicity. ^aTo reduce racial misclassification, incidence is limited to Purchased/Referred Care Delivery Area counties, and mortality is adjusted using factors published by the National Center for Health Statistics. ^bExcludes appendix. ^cAdjusted for hysterectomy prevalence. For more information about data methods, see Sources of Statistics, page 42.

Data sources: Incidence – North American Association of Central Cancer Registries, 2025. Mortality – National Center for Health Statistics, Centers for Disease Control and Prevention, 2025.

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among US-born Hispanic men is 15% higher than their foreign-born counterparts.⁴

See *Cancer Facts & Figures for Hispanic/Latino People 2024-2026* for more information.

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Cancer Risk Factors

Nearly half of cancer deaths in the US are attributable to potentially modifiable behavioral risk factors.¹ This section highlights the leading modifiable cancer risk factors (tobacco use, excess body weight, diet, physical activity, and alcohol consumption).¹ See *Cancer Prevention & Early Detection Facts & Figures, 2025-2026*, and Islami 2024 at doi.org/10.3322/caac.21858, for more information about the association between cancer and infectious agents.¹

Tobacco Use

Tobacco use remains the most preventable cause of cancer in the US.^{1,2} In 2023, about 49 million adults (20%) used a commercial tobacco product, including combustible products, e-cigarettes, and smokeless tobacco.³ Current smoking and use of other combustible tobacco products are especially high among persons who are Native American or are not heterosexual, have low socioeconomic status or a disability, live in a rural area, and who report serious psychological distress.^{4,6}

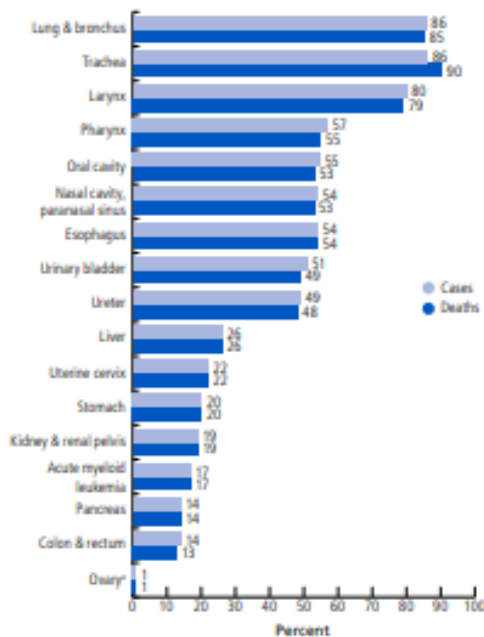
Cigarettes

- Cigarette smoking increases the risk of at least 12 cancers.⁷ More than 80% of lung and laryngeal cancers and 50% of esophagus, oral/nasal cavity, and urinary bladder cancers are caused by smoking (Figure 4).
- The prevalence of current cigarette smoking (ever smoked 100 cigarettes and currently smoke every day or some days) among US adults has declined from 42% in 1965 to 10% (25 million individuals) in 2024.^{8,9}
- Only 2% of US high school students smoked cigarettes in the past 30 days in 2024.⁹

Cigars

- Persons who regularly smoke cigars have an increased risk of cancers of the lung, oral cavity, larynx, and esophagus.¹⁰
- In 2024, 4% of adults (males: 7%, females: 1%) and 2% of high school students currently smoked cigars.^{8,9}

Figure 4. Proportion of Cancer Cases and Deaths Attributable to Cigarette Smoking in Adults 30 Years and Older, US, 2019



¹Limited to mucinous type.

²Data source: Islami F, et al. *CA Cancer J Clin* 2024.¹

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E-cigarettes

- In 2024, 8% of adults, 8% of high school students, and 4% of middle school students currently used e-cigarettes.^{8,9}

Smokeless Tobacco

- Smokeless tobacco is not a safe alternative to cigarettes, and causes oral, esophageal, and pancreatic cancers, as well as precancerous lesions in the mouth.¹¹
- In 2024, 3% of adults (males: 5%, females: <1%) and 2% of high school students used smokeless tobacco products.^{8,9}

- Nicotine pouches are an increasingly common form of smokeless tobacco among youth; current use ranges from 2% of high school students (males: 4%, females: 1%)⁹ to 12% of individuals ages 15-24 years.¹²

Secondhand Smoke

- Exposure to secondhand smoke (SHS), which can be measured by testing the blood for cotinine, a by-product of nicotine, causes more than 6,000 cases of lung cancer annually among former and never smokers.¹
- In 2017-March 2020 (the most recent years available), 20% of adults and 34% of youth ages 3-17 who did not smoke cigarettes were exposed to SHS.¹³
- SHS exposure among adults ranges from 17% in Hispanic persons to 34% in Black persons and from 16% in persons ≥200% of the federal poverty level to 32% in those below the federal poverty level.¹³

Tobacco Cessation

- In 2024, 65% (57 million) of adults who ever smoked ≥100 cigarettes had quit, up from 52% in 2009.^{1, 14}

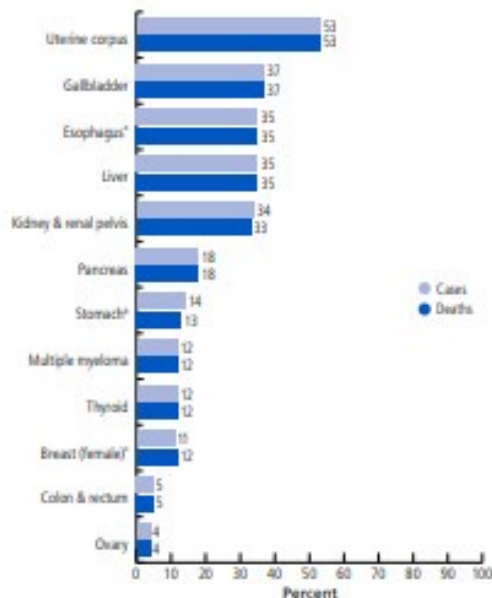
Nutrition and Physical Activity

Aside from avoiding tobacco use, maintaining a healthy body weight, being physically active, consuming a healthy diet, and avoiding or limiting alcohol intake are the most effective strategies for reducing cancer risk. Research has shown that adults who closely follow the American Cancer Society guideline on diet and physical activity (cancer.org/cancer/risk-prevention/diet-physical-activity/acs-guidelines-nutrition-physical-activity-cancer-prevention.html) are 10%-20% less likely to be diagnosed with cancer and 24%-30% less likely to die from the disease.^{15, 16}

Excess Body Weight

- Excess body weight (body mass index [BMI] ≥ 25 kg/m² for adults or BMI ≥85th percentile on CDC growth charts for youth) is associated with an increased risk of developing numerous cancers (Figure 5).¹ There is some evidence that excess body weight may also increase risk for cancers of the mouth, pharynx, larynx, and male breast, as well as fatal prostate cancer and a type of non-Hodgkin lymphoma (diffuse large B-cell lymphoma).^{17, 18}

Figure 5. Proportion of Cancer Cases and Deaths Attributable to Excess Body Weight in Adults 30 Years and Older, US, 2019



*Limited to adenocarcinomas. †Limited to cancers of the cardia. ‡Limited to postmenopausal cancers.

Data source: Islami F, et al. *CA Cancer J Clin* 2024.¹

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- The prevalence of excess body weight was 72% in adults (20+ years) and 36% in youth (2-19 years) in August 2021-August 2023.¹⁹
- Obesity (BMI ≥30 kg/m²) prevalence among adults ages 20+ years has increased from 23% in 1988-1994 to 40% in August 2021-August 2023, continuing a long-term increasing trend since 1960-1962 (ages 20-74 years: 13%).^{20, 21}
- Among youth ages 2-19 years, obesity prevalence (BMI ≥95th percentile) has more than quadrupled from 5% in 1971-1974 to 21% in August 2021-August 2023.^{21, 22}
- Severe obesity (BMI ≥40 kg/m²) among adults has increased more than 3-fold, rising from 3% during 1988-1994 to 10% during August 2021-August 2023.^{20, 21}

- Since 1971-1974, severe obesity (BMI $\geq 120\%$ of the 95th percentile) among youth has increased from 1% to 7% in August 2021-August 2023.^{21, 22}

Physical Activity

- Physical activity decreases the risk of cancers of the colon (but not rectum), female breast, endometrium, kidney, bladder, esophagus (adenocarcinoma), and stomach (cardia).²³
- In 2024, 48% of adults reported meeting recommended aerobic activity levels (150 minutes or more of moderate- or 75 minutes or more of vigorous-intensity activity per week), and 26% reported no leisure-time physical activity in the past week.³
- In 2023, only 25% of US high school students (males: 32%, females: 17%) engaged in the recommended minimum of 60 minutes of daily physical activity per week.^{24, 25}

Diet

- Unhealthy diet (low consumption of fruit, vegetables, and dietary fiber and calcium, and high consumption of red and/or processed meat) is associated with increased risk of cancer in the colorectum, oral cavity, esophagus, pharynx, and larynx.¹
- A median of 28% and 13% of adults reported eating ≥ 2 servings of fruit and ≥ 3 servings of vegetables per day, respectively, in 2021.⁵
- A median of 23% and 11% of high school students reported eating ≥ 2 servings of fruit and ≥ 3 servings of vegetables per day, respectively, in 2023.²⁴

Alcohol

- Alcohol consumption increases risk for cancers of the oral cavity, pharynx, larynx, esophagus (squamous cell carcinoma), liver (hepatocellular carcinoma), colorectum, and female breast.²⁶
- In 2024, 69% of adults reported current drinking (≥ 1 drink in the past year) and 6% reported heavy drinking (>14 drinks/week in the past year for males or >7 drinks/week in the past year for females).³

- In 2023, 22% of high school students reported current (past 30 days) use of alcohol, with higher levels among females (24%) than males (20%).^{24, 27}

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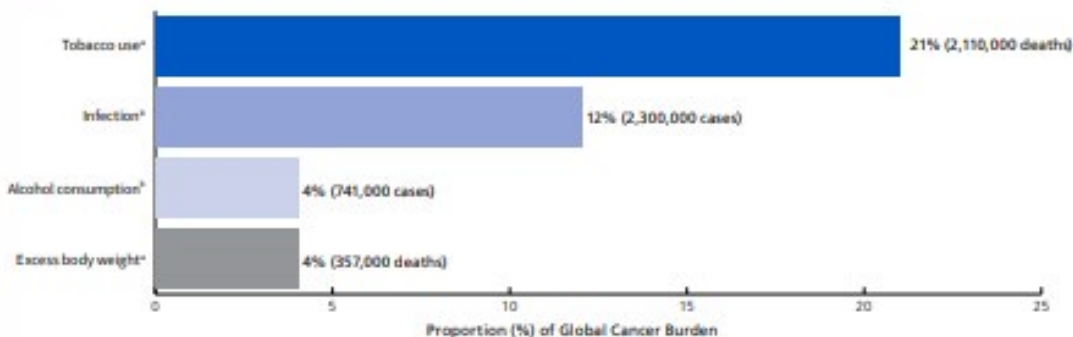
The Global Cancer Burden

An estimated 20 million new cancer cases and 9.7 million cancer deaths occurred globally in 2022, with cases expected to reach 35 million by 2050 solely based on projected population aging and growth. Lung cancer is the most commonly diagnosed cancer and the leading cause of cancer death worldwide, accounting for nearly 2.5 million cases and 1.8 million deaths (1 in 5) in 2022.¹ Cancer mortality rates are disproportionately high in low-income countries because of limited access to prevention, early detection, and adequate treatment. For example, the breast cancer death rate among women in Ethiopia is twice as high as in the US, despite 60% lower incidence.

- Up to half of all cancers worldwide are attributable to modifiable risk factors.²
- Tobacco use is the leading avoidable cause of cancer mortality worldwide, accounting for 21% of total cancer deaths and as many as 39% among men in the Western Pacific, largely reflecting the high prevalence of smoking.³

- Approximately 80% of the world's 1.3 billion tobacco users live in lower- and middle-income countries in Asia, Africa, Latin America, and Eastern Europe, where tobacco control efforts are limited.
- Infections cause about 12% of cancers globally and up to 26% in sub-Saharan Africa. East Asia has the highest number of infection-associated cancers because of the large population and the high prevalence of *Helicobacter pylori* (stomach cancer) and hepatitis B virus infection (HBV, liver cancer). Most infection-associated cancers are preventable through vaccination (human papillomavirus [HPV] and HBV), screening (HPV), treatment (*Helicobacter pylori* and hepatitis C virus), and behavioral changes.
- Excess body weight accounts for about 4% of all cancer deaths globally and 7% in North America and Europe.³
- Alcohol consumption causes about 4% of cancers globally and 6% in Eastern Asia and Central/Eastern Europe.⁴

Figure 6. Proportion and Number of Cancer Cases or Deaths Worldwide Attributable to Select Modifiable Risk Factors, 2020-2021



^aDerived from 2021 cancer mortality estimates. ^bDerived from 2020 cancer incidence estimates.

Data sources: Tobacco and Excess Body Weight: Global Burden of Disease Study 2021 (<https://vizhub.healthdata.org/gbd-results/>); Cancers attributable to infections: Global Cancer Observatory (<https://gco.iarc.who.int/causes/infections/>); Cancers attributable to alcohol: Global Cancer Observatory (<https://gco.iarc.who.int/causes/alcohol/>).

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The Role of the American Cancer Society

The American Cancer Society is uniquely positioned to help save lives from cancer globally by empowering health professionals, health institutions, and cancer organizations in low- and middle-income countries (LMICs) to implement evidence-based cancer control practices.

Increase demand and uptake of cancer prevention and screening services. Through the [Global HPV Cancer Free Initiative](#), the American Cancer Society partners with local social and behavioral experts and civil society organizations to co-develop evidence-based messages, interventions, and implementation strategies to increase the demand and uptake of HPV vaccination and cervical cancer screening in select LMICs. In each country, the initiative supports relevant systems, including national medical societies, ministries of health at national and local levels, and health insurers, with a focus on elevating local voices. Actionable tools and resources for these partners, as well as others around the world, are now available at PreventGlobalHPVCancers.org. As co-chair of [Cervical Cancer Action for Elimination](#), the American Cancer Society convenes, partners with, and mobilizes civil society organizations to share outcomes, tools, and strategies at a global level, expanding impact

and promoting promising practices in cervical cancer prevention.

Improve global patient support. Through the [Building Expertise, Advocacy, and Capacity for Oncology Navigation \(BEACON\) Initiative](#), the American Cancer Society supports health institutions and cancer organizations in LMICs to implement sustainable cancer patient navigation programs to overcome barriers to care. Supported by a global virtual community, the American Cancer Society's dynamic and self-service global oncology navigation toolkit helps stakeholders deliver patient-centered care through patient navigation programs tailored to local needs and resources. The BEACON initiative supports 42 community participating organizations across 25 countries.

The [Supporting Patient Navigation Adoption, Replication, and Knowledge \(SPARK\) Exchange](#), an extension of BEACON, seeks to advance patient navigation by using BEACON resources to drive policy and practice changes within a country. The initiative supports national leaders in identifying and addressing policy gaps and helps health institutions and cancer organizations design and implement effective, sustainable patient navigation programs tailored to their country's needs. The Global Patient Support team will co-design and implement SPARK with stakeholders in Indonesia, Kenya, and

Nigeria from 2025-2030 to create a replicable process for other LMICs interested in integrating patient navigation within their cancer care delivery system.

Organized by the American Cancer Society in 2024, the [Global Alliance for Cancer Patient Navigation](#) aims to unite stakeholders around sustainable patient navigation standards across the cancer care continuum in diverse, non-US settings. The Alliance currently includes representatives from all 6 continents, encompassing both high-income and low- and middle-income countries.

Our [Enabling Quality Interactions between Providers and Patients through Education Delivery \(EQUIPPED\)](#) Initiative helps health institutions and cancer organizations in LMICs train staff to deliver high-quality cancer education to patients and their caregivers. The initiative includes the dissemination of a suite of Cancer Education Materials for Patients and Caregivers (CEMPC) in various languages, including Arabic, French, Indonesian, Portuguese, and Spanish, as well as training curricula to develop patient-centered communication skills among health care providers.

Support providers and develop regional guidelines.

The American Cancer Society supports providers and health care systems to improve the quality of care for patients. In LMICs, we develop resource-appropriate training and toolkits for providers, policymakers, and hospital administrators that can be easily integrated into sustainable, routine practices.

Our [Treat the Pain Initiative](#) integrates cancer pain management into routine services by educating staff, raising awareness, documenting pain, and using an iterative, quality-improvement approach. Similarly, the [ChemoSafe Project](#) supports African Health Ministries

and cancer treatment centers in enhancing chemotherapy safety through the implementation of safety standards and training. The ChemoSafe facility assessment app aids hospitals and ministries of health in conducting baseline assessments and action plans to improve safety practices across all chemotherapy settings. These programs have been implemented in 15 African countries, nine of which have conducted national implementation strategies, allowing expansion to most of their hospitals providing cancer treatment.

Through our partnership with the [African Cancer Coalition](#) (ACC), and the [National Comprehensive Cancer Network](#), the American Cancer Society has collaborated on the creation of 55 cancer treatment guidelines for sub-Saharan African countries, covering more than 90% of the region's people with cancer. This work has fostered the growth of ACC, which now includes more than 250 oncologists from 19 countries. The American Cancer Society provides administrative and programmatic support to the ACC to continue this forward momentum in scaling impactful cancer care in the region.

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The American Cancer Society

The American Cancer Society is a leading cancer-fighting organization with a vision of ending cancer as we know it, for everyone. We are improving the lives of people with cancer and their families as the only organization combating cancer through advocacy, research, and patient support, and ensuring that everyone has an opportunity to prevent, detect, treat, and survive cancer.

Patient Support

The American Cancer Society works to ensure that no one has to feel alone at any point on their cancer journey. In 2024 alone, our patient support programs and services touched more than 111 million lives. Following are just some of the services the American Cancer Society offers.

Cancer Helpline. Cancer helpline specialists at our National Cancer Information Center are available 24/7 to answer questions about cancer and connect people with resources to help meet needs that emerge throughout the cancer journey. Services are provided in English, Spanish, and more than 200 other languages via our toll-free helpline (1-800-227-2345).

Online live chat sessions are also available in English on weekdays. Our cancer helpline addressed over 256,000 support inquiries in 2024. Visit cancer.org/about-us/online-help/contact-us to learn more.

Cancer.org and patient education materials. Our website, cancer.org, and educational materials offer evidence-based, understandable, and actionable health information curated by oncology physicians and nurses. In 2024, cancer.org content engaged more than 60 million viewers. Resources for people living in the US who speak languages other than English are available at cancer.org/cancer-information-in-other-languages. Visit cancer.org/materials to order patient education print materials. We also publish books to help people navigate their cancer journey at cancer.org/bookstore.

Scientific journals. The American Cancer Society publishes three peer-reviewed scientific journals for health care professionals and researchers: *Cancer*, *Cancer Cytopathology*, and *CA: A Cancer Journal for Clinicians*. Visit cancer.org/health-care-professionals/acs-publications to learn more.

ACS ACTS™ (Access to Clinical Trials & Support).

Our new comprehensive clinical trial matching service helps patients explore and connect with clinical trial options suited to their needs, while also offering wraparound services to overcome barriers such as lodging and transportation. Visit acts.cancer.org to learn more.

ACS CancerRisk360™. This platform asks users a series of questions about their genetics and family history, lifestyle habits, and screening to provide personalized recommendations about how to help reduce their risk of cancer and improve overall health. Visit acscancerrisk360.cancer.org to learn more and take the assessment.

ACS CARES™. ACS CARES (Community Access to Resources, Education, and Support) is a navigation support program designed to equip people facing cancer with curated content, programs, and services to fit their specific cancer journey. Patients can access the tool via a digital app on their mobile device or in person at 16 ACS CARES pilot sites. Visit cancer.org/acscares to learn more.

ACS LION™. ACS LION (Leadership in Oncology Navigation) provides nonclinical navigation training, credentialing, and implementation support to expand equitable access to high-quality, sustainable navigation. The program meets the Centers for Medicare & Medicaid Services' (CMS) training requirements for Principal Illness Navigation reimbursement and is aligned to the oncology navigation standards of professional practice. Visit cancer.org/lion to learn more.

Cancer Survivors Network™. The Cancer Survivors Network (CSN, csn.cancer.org) is a safe online community where patients, survivors, and caregivers support each other, ask questions, and share practical tips. CSN had approximately 742,500 users in 2024.

EverYou™. The EverYou program offers a curated selection of products for people coping with breast cancer, including wigs, hats, scarves, and other care products to help people keep feeling like themselves during and after treatment. Visit EverYou.com to learn more.

Hope Lodge®. American Cancer Society Hope Lodge communities provide free, temporary lodging for people facing cancer and their caregivers when treatment is far from home. The communities provided 547,091 nights of lodging in 2024. Visit cancer.org/hopelodge to learn more.

ACS EMPOWER. This educational program was created by the American Cancer Society to offer holistic well-being, community connection, patient navigation, and emotional support to Hope Lodge guests, as well as people in the local community with cancer and their caregivers. Visit cancer.org/support-programs-and-services/acs-empower to learn more.

Road To Recovery®. Volunteer drivers donate their time and the use of their vehicles to take people with cancer who do not have transportation to and from lifesaving treatment. The program provided 71,534 rides in 2024. Visit cancer.org/roadtorecovery to learn more.

Transportation and lodging grants. The American Cancer Society awards funds to health systems or health system foundations to provide direct assistance to people with cancer who need transportation to cancer-related appointments or temporary lodging near treatment centers. The grant program puts access to care solutions in the hands of the health care system to meet the specific needs of their patients, allowing them to provide individualized support. These grants provided transportation and lodging to 68,726 and 6,876 individuals, respectively, in 2024.

Addressing Barriers to Care (ABC) grants. The American Cancer Society is committed to addressing social drivers of health (SDoH) barriers to cancer care, both directly through programs and services and indirectly through grants and partnerships. We launched the ABC grant program in 2024 to better understand and address SDoH barriers to cancer care using a comprehensive and grassroots approach. These grants provided services to over 2,000 people in 2024.

Navigation Capacity-building Initiative Grant

Program. The American Cancer Society has awarded multiyear grants for patient navigation programs to 20 health systems that are part of a multi-institutional learning community convened to provide a platform

for grantees to share navigation best practices and lessons learned, and access training and expertise.

Support for caregivers. The American Cancer Society is committed to meeting the information, education, and support needs of the millions of people who are caregivers for people with cancer. Our [Caregiver Resource Guide](#) helps caregivers better understand what their loved one is going through, develop skills for coping and caring, and practice self-care to help protect their own health and well-being. The [Caregiver Support Video Series](#) educates caregivers in the everyday needs of people with cancer and also provides self-care techniques to improve their own quality of health.

Partners Engaged

The American Cancer Society unites organizations in collaborative partnerships through our mission-critical national roundtables and other coalitions to improve cancer outcomes for all people. Key leaders and partners from more than 3,790 organizations joined with us in 2024 to share resources and expertise to drive progress on cancer priorities. Below are just a few of these partnerships.

National roundtables. The American Cancer Society established our first roundtable, the American Cancer Society National Colorectal Cancer Roundtable, in 1997 in partnership with the Centers for Disease Control and Prevention (CDC). This was followed by national roundtables focused on HPV vaccination (2014), patient navigation (2017), lung cancer (2017), breast cancer (2022), cervical cancer (2022), and prostate cancer (2024). Visit cancer.org/about-us/our-partners/american-cancer-society-roundtables to learn more.

Cancer control coalitions. Since 1998, the American Cancer Society has partnered with the CDC's [National Comprehensive Cancer Control Program](#) to provide training and technical assistance to 65 coalitions. These cancer control coalitions regularly convene state-level partners from across the continuum in all 50 states, the District of Columbia, seven US Pacific Island jurisdictions and Puerto Rico, and seven tribes and tribal organizations. In addition to providing subject-matter expertise, the American Cancer Society is a founding member of the Comprehensive Cancer

Control (CCC) National Partnership, a collaborative group of diverse organizations that work together to build and strengthen CCC efforts across the nation.

Project ECHO®. Project ECHO (Extension for Community Healthcare Outcomes) is a learning framework that reaches across disciplines for sustainable and profound change. ECHO participants engage in a virtual community with their peers and subject-matter experts where they share support, guidance, and feedback to foster collective understanding of how to disseminate and implement best practices. The American Cancer Society serves as one of 39 Superhubs around the world that is authorized to recruit, train, and support new cancer-related partners. Visit echo.cancer.org/echo-programs to learn more.

Regional cancer support. American Cancer Society regional cancer support teams establish state and local partnerships to amplify initiatives across the cancer care continuum and extend our reach in communities. Regional teams partner with cancer treatment centers, community clinics, community-based organizations, state coalitions, and federally qualified health centers to reduce barriers in access to high-quality cancer early detection and treatment for members of the community.

Advocacy

Saving lives from cancer is as much a matter of public policy as scientific discovery. The American Cancer Society Cancer Action Network™ (ACS CAN) is the American Cancer Society's nonprofit, nonpartisan advocacy affiliate that makes evidence-based policies to reduce the cancer burden for everyone a top priority for public officials and candidates at the federal, state, and local levels. Since 2001, ACS CAN has successfully advocated for billions of dollars in cancer research funding, expanded access to quality health care, and advanced proven tobacco control measures.

The organization's recent advocacy work is highlighted in the following sections and described in more detail at fightcancer.org/what-we-do. Descriptions of federal laws and guidance were current as of June 2025 and do not reflect any potential changes to health care being considered by Congress, the administration, or the courts.

Access to Health Care

ACS CAN advocates to improve access to [affordable health care coverage](#), which includes:

- Ensuring access to quality, affordable health insurance that provides comprehensive benefits for the full continuum of care from early detection to treatment through survivorship
- Improving access to and affordability of prescription drugs
- Curbing the availability of inadequate health insurance plans
- Eliminating out-of-pocket costs for key cancer prevention and early-detection services
- Expanding eligibility for Medicaid programs and marketplace subsidies
- Advocating for coverage for all comprehensive biomarker testing in state-regulated insurance plans (including Medicaid; fightcancer.org/policy-resources)
- Urging policymakers to invest federal and state funding for colorectal, prostate, and breast cancer control programs

Specific policies that ACS CAN supports include:

- **Prostate-specific Antigen Screening for High-risk Insured Men (PSA Screening for HIM) Act:** Ensures those at high risk for prostate cancer, especially Black and African American men, have access to no-cost screenings.
- **Medicare Multi-Cancer Early Detection (MCED) Screening Coverage Act:** Creates a pathway for Medicare to consider covering new cancer early-detection blood tests once they are approved by the Food and Drug Administration and clinical benefit has been shown.
- **Screening for Communities to Receive Early and Equitable Needed Services (SCREENS) for Cancer Act:** Would reauthorize the National Breast and Cervical Cancer Early Detection Program and enable the program to have greater flexibility in providing access to lifesaving screening, as well as diagnostic and treatment services for breast and cervical cancers.

- **Access to Breast Cancer Diagnosis (ABCD) Act:** Bipartisan legislation to make breast cancer diagnostic tests and supplemental breast examinations more affordable and accessible to women by eliminating copays and additional out-of-pocket expenses.

Research Funding and Drug Development

ACS CAN is a leader in the effort to ensure full funding for the nation's public cancer research institutions, including:

- Supporting robust funding for cancer research at the National Institutes of Health (NIH), the National Cancer Institute (NCI), the Advanced Research Project Agency for Health (ARPA-H), and the Centers for Disease Control and Prevention's (CDC) cancer programs
- Opposing funding cuts and structural changes that jeopardize progress. Over the past several years, ACS CAN's advocacy played a key role in securing significant increases in FY24 cancer research and program funding, including a \$300 million increase to the NIH base budget, of which \$120 million was allocated to the NCI. Also, \$12.5 million in first-time dedicated funding for the development of palliative care research and a new \$6 million Improving Native American Cancer Outcomes initiative, which supports research, education outreach and clinical access related to cancer in American Indian and Alaska Native communities. Visit fightcancer.org/releases/congress-considers-fy24-appropriations-bill-prioritizes-cancer-research-and-proven-cancer to learn more.
- Supporting the **Clinical Trial Modernization Act**, which is bipartisan legislation aimed at reducing financial and geographic barriers that prevent many patients – especially those from underserved communities – from participating in clinical trials.
- Advocating for the prevention of **shortages of critical medicines**, which would ensure a stable supply of essential drugs, including pediatric drugs.

Cancer Prevention

ACS CAN is supporting local, state, and federal policies to help end cancer as we know it, for everyone.

Tobacco Control. ACS CAN is pursuing fact-based **tobacco control policies** that aim to reduce disparities and improve health outcomes for everyone, including:

- Increasing and protecting federal and state funding for tobacco control programs
- **Increasing the price of tobacco products**
- Increasing access to state Medicaid coverage of tobacco cessation programs
- Passing comprehensive **smoke-free laws** requiring all workplaces, including restaurants, bars, and gaming facilities, to be smoke-free
- Ensuring federal regulation of all tobacco products and industry marketing

Healthy Eating and Active Living. ACS CAN supports policies aimed at addressing **food and nutrition insecurity**, which has a direct impact on preventing, managing, and treating chronic diseases like cancer. By advocating for evidence-based national standards for child nutrition programs and increased access to free school meals, the organization supports food security programs, such as the Supplemental Nutrition Assistance Program (SNAP), the Food Distribution Program on Indian Reservations (FDPIR), and the Nutrition Assistance Program (NAP), to help people with limited incomes and disabilities access quality food. ACS CAN also supports policies and funding that increase access to **Food is Medicine (FIM)**, which is made up of initiatives and interventions intended to prevent, treat, or manage chronic diseases through addressing food and nutrition insecurity.

Quality of Life

ACS CAN advocates for legislation that ensures people with cancer have full access to **palliative care** services along with **curative treatment** – from diagnosis through treatment and beyond. The organization supports the **Palliative Care and Hospice Education and Training Act (PCHETA)**, which would create a nationwide public and provider education campaign to disseminate information about the benefits of palliative care, increase training programs and professional development for health professionals in palliative care, and support research on pain and symptom management with the intent of improving patient care.

Health Equity

ACS CAN advocates for policies that help **reduce cancer disparities** and ensure that everyone has a fair and just opportunity to prevent, detect, treat, and survive cancer, including:

- Maintaining the provision of the **Affordable Care Act (ACA)** that ensures broad protection against discrimination of LGBTQ+ individuals in health care services
- Supporting the Equality Act, which will amend the Civil Rights Act of 1964 to prohibit discrimination based on sex, sexual orientation, and gender identity in employment, housing, public accommodations, education, and federally funded programs. Discrimination can cause people with cancer and survivors to face greater access to care barriers and experience unfair and unjust cancer disparities. No one should be disadvantaged in their efforts to access health care – including cancer prevention, detection, treatment, and follow-up care – quickly and without fear of discrimination. ACS CAN supports this legislation because people who do not have access to such resources that protect, improve, and impact the quality of one's health may face life-threatening consequences.
- Supporting policies that expand federal insurance coverage eligibility for **Deferred Action for Childhood Arrival (DACA)** recipients
- Supporting funding and policies that promote the timely collection and publication of demographic data to aid researchers and policymakers in identifying **disparities** in cancer prevention, detection, and treatment.
- Advocating for increased funding for the Indian Health Service, which would provide funding stability for an agency that has been historically underfunded
- Supporting policies that ensure payment for patient navigation services is available across both public and private payers

Research

Research is at the heart of the American Cancer Society's mission. We have invested more than \$5.6 billion in research since 1946, all to find the causes of cancer, strategies to detect the disease earlier, more effective treatments, and ways to help people thrive during and after treatment. The American Cancer Society is unique among nongovernmental, nonprofit organizations in having both intramural and extramural research programs. The top-tier research we fund and conduct covers the cancer continuum from cell biology to survivorship and is currently organized under four departments, described briefly here and in more detail at cancer.org/research.

Extramural Discovery Science

The American Cancer Society's extramural research program supports a portfolio of highly innovative cancer research at top US academic research institutions. Since 1946, we have awarded more than 34,000 grants to academic research institutions across the US supporting over 25,000 investigators and made critical contributions to many of the most important discoveries in cancer. Fifty-three American Cancer Society grantees have been awarded the Nobel Prize, including – most recently – Victor Ambrose, PhD, from the University of Massachusetts Medical School; Gary Ruvkun, PhD, from Massachusetts General Hospital and Harvard Medical School; and David Baker, PhD, from the University of Washington School of Medicine and Howard Hughes Medical Institute; all were awarded in 2024. Current grantees publish over 1,800 scientific papers annually, detailing their discoveries across a wide range of cancers using a multitude of scientific approaches. Visit cancer.org/research/we-fund-cancer-research to learn more about Extramural Discovery Science research programs.

Population Science

The Population Science department has two primary focus areas: a long-standing epidemiology program that began in 1952 to increase knowledge of factors associated with cancer occurrence and survivorship, and more recent initiatives in behavioral interventions research. Their research is conducted in large-scale, longitudinal population cohort studies, including over 2.5 million participants with a variety of over 400,000

biologic samples collected over time. Contributions from Population Science ultimately inform our evidence-based programs and recommendations, which are focused on enhancing cancer prevention, improving outcomes, and reducing disparities. Visit cancer.org/research/population-science to learn more about Population Science research and their staff.

Surveillance, Prevention, and Health Services Research

The Surveillance, Prevention, and Health Services Research (SPHeRe) department informs and promotes cancer prevention and control via five overlapping areas of research: cancer surveillance, risk factor and screening surveillance, health services, disparities, and tobacco control. Information is disseminated via peer-reviewed journal articles for scientific audiences and this *Cancer Facts & Figures* educational publication for a lay audience. *Cancer Facts & Figures* has reported the national cancer burden annually since 1951, along with its accompanying Cancer Statistics article, published in *CA: A Cancer Journal for Clinicians* since 1967. These publications are the most widely cited sources of cancer statistics in the scientific literature and can be found at cancer.org/statistics. Data from these reports can also be accessed and customized using the Cancer Statistics Center, a mobile-friendly interactive website at cancerstatisticscenter.cancer.org. Visit cancer.org/research/surveillance.html to learn more about SPHeRe research and their staff.

Early Cancer Detection Science

The Early Cancer Detection Science (ECDS) department is responsible for subject matter expertise on the early

detection of cancer, including the continuum of screening, technical and quality issues related to existing and emerging cancer screening technology, and the development and regular update of the American Cancer Society's cancer screening guidelines (cancer.org/cancer/screening/american-cancer-society-guidelines-for-the-early-detection-of-cancer.html), most of which have been published in *CA: A Cancer Journal for Clinicians*. Staff in the ECDS department also advise and collaborate with other American Cancer Society departments and regions, cancer roundtables, the American Cancer Society Cancer Action Network™ (our nonprofit, nonpartisan advocacy affiliate), and national and international partners on research and publications; issues and policy related to early cancer detection; and technical issues in the evaluation of cancer screening and systematic evidence reviews that support the development of cancer screening guidelines. The department also manages the new ACS Multi-Cancer Early Detection Initiative, which is focused on the broad issues related to emerging molecular screening technology that aims to detect multiple cancers with a single blood draw. ECDS staff regularly publish summary updates of the American Cancer Society cancer screening guidelines and current issues in early cancer detection science and policy doi.org/10.3322/caac.21557. Visit cancer.org/health-care-professionals/american-cancer-society-prevention-early-detection-guidelines/overview to learn more about ECDS work.

Sources of Statistics

Estimated new cancer cases. The number of invasive cancer cases diagnosed in 2026 was calculated by estimating complete case counts during 2008 through 2022 in all 50 states and the District of Columbia and then projecting forward to 2026 based on the most recent 4-year average annual percent change (AAPC). Case counts through 2022 were estimated using cancer registry data that met high-quality standards set by the North American Association of Central Cancer Registries (NAACCR) and a spatiotemporal model that considers state variation in sociodemographic and lifestyle factors, medical settings, and cancer screening behaviors, and accounts for expected delays in case reporting. To improve the accuracy of the projection, the 9%-10% deficit in cases in 2020 caused by health care closures during the initial months (March-May) of the COVID-19 pandemic was adjusted using data from 2018 and 2019. These methods are described in more detail elsewhere.^{1,2}

New cases of melanoma in situ and ductal carcinoma in situ of the female breast were approximated for 2026 by estimating the number of cases diagnosed each year during 2013 through 2022 based on age-specific incidence rates adjusted for reporting delays for invasive cases and population estimates, then projecting 4 years ahead based on the overall AAPC. Incidence data for 2020 were excluded due to the impact of COVID-19 on cancer diagnoses.³

Incidence rates. Incidence rates are presented per 100,000 people per year and are age adjusted to the 2000 US standard population (19 age groups) to allow comparisons across populations with different age distributions. Rates for all racial groups exclude persons of Hispanic ethnicity. National cancer incidence rates and trends are based on NAACCR data adjusted for delays in case capture. Delay adjustment is especially important when quantifying temporal trends because it accounts for delays and error corrections that occur in case reporting, which are especially large in the most recent data year and for sites often diagnosed outside the hospital, such as leukemia and

melanoma. Incidence data for 2020 were excluded from trend analyses and the lifetime risk of developing cancer because these metrics are model based and cannot account for the anomalies in diagnoses that occurred due to health care closures during the first year of the COVID-19 pandemic.^{3,4}

Stage distribution. Stage at diagnosis (in situ, local, regional, or distant stage) is based on cases during 2018 through 2022 in the NAACCR database (described above for incidence rates) using the SEER Summary Stage classification system (training.seer.cancer.gov/staging/systems/summary.html).

Estimated cancer deaths. The number of cancer deaths in the US in 2026 was estimated by fitting the observed number of cancer deaths from 2009 to 2023 to the same log-linear regression model used to produce estimated cases,^{1,2} and then similarly using the most recent 4-year AAPC to forecast the number of deaths expected in 2026. Data on the number of deaths were obtained from the National Center for Health Statistics (NCHS) at the Centers for Disease Control and Prevention.

Mortality rates. Mortality rates in this publication are based on cancer reported as the underlying cause of death on death certificates compiled by the NCHS, presented per 100,000 people per year and age-adjusted to the 2000 US standard population (20 age groups). The trends in cancer mortality rates presented in the text were based on mortality data from 1975 to 2023. Mortality rates for non-Hispanic AIAN individuals were adjusted for misclassification using factors published by the NCHS.⁵

Important note about estimated cancer cases and deaths for the current year. The methodologies for predicting cancer cases and deaths in the current year were updated in 2021. While these estimates provide a reasonably accurate portrayal of the contemporary cancer burden in the absence of surveillance data, they should be interpreted with caution because they are model-based projections that may vary from year to year due to factors other than changes in cancer

occurrence and methodology. Therefore, they are not suitable for tracking cancer trends, which should be based on age-adjusted incidence rates reported by population-based cancer registries and mortality rates reported by the NCHS.

Survival. This report describes survival in terms of relative survival rates, which is a measure of life expectancy among people with cancer compared to that among the general population of the same age, race/ethnicity, and sex. Survival rates herein were based on data from all 21 National Cancer Institute (NCI) SEER registries; 5- and 10-year relative survival were based on individuals diagnosed from 2015 through 2021 and 2007 through 2021, respectively, with all patients followed through 2022. Contemporary survival rates for White and Black individuals were exclusive of Hispanic ethnicity. All rates were generated using SEER*Stat software version 9.0.40.0.⁶

Probability of developing cancer. Probabilities of developing cancer were calculated using DevCan (Probability of Developing Cancer) software version 6.9.2, developed by the NCI, and were based on all 21 SEER registries.⁷ These probabilities reflect the average experience of people in the US and do not account for individual behaviors or risk factors. Estimates are based on incidence from 2019 to 2022, excluding 2020 due to the impact of the COVID-19 pandemic.⁸

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American Cancer Society Recommendations for the Early Detection of Cancer in Average-risk Asymptomatic People³

Cancer Site	Population	Test or Procedure	Recommendation
Breast	Women, ages 40-54	Mammography	Women should have the opportunity to begin annual screening between the ages of 40 and 44. Women should undergo regular screening mammography starting at age 45. Women ages 45 to 54 should be screened annually.
	Women, ages 55+		Transition to biennial screening, or have the opportunity to continue annual screening. Continue screening as long as overall health is good and life expectancy is 10+ years.
Cervix^a	Women, ages 25-65	FDA-approved Primary HPV DNA test, OR	Preferred: Every 5 years with clinician-collected cervical specimen Acceptable: Every 3 years with self-collected vaginal specimen in a health care setting or at home
		Pap & HPV DNA co-testing, OR	Acceptable: Every 5 years
		Pap test alone	Acceptable: Every 3 years
	Women ages ≥65		May discontinue screening with 2 consecutive negative primary HPV tests (preferred) OR Pap/HPV co-test OR 3 consecutive negative Pap tests, with last test at 65 years or older.
	With HPV vaccination		Follow age-specific screening recommendations (same as unvaccinated individuals).
	Women with total hysterectomy		Women and individuals without a cervix and without a history of cervical cancer or a history of CIN2 or a more severe diagnosis in the past 25 years should not be screened.
Colorectal^b	Adults, ages 45+	High-sensitivity guaiac-based fecal occult blood test (gFOBT) or fecal immunochemical test (FIT), OR	Every year
		Multi-target stool DNA test, OR	Every 3 years
		Flexible sigmoidoscopy, OR	Every 5 years alone or combined with a high-sensitivity gFOBT or FIT annually
		Colonoscopy, OR	Every 10 years
		CT Colonography	Every 5 years
Endometrial^c	Women at menopause		Women should be informed about risks and symptoms of endometrial cancer and encouraged to report unexpected bleeding to a physician.
Lung	Adults ages 50-80 with a 20+ pack-year smoking history	Low-dose helical CT	Annual screening in generally healthy (at least 5-year life expectancy) adults who have a 20-pack-year or more smoking history (e.g., smoked 1 pack per day for 20 years or ½ pack per day for 40 years), regardless of whether or when they have quit.
Prostate	Men, ages 50+	Prostate-specific antigen test with or without digital rectal examination	Men who have at least a 10-year life expectancy should have an opportunity to make an informed decision with their health care provider about whether to be screened for prostate cancer after receiving information about the potential benefits, risks, and uncertainties. Prostate cancer screening should not occur without informed decision-making. African American men should have this conversation with their provider beginning at age 45.

CT-Computed tomography. ^aAll individuals should become familiar with the potential benefits, limitations, and harms associated with cancer screening. ^bGuidelines apply to all individuals with a cervix, including those with HPV vaccination. ^cAll positive tests (other than colonoscopy) should be followed up with a colonoscopy. ^dGuideline applies to all individuals with a uterus.

Acknowledgments

We gratefully acknowledge all cancer registries and their staff for their hard work and diligence in collecting cancer information, without which this report would not exist. We would also like to acknowledge the following subject matter experts and production team members for their valuable contributions: Anu Agrawal; Rick Alteri; Meenu Anand; Christina Annunziata; Priti Bandi; Deana Baptiste; Nina DaSilva Batista; Steve Bouvier; Susan Brinkley; Esmeralda Buchanan; Jada Desmarais; Mark Fleury; Kayla Foster; Ted Gansler; Angela Giaquinto; Jennifer Greenwald; Hillary Grice; Xuesong Han; Trista Hargrove; Farhad Islami; Kieran Kelly; Reid London; Laura Makaroff; Kristie McComb; Katie McMahon; Karen Murphy; Nigar Nargis; Kristina Ogburn; Alpa Patel; Catherine Peters; Nicole Robertson; Scott Roskilly; Angela Sailor; Anatu Saka; Melanie Schneider; Sarah Shafir; Scott Simpson; Robert Smith; Jessica Star; Carter Steger; Nicole Stout; Brooke Street; Hyuna Sung; Justine Swindell; Madilyn Tortat; Britton Trabert; Lynn Urquhart; Marty Weinstock; Tracy Wyant; Gail Wyche; Robin Yabroff; Kathy Zamora; Qin Zhang; and Joe Zou.

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Surveillance, Prevention, and Health Services Research department

The American Cancer Society's mission is to improve the lives of people with cancer and their families through advocacy, research, and patient support, to ensure everyone has an opportunity to prevent, detect, treat, and survive cancer.



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Alabama Cancer Statistics 2023



A sourcebook of cancer data for cancer
prevention and control activities in Alabama





Scott Harris, M.D., M.P.H.
STATE HEALTH OFFICER

December 11, 2023

Dear Colleagues:

I am pleased to present the annual *Alabama Cancer Statistics* report produced by the Alabama Statewide Cancer Registry.

Cancer is the second leading cause of death in Alabama, exceeded only by heart disease. Breast, colorectal, lung, and prostate cancers are the most commonly diagnosed cancers, accounting for more than 47 percent of all new cases in Alabama; however, more Alabamians die from lung cancer than from breast, colorectal, and prostate cancers combined. Eliminating tobacco use, one of the single most preventable causes of disease, and eliminating exposure to secondhand smoke could greatly reduce the incidence and mortality not only for lung cancer but many other cancers as well. For some cancers such as breast, cervical, and colorectal, there are established, effective screening tests which can diagnose these cancers at an early stage when treatment is more effective and survival is more likely. Additionally, engaging in healthy lifestyle habits, such as being physically active and consuming a healthy diet, can also contribute to cancer prevention efforts.

It is my hope that the information presented in this report will assist the partners, agencies, and organizations involved in cancer prevention efforts throughout the state as we continue to work toward reducing Alabama's cancer burden.

Sincerely,

Scott Harris, M.D., M.P.H.
State Health Officer

SH/JTG

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Visit the Alabama Statewide Cancer Registry website at alabamapublichealth.org/ascr for additional copies of *Alabama Cancer Statistics 2023*.

Cancer: Basic Facts

What Is Cancer?

Cancer is a group of diseases characterized by the uncontrolled growth and spread of abnormal cells that can result in death if not treated. Although the causes of cancer are not completely understood, numerous factors are known to increase risk, including many that are potentially modifiable (e.g., tobacco use and excess body weight) and those that are not (e.g., inherited genetic mutations). These risk factors may act simultaneously or in sequence to initiate and/or promote cancer growth.¹

Can Cancer Be Prevented?

A substantial proportion of cancers could be prevented, including all cancers caused by tobacco use and other unhealthy behaviors. Excluding non-melanoma skin cancer, at least 42 percent of newly diagnosed cancers in the U.S. – about 820,000 cases in 2023 – are potentially avoidable, including the 19 percent of cancers caused by smoking and the 18 percent caused by a combination of excess body weight, alcohol consumption, poor nutrition, and physical inactivity. Certain cancers caused by infectious agents, such as human papillomavirus (HPV), hepatitis B virus (HBV), hepatitis C virus (HCV), and *Helicobacter pylori* (*H. pylori*), could be prevented through behavioral changes or vaccination to avoid the infection or by treating the infection. Many of the more than five million skin cancer cases that are diagnosed annually could be prevented by protecting the skin from excessive sun exposure and not using indoor tanning devices.¹

Screening can help prevent colorectal and cervical cancers by detecting and removing precancerous lesions in the colon, rectum, and uterine cervix. Screening can also detect these and some cancers early, when treatment is often less intensive and more successful. Screening is known to help reduce mortality for cancers of the breast, colon, rectum, cervix, lung (among people who smoke or used to smoke), and probably prostate. In addition, being aware of changes in the body, such as the breast, skin, mouth, eyes, or genitalia, and bringing these to the attention of a health care professional may also result in the early detection of cancer.¹

Who Is at Risk of Developing Cancer?

The risk of developing cancer increases with advancing age; 88 percent of all cancers in the U.S. are diagnosed in people 50 years of age or older and 57 percent are 65 or older. Certain behaviors also increase risk, such as smoking, having excess body weight, drinking alcohol, and having an unhealthy diet. In the U.S., approximately 41 out of 100 men and 39 out of 100 women will develop cancer during their lifetime. However, these probabilities are estimated based on cancer occurrence in the general population and may differ because of variations in individual exposures (e.g., smoking), family history, and/or genetic susceptibility.¹

A family history of cancer is thought to primarily reflect inheritance of genetic variations that confer slight-to-moderate increased risk in concert with similar exposures to lifestyle/environmental risk factors among family members. Inheritance of genetic alterations that confer a very high risk occurs much less frequently.¹

Relative risk is the strength of the relationship between exposure to a given risk factor and cancer. It is measured by comparing the rate of cancer in a group of people with a certain exposure or trait to the rate in a group of people without this characteristic. For example, men and women who smoke are about 25 times more likely to develop lung cancer than people who never smoked, so the relative risk of lung cancer among people who smoke is 25. Most relative risks are not this large; for example, the relative risk of breast cancer among women who have a mother, sister, or daughter with a history of breast cancer is about two. However, even exposures associated with a relatively small excess risk can have a large influence on the number of cancers diagnosed in the population if they are common (e.g., excess body weight).¹

How Many New Cancer Cases Are Expected to Occur in 2023 in Alabama?

In Alabama, approximately 30,730 new cancer cases are expected to be diagnosed in 2023, which translates to slightly more than 84 people per day.¹

Estimated Number² of New Cancer Cases for Selected Cancer Sites, Alabama, 2023

Site	New Cases
All Sites	30,730
Female Breast	4,500
Uterine Cervix	240
Colon & Rectum	2,570
Uterine Corpus	830
Leukemia	780
Lung & Bronchus	4,280
Melanoma	1,510
Non-Hodgkin Lymphoma	1,030
Prostate	5,320
Urinary Bladder	1,180

²Rounded to the nearest 10. Excludes basal and squamous cell skin cancers and *in situ* carcinomas except urinary bladder.

Source: American Cancer Society. *Cancer Facts & Figures 2023*. Atlanta: American Cancer Society.

How Many People Are Expected to Die of Cancer in 2023 in Alabama?

In Alabama, 10,640 people are expected to die of cancer in 2023. Lung cancer will account for 2,610 deaths, more than 24 percent of all estimated cancer deaths in the state.¹

Estimated Number* of Cancer Deaths for Selected Cancer Sites, Alabama, 2023	
Site	Deaths
All Sites	10,640
Brain/Nervous System	330
Female Breast	720
Colon & Rectum	900
Leukemia	370
Liver	520
Lung & Bronchus	2,610
Non-Hodgkin Lymphoma	290
Ovary	200
Pancreas	840
Prostate	540

*Rounded to the nearest 10.

Source: American Cancer Society, Cancer Facts & Figures 2023. Atlanta: American Cancer Society.

Impact of COVID-19 Pandemic on Cancer Diagnoses

During the height of the COVID-19 pandemic, hospitals and physician offices were unable to see patients at the same level as before the pandemic because of COVID-19 infections. This disruption of health services resulted in missed or postponed appointments for cancer screening, as well as follow-up of abnormal results and symptoms. Patients also experienced treatment delays or modifications to treatment during this time.¹

In Alabama, there was a statistically significant 9.9 percent decline in the all sites cancer incidence rate from 2019 to 2020.² Similarly, for the U.S. there was a 10.2 percent decline in the all sites cancer incidence rate, and this decline was also statistically significant.³ For this reason, incidence trend data should be interpreted with caution. However, there was no significant change from 2019 to 2020 in the all sites cancer mortality rate for either Alabama or the U.S.^{2,4} It may take several years for the consequences of the interruption in healthcare services due to the pandemic to become fully evident in our statistics.

All Cancers

Incidence Rates

For both genders combined, Alabama's cancer incidence rate is 447.0 – significantly higher than the U.S. rate of 442.0.^{2,3} Males in the state have a significantly higher cancer incidence rate than females, with a rate of 513.2 versus 399.0.² Among males, black males have a significantly higher cancer incidence rate than white males, with a rate of 538.2 versus 499.8.² Among females, white females have a significantly higher cancer incidence rate than black females, with a rate of 405.0 versus 379.5.² (See Figure 1 below and Table 11 on page 29.)

Mortality Rates

For both genders combined, Alabama's cancer mortality rate is 173.7 – significantly higher than the U.S. rate of 160.3.^{2,4} Males in the state have a significantly higher cancer mortality rate than females, with a rate of 218.7 versus 141.2.² Among males, black males have a significantly higher cancer mortality rate than white males, with a rate of 250.7 versus 213.1.² Among females, black females have a significantly higher cancer mortality rate than white females, with a rate of 152.3 versus 139.0.² (See Figure 1 below and Table 12 on page 30.)

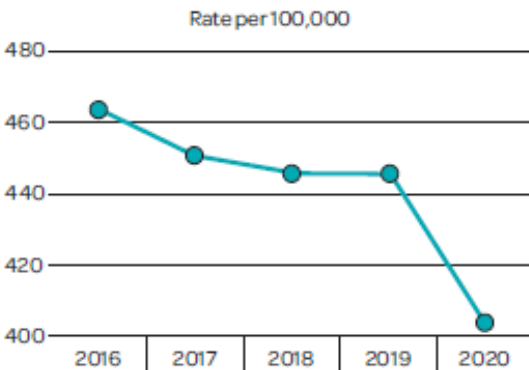
Figure 1. All Sites Cancer Incidence and Mortality Rates,* by Sex and Race, Alabama



*Malignant only, with the exception of *in situ* bladder cancer, per 100,000 and age-adjusted to the 2000 U.S. standard population.

Source: Alabama Statewide Cancer Registry, 2023. Cancer Incidence (2011-2020), Cancer Mortality (2011-2020).

Figure 2. Trends in Cancer Incidence Rates,* All Sites, Males and Females, Alabama, 2016-2020



*Malignant only with the exception of *in situ* bladder cancer, per 100,000 and age-adjusted to the 2000 U.S. standard population.

Source: Alabama Statewide Cancer Registry, 2023

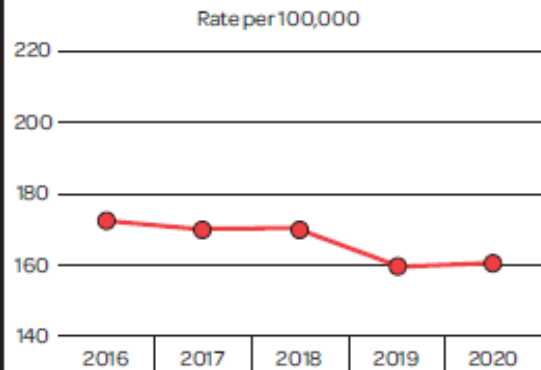
Trends

Between 2016 and 2020, the percentage change (PC) of cancer incidence for all sites in Alabama had an overall decrease of 13.2 percent; the annual percentage change (APC) during this time was -2.8 percent.² There was a 9.9 percent decline from 2019 to 2020 due in large part to the pandemic restricting treatment and screening access. The trend in cancer incidence rates was not found to be statistically significant even including the massive decline from 2019 to 2020. (See Figure 2 top left and Table 2 on page 17.)

Between 2016 and 2020, the PC of cancer mortality for all sites cancer in Alabama had an overall decrease of 7.5 percent; the APC during this time was -2.1 percent.² The decrease in cancer mortality was found to be statistically significant. (See Figure 3 top right and Table 10 on page 28.)

Visit the Alabama Statewide Cancer Registry website at alabamapublichealth.org/ascr for additional maps based on the data found in the *Alabama Cancer Statistics 2023*.

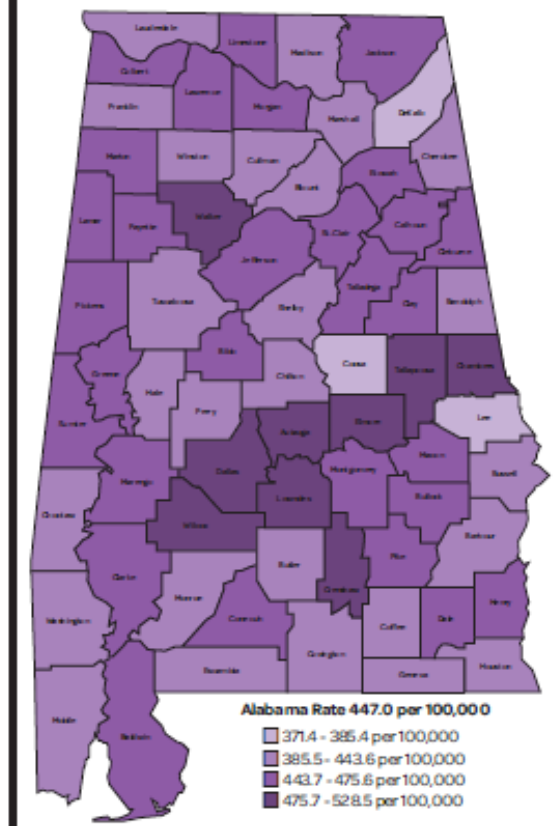
Figure 3. Trends in Cancer Mortality Rates,* All Sites, Males and Females, Alabama, 2016-2020



*Per 100,000, age-adjusted to the 2000 U.S. standard population.

Source: Alabama Statewide Cancer Registry, 2023

Alabama Cancer Incidence Rates, All Sites Males and Females, All Races, 2011-2020



All rates are age-adjusted to the 2000 U.S. (19+ age group) standard. Rates are for malignant tumors only except all sites which includes bladder cancer *in situ*. County groupings were determined using natural breaks (Jenks).

Source: Alabama Statewide Cancer Registry, 2023.

Selected Cancers

Lung Cancer

2023 Estimates

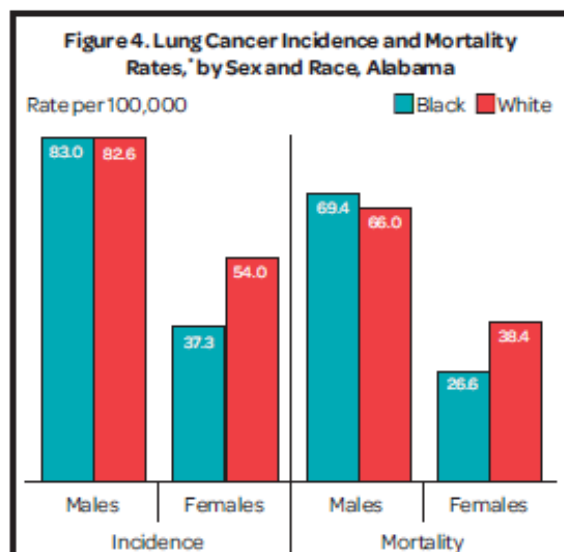
In 2023, an estimated 4,280 new cases of lung and bronchus cancer and approximately 2,610 deaths from lung and bronchus cancer are expected to occur in Alabama.¹

Incidence Rates

For both genders combined, the lung cancer incidence rate in Alabama is 63.9 – significantly higher than the U.S. rate of 50.8.^{2,3} Males in the state have a significantly higher lung cancer incidence rate than females, with a rate of 82.2 versus 49.8.² Among males in Alabama, black males have a higher lung cancer incidence rate than white males, with a rate of 83.0 versus 82.6.² Among females in the state, white females have a significantly higher lung cancer incidence rate than black females, with a rate of 54.0 versus 37.3.² (See Figure 4 below and Table 11 on page 29.)

Mortality Rates

For both genders combined, the lung cancer mortality rate in Alabama is 48.7 – significantly higher than the U.S. rate of 38.9.^{2,4} Males in the state have a significantly higher lung cancer mortality rate than females, with a rate of 66.2 versus 35.5.² Among males in Alabama, black males have a higher lung cancer mortality rate than white males, with a rate of 69.4 versus 66.0.² Among females in the state, white females have a significantly higher lung cancer mortality rate than black females, with a rate of 38.4 versus 26.6.² (See Figure 4 below and Table 11 on page 29.)

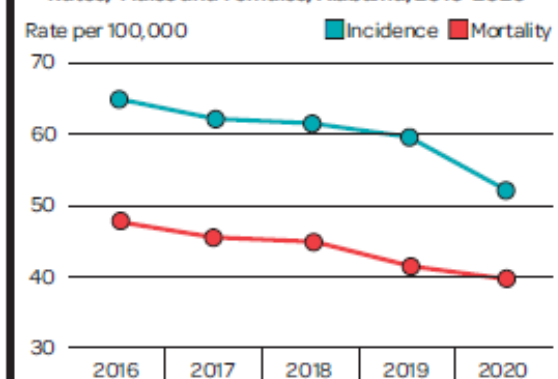


¹Malignant only, per 100,000 and age-adjusted to the 2000 U.S. standard population.
Source: Alabama Statewide Cancer Registry, 2023. Cancer Incidence (2011-2020). Cancer Mortality (2011-2020).

Trends

Between 2016 and 2020, the PC for lung cancer incidence in Alabama had an overall decrease of 19.0 percent; the APC during this time was -4.4 percent.² For lung cancer mortality between 2016 and 2020, the PC had an overall decrease of 17.5 percent; the APC during this time was -4.8 percent.² The decreases in incidence rates and mortality rates were found to be statistically significant. (See Figure 5 below, Table 2 on page 17, and Table 10 on page 28.) However, there was a statistically significant 12.5 percent decline in the lung cancer incidence rate from 2019 to 2020, and without that decline the 2016 to 2020 trend would not have been statistically significant.

Figure 5. Trends in Lung Cancer Incidence and Mortality Rates,¹ Males and Females, Alabama, 2016-2020



¹Malignant only, per 100,000 and age-adjusted to the 2000 U.S. standard population.
Source: Alabama Statewide Cancer Registry, 2023.

Risk Factors

Cigarette smoking is by far the most important risk factor for lung cancer, with approximately 80 percent of lung cancer deaths in the U.S. caused by smoking. Risk increases with both quantity and duration of smoking. Cigar and pipe smoking also increase risk. Exposure to radon gas, which is released from soil and can accumulate in indoor air, is the second-leading cause of lung cancer in the U.S. Other risk factors associated with increased risk include exposure to secondhand smoke, asbestos (particularly among smokers), certain metals (chromium, cadmium, arsenic), some organic chemicals, radiation, air pollution, and diesel exhaust. Specific occupational exposures that increase risk include rubber manufacturing, paving, roofing, painting, and chimney sweeping.¹

Tobacco Use

Alabama adults have higher rates of cigarette smoking than the national averages. While 17.5 percent of Alabama adults smoke, the national average is 14.4 percent.⁵ Adults with low levels of education have the highest rates of cigarette smoking in the state.⁵ (See Table 13 on page 31 for additional information on smoking rates in Alabama and the U.S.)

Colorectal Cancer

2023 Estimates

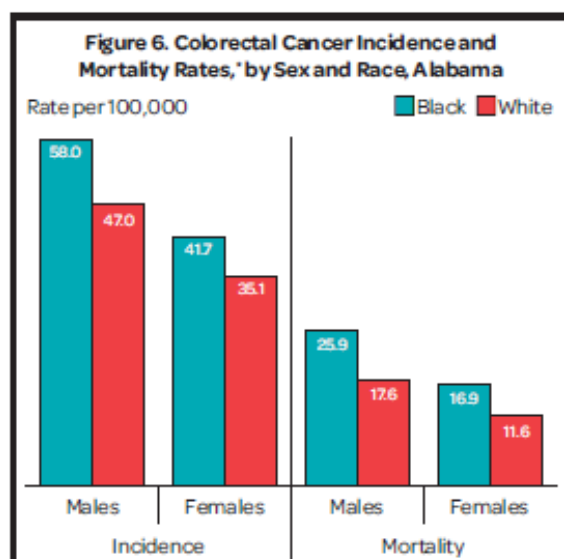
In 2023, an estimated 2,570 new cases of colorectal cancer and approximately 900 colorectal cancer deaths are expected to occur in Alabama.¹

Incidence Rates

For both genders combined, the colorectal cancer incidence rate in Alabama is 42.3 – significantly higher than the U.S. rate of 37.9.^{2,3} Males in the state have a significantly higher colorectal cancer incidence rate than females, with a rate of 49.2 versus 36.7.² Among males in Alabama, black males have a significantly higher colorectal cancer incidence rate than white males, with a rate of 58.0 versus 47.0.² Among females in the state, black females have a significantly higher colorectal cancer incidence rate than white females, with a rate of 41.7 versus 35.1.² (See Figure 6 below and Table 11 on page 29.)

Mortality Rates

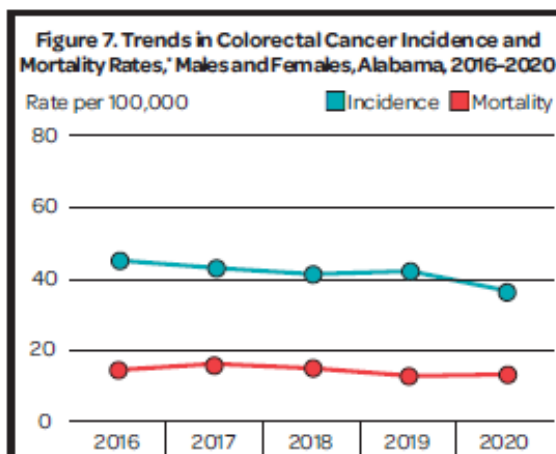
For both genders combined, the colorectal cancer mortality rate in Alabama is 15.5 – significantly higher than the U.S. rate of 13.7.^{2,4} Males in the state have a significantly higher colorectal cancer mortality rate than females, with a rate of 19.1 versus 12.6.² Among males in Alabama, black males have a significantly higher colorectal cancer mortality rate than white males, with a rate of 25.9 versus 17.6.² Among females in the state, black females have a significantly higher colorectal cancer mortality rate than white females, with a rate of 16.9 versus 11.6.² (See Figure 6 below and Table 12 on page 30.)



*Malignant only, per 100,000 and age-adjusted to the 2000 U.S. standard population.
Source: Alabama Statewide Cancer Registry, 2023. Cancer Incidence (2016-2020).
Cancer Mortality (2011-2020).

Trends

Between 2016 and 2020, the PC for colorectal cancer incidence in Alabama had an overall decrease of 15.6 percent; the APC during this time was -3.4 percent.² For colorectal cancer mortality between 2016 and 2020, the PC had an overall decrease of 4.7 percent; the APC during this time was -2.3 percent.² Neither trend was statistically significant. (See Figure 7 below, Table 2 on page 17, and Table 10 on page 28.)



*Malignant only, per 100,000 and age-adjusted to the 2000 U.S. standard population.
Source: Alabama Statewide Cancer Registry, 2023.

Risk Factors

More than half (55 percent) of colorectal cancers in the U.S. are attributable to potentially modifiable risk factors, including excess body weight, physical inactivity, long-term smoking, high consumption of red or processed meat, low calcium intake, heavy alcohol consumption, and very low intake of fruits and vegetables and whole-grain fiber. Hereditary/genetic and medical factors that increase risk include a personal or family history of colorectal cancer or adenomatous polyps, certain inherited genetic syndromes (e.g., Lynch syndrome), a personal history of chronic inflammatory bowel disease (ulcerative colitis or Crohn's disease), and type 2 diabetes.¹

Early Detection

Screening can prevent colorectal cancer through the detection and removal of precancerous growths (polyps), as well as detect cancer at an early stage, when treatment is usually less intensive and more successful. Regular adherence to screening with either stool testing (e.g., fecal immunochemical tests) or structural exams (e.g., colonoscopy) results in a similar reduction in premature colorectal cancer death over a lifetime. The American Cancer Society and the U.S. Preventive Services Task Force (USPSTF) recommend that individuals at average risk for colorectal cancer begin screening at 45 years

of age and continue up to 75 years, with more individualized decision making from ages 76 to 85 based on health status/life expectancy, patient preferences, and prior screening history.¹ When colorectal cancers are detected at an early, localized stage, the 5-year survival rate is 91 percent; however, only 1 in 3 cases of colorectal cancer cases are diagnosed at this stage.¹ Alabama adults 50 years of age and older have higher rates of meeting USPSTF recommendations for colorectal cancer screening than the national average.² Adults with low education have the lowest screening rates.³ (See Table 14 on page 31 for more information on colorectal cancer screening in Alabama and the U.S.)

Melanoma

2023 Estimate

In 2023, an estimated 1,510 new cases of melanoma are expected to occur in Alabama.¹

Incidence Rates

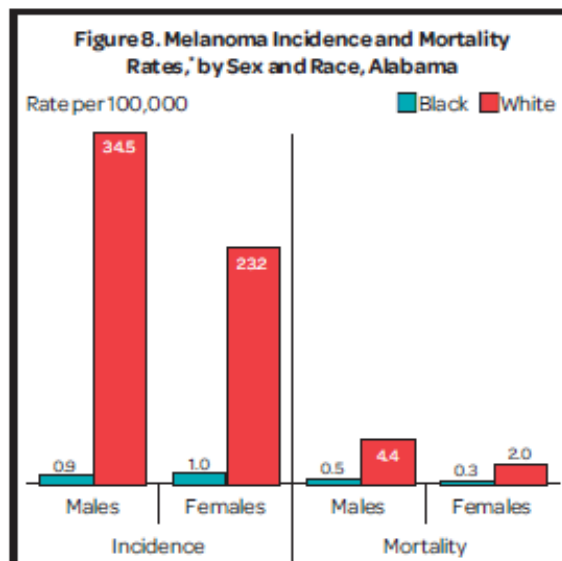
For both genders combined, the melanoma incidence rate in Alabama is 21.3 – significantly lower than the U.S. rate of 23.4.^{2,3} Males in the state have a significantly higher melanoma incidence rate than females, with a rate of 27.4 versus 17.1.² Among males in Alabama, white males have a significantly higher melanoma incidence rate than black males, with a rate of 34.5 versus 0.9.² Among females in the state, white females have a significantly higher melanoma incidence rate than black females, with a rate of 23.2 versus 1.0.² (See Figure 8 top right and Table 11 on page 29.)

Mortality Rates

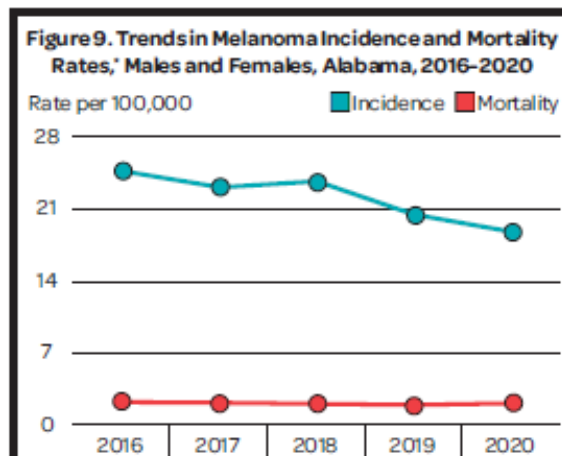
For both genders combined, the melanoma mortality rate in Alabama is 2.4 – roughly the same as the U.S. rate of 2.3.^{2,4} Males in the state have a significantly higher melanoma mortality rate than females, with a rate of 3.6 versus 1.5.² Among males in Alabama, white males have a significantly higher melanoma mortality rate than black males, with a rate of 4.4 versus 0.5.² Among females in the state, white females have a significantly higher melanoma mortality rate than black females, with a rate of 2.0 versus 0.3.² (See Figure 8 top right and Table 12 on page 30.)

Trends

Between 2016 and 2020, the PC for melanoma incidence in Alabama had an overall decrease of 24.7 percent; the APC during this time was -6.6 percent.² For melanoma mortality between 2016 and 2020, the PC had an overall decrease of 7.0 percent; the APC during this time was -3.0 percent.² The trend in incidence rates was statistically significant. (See Figure 9 middle right, Table 2 on Page 17, and Table 10 on page 28.) There was a statistically significant 8.4 percent decline in the melanoma incidence rate from 2019 to 2020, but without that decline, the 2016 to 2020 trend would have been statistically significant.



*Malignant only, per 100,000 and age-adjusted to the 2000 U.S. standard population.
Source: Alabama Statewide Cancer Registry, 2023. Cancer Incidence (2016-2020), Cancer Mortality (2011-2020).



*Malignant only, per 100,000 and age-adjusted to the 2000 U.S. standard population.
Source: Alabama Statewide Cancer Registry, 2023.

Risk Factors

For melanoma, major risk factors include a personal or family history of melanoma and the presence of atypical, large, or numerous (more than 50) moles. Heavy exposure to ultraviolet (UV) radiation, from sunlight or the use of indoor tanning, is a risk factor for all types of skin cancer, and indoor tanning devices are classified as carcinogenic by the International Agency for Research on Cancer. Risk is also increased for people who are sun-sensitive (e.g., sunburn

easily or have natural blond or red hair color) and those who have a history of excessive sun exposure (including sunburns) or skin cancer. People with a weakened immune system are also at increased risk for skin cancer.³

Early Detection

The best way to detect skin cancer early is to be aware of new or changing skin growths, particularly those that look unusual. Any new lesions, or a progressive change in a lesion's appearance (size, shape, color, new bleeding, etc.), should be evaluated promptly by a clinician. The ABCDE rule outlines warning signs of the most common type of melanoma: A is for asymmetry (one half of the mole does not match the other half); B is for border irregularity (the edges are ragged, notched, or blurred); C is for color (the pigmentation is not uniform); D is for diameter greater than 6 millimeters (about the size of a pencil eraser); and E is for evolution, meaning a change in the mole's appearance over time. Not all melanomas have these signs, so be alert for any new or changing skin growths or spots. If detected at its earliest stages and treated properly, melanoma is highly curable.³ When detected at a localized stage, the 5-year survival rate is 99 percent.³

Prostate Cancer

2023 Estimates

In 2023, an estimated 5,320 new cases of prostate cancer and approximately 540 prostate cancer deaths are expected to occur in Alabama.³

Incidence Rates

The prostate cancer incidence rate in Alabama is 122.6 – significantly higher than the U.S. rate of 112.8.^{2,3} Black males in the state have a significantly higher prostate cancer incidence rate than white males, with a rate of 188.0 versus 100.3. (See Figure 10 top right and Table 11 on page 29.)

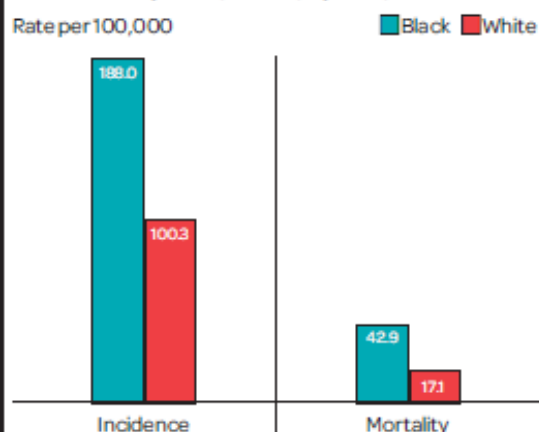
Mortality Rates

The prostate cancer mortality rate in Alabama is 21.4 – significantly higher than the U.S. rate of 19.0.^{2,4} Black males in the state have a significantly higher prostate cancer mortality rate than white males, with a rate of 42.9 versus 17.1.² (See Figure 10 top right and Table 12 on page 30.)

Trends

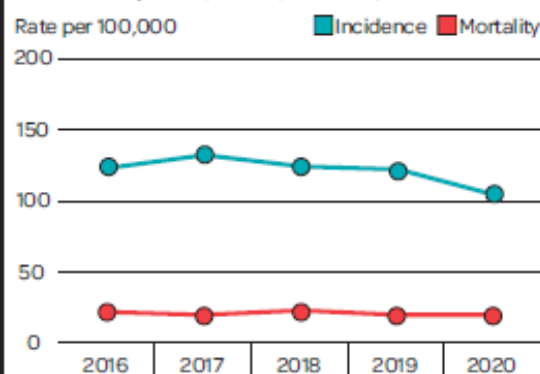
Between 2016 and 2020, the PC for prostate cancer incidence in Alabama had an overall decrease of 16.5 percent; the APC during this time was -4.4 percent. For prostate cancer mortality between 2016 and 2020, the PC had an overall decrease of 6.5 percent; the APC during this time was -1.3 percent. Neither trend was statistically significant.² (See Figure 11 middle right, Table 2 on page 17, and Table 10 on page 28.)

Figure 10. Prostate Cancer Incidence and Mortality Rates, * Males, by Race, Alabama



*Malignant only, per 100,000 and age-adjusted to the 2000 U.S. standard population.
Source: Alabama Statewide Cancer Registry, 2023. Cancer Incidence (2016-2020), Cancer Mortality (2011-2020).

Figure 11. Trends in Prostate Cancer Incidence and Mortality Rates, * Males, Alabama, 2016-2020



*Malignant only, per 100,000 and age-adjusted to the 2000 U.S. standard population.
Source: Alabama Statewide Cancer Registry, 2023.

Risk Factors

Well established risk factors for prostate cancer are increasing age, African ancestry, a family history of the disease, and certain inherited genetic conditions (e.g., Lynch syndrome and BRCA1 and BRCA2 mutations). Black men in the U.S. and the Caribbean have the highest documented prostate cancer incidence rates in the world. Genetic studies suggest that strong familial predisposition may be responsible for 5 to 10 percent of prostate cancers. There is accumulating evidence that smoking increases the risk of fatal prostate cancer and excess body weight increases risk of aggressive and fatal prostate cancer.³

Early Detection

Although studies have shown the prostate-specific antigen (PSA) testing reduces prostate cancer mortality, no major medical organizations presently endorse routine prostate cancer screening for men at average risk because of concerns about the high rate of overdiagnosis (detecting disease that would never have caused symptoms or harm), along with the high potential for serious side effects associated with prostate cancer treatment. However, because prostate cancer is a leading cause of cancer death in men, many organizations recommend an "informed decision-making" approach whereby men are educated about screening and encouraged to make a personal choice. The American Cancer Society recommends that beginning at age 50, men who are at average risk of prostate cancer and have a life expectancy of at least 10 years have a conversation with their healthcare provider about the benefits and limitations of PSA testing and make an informed decision about whether to be tested based on their personal values and preferences. Black men and those with a close relative diagnosed with prostate cancer before the age of 65 should have this discussion beginning at age 45, and men at even higher risk (several close relatives diagnosed at an early age and BRCA mutation carriers) should have this discussion beginning at age 40. The 5-year survival rate for prostate cancer is almost 100 percent when the disease is diagnosed and treated at the local and regional stages.¹ Males in Alabama have significantly higher rates of PSA screening than the U.S. averages across all categories.² Males of low education have the lowest rates of PSA screening of all groups.³ (See Table 16 on page 31 for more information on prostate cancer screening rates in Alabama and the U.S.)

Breast Cancer

2023 Estimates

In 2023, an estimated 4,500 new cases of female breast cancer and approximately 720 female breast cancer deaths are expected to occur in Alabama.¹

Incidence Rates

The female breast cancer incidence rate in Alabama is 121.8 – significantly lower than the U.S. rate of 126.8.^{2,3} Black females in the state have a significantly higher breast cancer incidence rate than white females, with a rate of 126.8 versus 119.4.² (See Figure 12 top right and Table 11 on page 29.)

Mortality Rates

The female breast cancer mortality rate in Alabama is 21.3 – significantly higher than the U.S. rate of 20.2.^{2,4} However, both white females and black females in Alabama have slightly lower mortality rates than their U.S. counterparts. Black females in the state have a significantly higher breast cancer mortality rate than white females, with a rate of 27.4 versus 19.4.² (See Figure 12 top right and Table 12 on page 30.)

Figure 12. Breast Cancer Incidence and Mortality Rates,¹ Females, by Race, Alabama

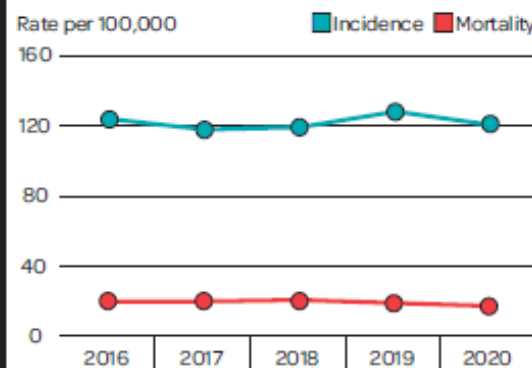


¹Malignant only, per 100,000 and age-adjusted to the 2000 U.S. standard population.
Source: Alabama Statewide Cancer Registry, 2023. Cancer Incidence (2016-2020), Cancer Mortality (2011-2020).

Trends

Between 2016 and 2020, breast cancer incidence rates in Alabama were almost constant, with the PC having an overall decrease of only 0.7 percent; the APC during this time was 0.6 percent.² Breast cancer is one of the few cancer groupings that did not decline more than 5 percent from 2019 to 2020. For breast cancer mortality between 2016 and 2020, the PC had an overall decrease of 5.2 percent; the APC during this time was -1.5 percent.² Neither trend was statistically significant. (See Figure 13 below, Table 2 on page 17, and Table 10 on page 28.)

Figure 13. Trends in Breast Cancer Incidence and Mortality Rates,¹ Females, Alabama, 2016-2020



¹Malignant only, per 100,000 and age-adjusted to the 2000 U.S. standard population.
Source: Alabama Statewide Cancer Registry, 2023.

Risk Factors

Increasing age and being born female are the strongest risk factors for breast cancer. Potentially modifiable factors associated with increased risk include weight gain after the age of 18 and/or being overweight or obese (for postmenopausal breast cancer), menopausal hormone therapy (combined estrogen and progestin), alcohol consumption, and physical inactivity. Breastfeeding for at least 1 year decreases risk. Non-modifiable factors that increase risk include inherited mutations genetic alterations in breast cancer susceptibility genes (e.g., BRCA1 or BRCA2). These mutations are most common among people with a family history of breast, ovarian, and/or some other cancers. Other non-modifiable factors include a personal or family history of breast or ovarian cancer, certain benign breast conditions, such as atypical hyperplasia, a history of ductal carcinoma *in situ* (DCIS) or lobular carcinoma *in situ* (LCIS), high breast tissue density (the amount of glandular tissue relative to fatty tissue measured on a mammogram), and high-dose radiation to the chest at a young age (e.g., for treatment of lymphoma). Reproductive factors that increase risk include a long menstrual history (menstrual periods that start early and/or end late in life), not having children or having children after age 30, high natural levels of estrogen or testosterone, and recent use of hormonal contraceptives.¹

Early Detection

Mammography is a low-dose x-ray procedure used to detect breast cancer at an early stage. Early diagnosis reduces the risk of dying from breast cancer and increases treatment options. However, like any screening tool, mammography is not perfect. It can miss cancer (false negative) or appear abnormal in the absence of cancer (false positive); approximately 12 percent of women who are screened have an abnormal mammogram, but only about 4 percent of these women have cancer. Other potential harms include detection of cancers and *in situ* lesions (e.g., DCIS) that would never have progressed or caused harm (i.e., overdiagnoses), and anxiety and medical costs associated with additional diagnostic testing in women without cancer. Although radiation exposure from mammograms is cumulative over time, it does not meaningfully increase breast cancer risk. The American Cancer Society recommends that women at average risk of developing breast cancer undergo annual mammography beginning at age 45 with the option to transition to biennial mammography beginning at age 55. Women ages 40 to 44 should have the option to begin annual mammography. Women should continue mammography as long as overall health is good and life expectancy is 10 or more years. For some women at high risk of breast cancer, annual magnetic resonance imaging (MRI) is recommended to accompany mammography, often starting before age 40. The 5-year relative survival rate for women with invasive breast cancer is 91 percent. When the disease is detected and diagnosed at the localized stage, the relative 5-year survival rate is 99 percent, compared to a rate of only 30 percent for breast cancers detected at the distant stage.¹

Alabama females have an identical rate of mammography screening compared to U.S. females.² Black females in the state have a higher rate of mammography screening than white females.² Females with a low education have the lowest rate of mammography of all age groups and races.² (See Table 15 on page 31 for more information on breast cancer screening rates in Alabama and the U.S.)

Cervical Cancer

2023 Estimate

In 2023, an estimated 240 new cases of cervical cancer are expected to occur in Alabama.¹

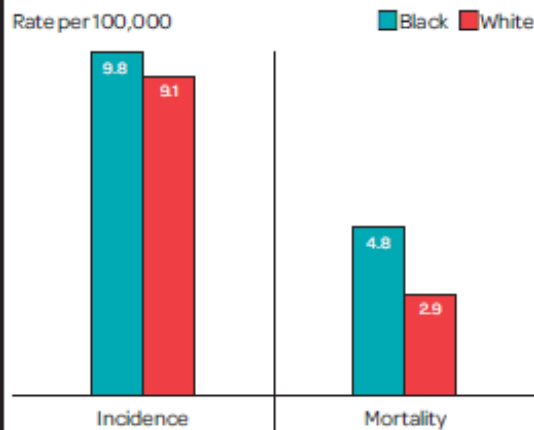
Incidence Rates

The cervical cancer incidence rate in Alabama is 9.2 – significantly higher than the U.S. rate of 7.4.^{2,3} Black females in the state have a significantly higher cervical cancer incidence rate than white females, with a rate of 9.8 versus 9.1.² (See Figure 14 below and Table 11 on page 29.)

Mortality Rates

The cervical cancer mortality rate in Alabama is 3.3 – significantly higher than the U.S. rate of 2.2.^{2,4} Black females in the state have a significantly higher cervical cancer mortality rate than white females, with a rate of 4.8 versus 2.9.² (See Figure 14 below and Table 12 on page 30.)

Figure 14. Cervical Cancer Incidence and Mortality Rates,* Females, by Race, Alabama

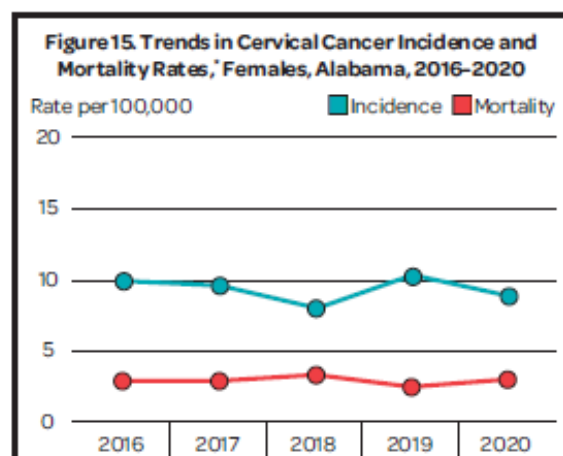


*Malignant only, per 100,000 and age-adjusted to the 2000 U.S. standard population. Source: Alabama Statewide Cancer Registry, 2023. Cancer Incidence (2016-2020), Cancer Mortality (2011-2020).

Trends

Between 2016 and 2020, the PC for cervical cancer incidence in Alabama had an overall decrease of 9.9 percent, and the APC during this time was -1.6 percent.² For cervical cancer mortality between 2016 and 2020, the PC had an overall increase of 9.4 percent; the APC during this time was

0.5 percent.² Neither trend was statistically significant. (See Figure 5 below, Table 2 on page 17, and Table 10 on page 28.)



Source: Alabama Statewide Cancer Registry, 2023.

Risk Factors

Almost all cervical cancers are caused by persistent infection with certain types of HPV, although these infections are common in healthy people and only rarely cause cancer. Individuals who begin having sex at an early age or who have had many sexual partners are at increased risk for HPV infection, although infection can occur with only one sexual partner. Several factors are known to increase the risk of both persistent HPV infection and progression to cancer, including a suppressed immune system, a high number of childbirths, and cigarette smoking. Long-term use of oral contraceptives is also associated with increased risk that gradually declines after cessation.¹

Prevention

The HPV vaccine protects against the types of HPV that cause 90 percent of cervical cancers, as well as several other cancers and diseases. A population-based study recently demonstrated that the vaccine substantially reduces the

risk of invasive cervical cancer, especially among women who were immunized before age 17. The American Cancer Society recommends routine vaccination between ages 9 and 12 years with catchup vaccinations for all persons through age 26 years who are not adequately vaccinated. HPV vaccines cannot protect against established infections or all types of HPV, which is why it is important for all people with a cervix, even those who have been vaccinated, to follow cervical cancer screening guidelines.

Screening can prevent cervical cancer through detection and treatment of precancerous lesions, which are now detected far more frequently than invasive cancer. The Pap test is a simple procedure in which a small sample of cells is collected from the cervix and examined under a microscope. The HPV test, which can be done on the same sample, detects HPV infections associated with cervical cancer and can forecast cervical cancer risk. The HPV test can also identify women at risk for a type of cervical cancer (adenocarcinoma) that is often missed by Pap tests and accounts for 29 percent of cases.

Early Detection

In addition to preventing cervical cancer, screening can detect invasive cancer early, when treatment is more successful. Most women diagnosed with cervical cancer have not been screened recently.

The updated guideline from the American Cancer Society recommends that individuals with a cervix at average risk for cervical cancer initiate screening at age 25 years with primary HPV testing every 5 years through age 65 years. If a primary HPV test is not available, these individuals should undergo co-testing (HPV testing in combination with Pap test) every 5 years or screening with a Pap test alone every 3 years. When detected at a localized stage, the 5-year survival rate for invasive cervical cancer is 92 percent.¹ As a group, females 18 years of age and older in Alabama have a slightly higher rate of cervical cancer screening than the U.S. average.² Females of low education have the lowest rate of screening for all ages and races.³ (See Table 17 on page 32 for more information on cervical cancer screening rates in Alabama.)

Table 1. Alabama Cancer Incidence Rates and Counts, by Site, Race, and Sex, 2011-2020 Combined												
	Male and Female						Male					
	All Races		White		Black		All Races		White		Black	
	Rate	Count	Rate	Count	Rate	Count	Rate	Count	Rate	Count	Rate	Count
All Malignant Cancers	447.0	264,979	444.4	200,644	443.9	58,503	513.2	139,639	499.8	105,794	538.2	30,405
Oral Cavity and Pharynx	12.8	7,669	13.8	6,285	8.6	1,182	19.7	5,452	21.0	4,499	13.8	817
Digestive System	82.0	48,712	78.0	35,499	95.6	12,336	100.7	27,200	96.1	20,228	118.1	6,496
Esophagus	4.5	2,801	4.6	2,152	4.5	615	8.0	2,250	8.1	1,766	7.7	458
Stomach	6.5	3,866	5.4	2,462	10.3	1,289	8.6	2,280	7.2	1,509	13.7	717
Small Intestine	2.6	1,537	2.4	1,049	3.5	460	2.9	790	2.8	573	3.6	201
Colon and Rectum	42.3	24,761	40.5	18,124	48.5	6,181	49.2	13,063	47.0	9,718	58.0	3,109
Colon Excluding Rectum	31.2	18,281	29.6	13,292	37.0	4,682	35.2	9,305	33.3	6,868	43.2	2,282
Rectum and Rectosigmoid Junction	11.1	6,480	10.9	4,832	11.5	1,499	14.0	3,758	13.7	2,850	14.9	827
Anus, Anal Canal, and Anorectum	1.9	1,087	2.0	880	1.5	196	1.5	388	1.4	293	1.8	98
Liver and Intrahepatic Bile Duct	7.8	4,902	7.6	3,624	8.1	1,160	12.1	3,490	11.6	2,581	13.0	831
Gallbladder	0.8	486	0.7	318	1.3	156	0.7	166	0.6	117	1.0	45
Pancreas	13.0	7,842	12.4	5,789	15.5	1,962	15.1	4,086	14.8	3,153	16.5	891
Other Digestive Organs	0.4	219	0.3	146	0.5	69	0.4	114	0.4	76	0.7	35
Respiratory System	69.0	42,546	71.5	34,099	61.3	8,080	90.7	24,956	90.6	19,607	93.2	5,156
Larynx	4.1	2,591	4.1	1,932	4.4	614	7.3	2,080	6.9	1,522	8.9	525
Lung and Bronchus	63.9	39,430	66.5	31,767	56.1	7,355	82.2	22,562	82.6	17,848	83.0	4,564
Bones and Joints	1.1	552	1.1	400	1.1	141	1.3	300	1.2	223	1.2	70
Soft Tissue Including Heart	3.4	1,855	3.3	1,358	3.5	446	4.0	998	4.0	762	3.8	213
Skin Excluding Basal and Squamous	22.6	12,833	29.3	12,535	1.5	188	29.2	7,542	36.6	7,410	1.4	73
Melanoma of the Skin	21.3	12,083	27.9	11,894	1.0	117	27.4	7,093	34.5	7,004	0.9	48
Other Non-Epithelial Skin	1.3	750	1.4	641	0.6	71	1.8	449	2.1	406	0.5	25
Breast	66.2	38,158	63.7	27,945	73.1	9,509	1.4	376	1.3	280	1.7	91
Female Genital System	*	*	*	*	*	*	*	*	*	*	*	*
Cervix Uteri	*	*	*	*	*	*	*	*	*	*	*	*
Corpus and Uterus, NOS	*	*	*	*	*	*	*	*	*	*	*	*
Corpus Uteri	*	*	*	*	*	*	*	*	*	*	*	*
Uterus, NOS	*	*	*	*	*	*	*	*	*	*	*	*
Ovary	*	*	*	*	*	*	*	*	*	*	*	*
Vagina	*	*	*	*	*	*	*	*	*	*	*	*
Vulva	*	*	*	*	*	*	*	*	*	*	*	*
Other Female Genital Organs	*	*	*	*	*	*	*	*	*	*	*	*
Male Genital System	*	*	*	*	*	*	128.0	36,907	106.8	23,890	190.4	11,268
Prostate	*	*	*	*	*	*	122.6	35,648	100.3	22,814	188.0	11,132
Testis	*	*	*	*	*	*	4.3	968	5.3	837	1.6	92
Penis	*	*	*	*	*	*	0.9	246	1.0	206	0.6	35
Other Male Genital Organs	*	*	*	*	*	*	0.2	45	0.2	33	^	^
Urinary System	36.6	21,721	38.7	17,671	29.3	3,787	57.3	15,110	60.5	12,563	43.5	2,356
Urinary Bladder	17.9	10,756	19.8	9,283	10.7	1,315	31.8	8,255	34.9	7,249	17.7	881
Kidney and Renal Pelvis	17.9	10,513	18.1	8,003	18.1	2,412	24.3	6,556	24.3	5,050	25.1	1,445
Ureter	0.5	312	0.6	282	0.2	26	0.8	208	0.9	190	^	^
Other Urinary Organs	0.2	140	0.2	103	0.3	34	0.4	91	0.4	74	^	^
Eye and Orbit	0.8	479	1.0	443	0.2	28	1.1	280	1.3	259	0.2	16
Brain and Other Nervous System	6.6	3,601	7.2	2,953	4.4	584	7.6	1,964	8.3	1,622	5.1	309
Endocrine System	10.2	5,331	11.0	4,135	7.8	1,026	5.7	1,457	6.2	1,183	3.9	229
Thyroid	9.4	4,898	10.3	3,869	6.6	866	4.9	1,243	5.4	1,042	2.8	160
Other Endocrine Including Thymus	0.8	433	0.7	266	1.2	160	0.8	214	0.8	141	1.1	69
Lymphoma	18.0	10,274	18.7	8,207	13.9	1,790	21.8	5,597	22.5	4,533	16.9	928
Hodgkin Lymphoma	2.3	1,147	2.2	782	2.5	329	2.6	619	2.4	421	3.0	177
Non-Hodgkin Lymphoma	15.7	9,127	16.5	7,425	11.3	1,461	19.2	4,978	20.1	4,112	13.9	751
Myeloma	7.0	4,193	5.3	2,466	13.0	1,652	8.4	2,257	6.9	1,441	14.6	778
Leukemia	12.4	6,995	12.6	5,388	9.5	1,208	15.7	3,977	16.0	3,127	12.0	642
Lymphocytic Leukemia	5.6	3,176	5.7	2,443	4.1	519	7.4	1,883	7.4	1,457	5.8	304
Acute Lymphocytic Leukemia	1.4	638	1.6	507	0.9	116	1.6	371	1.8	294	1.1	68
Chronic Lymphocytic Leukemia	3.9	2,316	3.8	1,759	3.0	376	5.2	1,367	5.0	1,041	4.4	224
Myeloid and Monocytic Leukemia	5.8	3,259	5.9	2,540	4.4	571	7.1	1,788	7.3	1,438	4.9	278
Acute Myeloid Leukemia	3.7	2,107	4.0	1,719	2.7	353	4.6	1,160	4.9	970	3.1	174
Chronic Myeloid Leukemia	1.7	949	1.5	651	1.4	187	2.0	513	1.9	371	1.5	87
Other Leukemia	1.0	560	0.9	405	1.0	118	1.3	306	1.2	232	1.3	60
Miscellaneous Malignant Cancer	15.7	9,134	15.6	7,027	14.8	1,852	18.8	4,862	19.0	3,849	16.7	881

Rates are per 100,000 and age-adjusted to the 2000 U.S. (19 age groups) standard. Rates are for malignant cases only, with the exception of All Sites, which includes bladder cancer *in situ*.

*Statistic not displayed because it is not applicable. ^Statistic not displayed due to fewer than 15 cases. Source: Alabama Statewide Cancer Registry, 2023. Data Years: 2011-2020.

Rates are per 100,000 and age-adjusted to the 2000 U.S. (19 age groups) standard. Rates are for malignant cases only, with the exception of All Sites, which includes bladder cancer in situ.
 *Statistic not displayed because it is not applicable. ^Statistic not displayed due to fewer than 15 cases. Source: Alabama Statewide Cancer Registry, 2025. Data Years: 2011-2020.

Table 1. Alabama Cancer Incidence Rates and Counts, by Site, Race, and Sex, 2011–2020 Combined

	Female					
	All Races		White		Black	
	Rate	Count	Rate	Count	Rate	Count
All Malignant Cancers	399.0	125,340	405.0	94,850	379.5	28,098
Oral Cavity and Pharynx	6.9	2,207	7.5	1,786	4.8	366
Digestive System	66.5	21,512	62.6	15,271	79.2	5,840
Esophagus	1.6	551	1.5	386	2.1	157
Stomach	4.9	1,576	3.9	953	7.9	572
Small Intestine	2.4	747	2.0	476	3.5	259
Colon and Rectum	36.7	11,698	35.1	8,406	41.7	3,072
Colon Excluding Rectum	27.9	8,976	26.5	6,424	32.6	2,400
Rectum and Rectosigmoid Junction	8.7	2,722	8.5	1,982	9.1	672
Anus, Anal Canal, and Anorectum	2.2	699	2.5	597	1.3	98
Liver and Intrahepatic Bile Duct	4.3	1,412	4.2	1,043	4.3	329
Gallbladder	1.0	320	0.8	201	1.5	111
Pancreas	11.2	3,756	10.3	2,636	14.6	1,071
Other Digestive Organs	0.3	105	0.3	70	0.4	34
Respiratory System	52.1	17,590	56.4	14,492	39.0	2,924
Larynx	1.6	511	1.7	410	1.1	89
Lung and Bronchus	49.8	16,868	54.0	13,919	37.3	2,791
Bones and Joints	0.9	252	0.9	177	1.0	71
Soft Tissue Including Heart	3.0	857	2.8	596	3.2	233
Skin Excluding Basal and Squamous	18.0	5,291	24.2	5,125	1.6	115
Melanoma of the Skin	17.1	4,990	23.2	4,890	1.0	69
Other Non-Epithelial Skin	1.0	301	1.0	235	0.6	46
Breast	121.8	37,782	119.4	27,665	126.8	9,418
Female Genital System	44.2	13,522	44.5	9,944	44.5	3,322
Cervix Uteri	9.2	2,353	9.1	1,605	9.8	682
Corpus and Uterus, NOS	19.7	6,396	19.3	4,600	21.7	1,687
Corpus Uteri	18.7	6,070	18.6	4,430	19.7	1,535
Uterus, NOS	1.0	326	0.7	170	2.0	152
Ovary	11.1	3,444	11.5	2,672	9.6	714
Vagina	0.8	261	0.8	188	0.9	69
Vulva	2.9	871	3.2	734	1.8	121
Other Female Genital Organs	0.6	197	0.6	145	0.7	49
Male Genital System	*	*	*	*	*	*
Prostate	*	*	*	*	*	*
Testis	*	*	*	*	*	*
Penis	*	*	*	*	*	*
Other Male Genital Organs	*	*	*	*	*	*
Urinary System	20.4	6,611	21.1	5,108	19.2	1,431
Urinary Bladder	7.5	2,501	7.9	2,034	6.0	434
Kidney and Renal Pelvis	12.5	3,957	12.7	2,953	12.8	967
Ureter	0.3	104	0.4	92	^	^
Other Urinary Organs	0.1	49	0.1	29	0.3	19
Eye and Orbit	0.6	199	0.8	184	^	^
Brain and Other Nervous System	5.6	1,637	6.3	1,331	3.8	275
Endocrine System	14.4	3,874	15.7	2,952	11.0	797
Thyroid	13.7	3,655	15.1	2,827	9.7	706
Other Endocrine Including Thymus	0.8	219	0.6	125	1.2	91
Lymphoma	15.0	4,677	15.6	3,674	11.7	862
Hodgkin Lymphoma	2.1	528	2.0	361	2.2	152
Non-Hodgkin Lymphoma	12.9	4,149	13.5	3,313	9.5	710
Myeloma	5.9	1,936	4.0	1,025	11.9	874
Leukemia	9.8	3,018	9.9	2,261	7.8	566
Lymphocytic Leukemia	4.2	1,293	4.3	986	2.9	215
Acute Lymphocytic Leukemia	1.1	267	1.3	213	0.7	48
Chronic Lymphocytic Leukemia	2.8	949	2.8	718	2.1	152
Myeloid and Monocytic Leukemia	4.8	1,471	4.9	1,102	4.0	293
Acute Myeloid Leukemia	3.1	947	3.3	749	2.4	179
Chronic Myeloid Leukemia	1.5	436	1.3	280	1.4	100
Other Leukemia	0.8	254	0.7	173	0.8	58
Miscellaneous Malignant Cancer	13.3	4,272	13.0	3,178	13.5	971

Rates are per 100,000 and age-adjusted to the 2000 U.S. (19 age groups) standard. Rates are for malignant cases only, with the exception of All Sites, which includes bladder cancer in situ.
 *Statistic not displayed because it is not applicable. ^Statistic not displayed due to fewer than 15 cases. Source: Alabama Statewide Cancer Registry, 2023. Data Years: 2011–2020.

Table 2. Trends in Alabama Cancer Incidence Rates, Selected Sites, 2016-2020

Females									
Breast	P-Value	0.5576			Cervix	P-Value	0.5883		
	Rate/Trend	Std. Error	Lower CI	Upper CI		Rate/Trend	Std. Error	Lower CI	Upper CI
Total PC	-0.7				Total PC	-9.9			
Total APC	0.6		-2.4	3.7	Total APC	-1.6		-9.8	7.3
2016 Rate	123.0	2.1	119.0	127.1	2016 Rate	9.9	0.7	8.7	11.3
2017 Rate	117.9	2.0	113.9	121.9	2017 Rate	9.7	0.6	8.5	11.1
2018 Rate	120.9	2.0	117.0	125.0	2018 Rate	8.3	0.6	7.2	9.6
2019 Rate	127.2	2.1	123.2	131.4	2019 Rate	10.1	0.7	8.9	11.5
2020 Rate	122.1	2.0	118.2	126.2	2020 Rate	9.0	0.6	7.8	10.2
Males					Males and Females				
Prostate	P-Value	0.0916			All Sites	P-Value	0.0671		
	Rate/Trend	Std. Error	Lower CI	Upper CI		Rate/Trend	Std. Error	Lower CI	Upper CI
Total PC	-16.5				Total PC	-13.2			
Total APC	-4.4		-9.8	1.3	Total APC	-2.8		-5.9	0.4
2016 Rate	124.9	2.1	120.8	129.1	2016 Rate	462.9	2.9	457.3	468.6
2017 Rate	131.5	2.1	127.3	135.8	2017 Rate	451.4	2.8	445.9	456.9
2018 Rate	123.6	2.1	119.6	127.7	2018 Rate	445.8	2.8	440.4	451.3
2019 Rate	119.6	2.0	115.7	123.6	2019 Rate	446.3	2.8	440.9	451.7
2020 Rate	104.2	1.9	100.6	107.9	2020 Rate	401.9	2.6	396.8	407.1
Males and Females									
Colorectal	P-Value	0.0531			Lung	P-Value	0.0380		
	Rate/Trend	Std. Error	Lower CI	Upper CI		Rate/Trend	Std. Error	Lower CI	Upper CI
Total PC	-15.6				Total PC	-19.0			
Total APC	-3.4		-6.8	0.1	Total APC	-4.4*		-8.2	-0.5
2016 Rate	44.0	0.9	42.2	45.7	2016 Rate	64.8	1.0	62.7	66.8
2017 Rate	42.4	0.9	40.7	44.1	2017 Rate	62.4	1.0	60.5	64.5
2018 Rate	40.8	0.8	39.2	42.5	2018 Rate	61.8	1.0	59.9	63.8
2019 Rate	41.8	0.9	40.1	43.5	2019 Rate	59.9	1.0	58.0	61.8
2020 Rate	37.1	0.8	35.5	38.7	2020 Rate	52.4	0.9	50.7	54.2
Melanoma	P-Value	0.0245			Oral	P-Value	0.1357		
	Rate/Trend	Std. Error	Lower CI	Upper CI		Rate/Trend	Std. Error	Lower CI	Upper CI
Total PC	-24.7				Total PC	-13.2			
Total APC	-6.6*		-11.3	-1.6	Total APC	-3.2		-8.0	1.9
2016 Rate	24.5	0.7	23.2	25.9	2016 Rate	13.8	0.5	12.8	14.8
2017 Rate	22.9	0.6	21.7	24.3	2017 Rate	13.0	0.5	12.1	13.9
2018 Rate	23.5	0.7	22.2	24.8	2018 Rate	11.6	0.4	10.7	12.5
2019 Rate	20.2	0.6	19.0	21.4	2019 Rate	12.5	0.5	11.6	13.5
2020 Rate	18.5	0.6	17.3	19.6	2020 Rate	12.0	0.4	11.1	12.9

Rates are per 100,000 and age-adjusted to the 2000 U.S. (19 age groups) standard; Confidence intervals (CI) are 95 percent for rates and trends.

Rates are for malignant cases only, with the exception of All Sites, which includes bladder cancer *in situ*.

Percent changes were calculated using 1 year for each end point; APCs were calculated using the weighted least squares method.

*APC is significantly different from zero ($p < 0.05$).

Source: Alabama Statewide Cancer Registry, 2023. Data Years: 2016-2020.

Table 3. Alabama Cancer Incidence Rates and Counts, by County, Males and Females, All Races, 2011-2020 Combined

	All Sites		Lung		Colorectal		Oral		Melanoma	
	Rate	Count	Rate	Count	Rate	Count	Rate	Count	Rate	Count
Alabama	447.0	26,497	63.9	39,430	42.3	24,761	12.8	7,659	21.3	12,083
Autauga	488.4	3,101	70.9	458	47.2	295	12.6	79	27.5	169
Baldwin	447.1	12,751	64.5	1,955	39.4	1,108	14.9	430	33.6	917
Barbour	441.4	1,515	65.0	230	40.6	134	17.7	57	18.2	62
Bibb	474.6	1,297	79.8	227	44.8	121	16.0	43	15.1	39
Blount	431.1	3,166	68.5	535	38.3	273	13.0	96	22.2	153
Bullock	459.4	578	67.3	87	36.9	48	17.1	21	^	^
Butler	434.9	1,178	57.4	168	45.3	123	12.4	35	15.9	41
Calhoun	469.0	6,799	75.9	1,148	46.6	672	16.2	238	19.3	262
Chambers	496.5	2,296	64.5	311	50.6	232	17.8	82	13.5	60
Cherokee	412.4	1,617	69.7	298	35.2	135	16.9	69	15.7	56
Chilton	422.4	2,247	62.5	349	41.1	215	12.0	63	17.4	90
Choctaw	419.5	833	46.9	104	56.6	109	13.3	24	12.6	26
Clarke	471.5	1,562	63.0	220	67.6	222	11.4	37	19.5	62
Clay	475.6	890	86.1	174	48.5	87	9.4	19	19.3	33
Cleburne	449.9	907	74.2	154	51.3	107	16.2	33	17.9	35
Coffee	423.9	2,671	64.0	424	32.0	197	12.1	80	22.7	137
Colbert	450.0	3,369	68.5	547	46.6	350	14.7	107	23.3	167
Conecuh	447.0	809	66.5	133	43.6	82	15.2	28	19.4	33
Coosa	371.4	625	61.8	111	33.5	53	10.7	18	^	^
Covington	443.6	2,344	78.2	447	48.6	257	14.5	77	22.6	111
Crenshaw	499.8	921	81.1	161	55.9	104	12.7	26	24.4	39
Cullman	434.3	4,628	67.7	772	38.7	416	14.8	160	30.4	312
Dale	447.4	2,686	73.0	462	39.5	230	14.8	91	23.7	137
Dallas	480.8	2,413	66.0	346	56.6	287	9.9	52	11.6	53
DeKalb	379.3	3,333	56.9	521	41.7	367	10.8	96	16.7	140
Elmore	492.6	4,607	71.9	685	40.8	375	14.3	137	35.0	314
Escambia	427.8	2,048	74.2	374	47.0	223	11.1	51	17.7	81
Etowah	467.3	6,375	73.1	1,051	45.1	618	14.6	203	21.3	279
Fayette	449.4	1,061	66.3	173	50.7	121	12.1	27	17.3	37
Franklin	432.2	1,652	69.9	277	44.8	173	11.0	43	23.5	85
Geneva	436.9	1,635	81.0	321	32.4	117	16.7	66	35.8	123
Greene	451.4	548	65.5	83	53.0	63	^	^	^	^
Hale	423.8	854	58.1	124	39.4	81	10.1	21	^	^
Henry	452.3	1,138	66.2	181	35.7	86	12.6	32	32.0	78
Houston	443.4	5,821	60.0	826	41.3	534	15.0	198	26.8	343
Jackson	449.8	3,241	76.6	595	45.3	320	11.6	79	24.2	163
Jefferson	451.2	34,996	57.7	4,570	38.0	2,911	11.4	899	16.1	1,185
Jenifer	472.7	969	82.2	176	52.3	110	10.9	24	22.3	40
Lauderdale	418.3	5,220	61.7	821	41.5	509	11.4	139	25.6	302
Lawrence	471.4	2,071	80.5	375	55.4	239	14.8	63	30.4	127
Lee	385.4	5,590	50.0	710	33.2	475	11.6	171	15.7	222
Lincoln	451.1	4,899	62.0	684	37.9	411	11.5	133	27.3	284
Lowndes	528.5	716	69.3	100	61.5	83	^	^	17.1	21
Macon	455.5	1,160	57.6	162	56.7	143	12.8	33	6.4	17
Madison	431.3	17,755	55.9	2,355	38.0	1,545	11.3	473	23.4	995
Marengo	450.1	1,180	57.2	155	55.1	147	8.1	21	11.2	28
Marion	444.8	1,923	68.6	319	47.4	202	15.3	64	16.9	66
Marshall	438.8	5,109	72.1	885	42.5	482	13.7	160	21.0	236
Mobile	440.8	21,634	64.6	3,270	46.0	2,229	11.7	579	21.5	1,016
Monroe	425.2	1,253	57.1	185	53.2	158	7.3	21	13.4	39
Montgomery	444.8	11,266	54.1	1,396	43.2	1,077	11.2	286	17.7	436
Morgan	468.4	6,996	69.9	1,099	44.4	658	14.4	215	28.2	398
Perry	437.9	535	46.9	62	44.6	55	14.1	17	^	^
Pickens	459.1	1,225	61.7	181	42.3	117	11.7	32	12.1	32
Pike	450.9	1,596	58.8	217	39.2	137	14.2	51	23.3	80
Randolph	428.6	1,369	68.9	233	46.3	144	9.8	33	16.2	47
Russell	438.3	2,787	71.5	468	44.1	273	14.0	88	12.2	75
St. Clair	462.0	4,919	75.0	832	42.8	449	13.4	146	23.9	241
Shelby	414.5	9,805	48.4	1,132	36.2	841	11.5	279	21.9	508
Sumter	454.8	714	61.4	99	51.9	77	^	^	^	^
Talladega	455.1	4,686	71.1	769	46.8	475	16.0	164	16.8	163
Tallapoosa	483.5	2,807	73.4	457	42.7	241	11.9	68	24.3	127
Tuscaloosa	441.3	9,127	61.2	1,286	39.5	808	11.1	237	13.8	277
Walker	515.1	4,493	89.0	839	46.3	389	15.5	138	24.7	191
Washington	422.0	932	56.0	129	49.2	106	11.5	25	18.4	37
Wilcox	486.9	693	64.5	97	58.2	77	^	^	16.5	23
Winston	427.5	1,481	74.4	281	38.2	132	15.7	54	24.7	79

Rates are per 100,000 and age-adjusted to the 2000 U.S. (19 age groups) standard.
 Rates are for malignant cases only, except for All Sites, which contains *in situ* bladder cases.
 ^ Statistic not displayed due to fewer than 15 cases.
 Source: Alabama Statewide Cancer Registry, 2023. Data Years: 2011-2020.

Table 4. Alabama Cancer Incidence Rates and Counts, by County, Males, All Races, 2011-2020 Combined												
	All Sites		Lung		Colorectal		Prostate		Oral		Melanoma	
	Rate	Count	Rate	Count	Rate	Count	Rate	Count	Rate	Count	Rate	Count
Alabama	513.2	139,639	82.2	22,562	49.2	13,063	122.6	35,648	19.7	5,452	27.4	7,093
Autauga	555.1	1,631	87.2	252	52.0	151	135.8	419	19.8	59	32.3	92
Baldwin	497.4	6,820	75.4	1,078	45.5	598	92.5	1,372	21.6	300	44.0	584
Barbour	532.3	853	90.3	142	44.7	68	153.9	262	26.9	43	20.7	33
Bibb	541.5	716	98.5	131	60.8	78	112.0	157	27.4	37	20.5	24
Blount	482.3	1,677	86.1	310	46.9	153	92.3	345	21.8	77	26.1	84
Bullock	509.8	308	86.5	54	50.5	28	156.4	102	^	^	^	^
Butler	507.4	616	81.0	102	57.4	69	132.9	176	20.0	25	21.5	23
Calhoun	554.8	3,603	96.4	628	57.8	366	132.9	907	25.3	171	25.0	159
Chambers	589.0	1,251	90.3	194	60.7	125	144.9	336	24.2	53	13.6	29
Cherokee	471.7	921	89.0	180	39.6	76	89.6	196	26.4	53	22.8	41
Chilton	487.7	1,223	77.1	198	50.6	122	111.2	290	16.5	43	20.7	52
Choctaw	507.2	476	64.5	65	68.6	61	158.0	158	20.3	17	16.6	16
Clarke	545.2	833	83.0	131	80.6	123	126.3	205	20.1	29	22.0	33
Clay	533.9	481	115.3	107	49.4	43	122.9	114	^	^	19.9	17
Cleburne	530.4	511	91.3	88	71.5	69	101.7	107	24.0	23	27.0	26
Coffee	487.6	1,424	82.7	244	37.6	106	120.0	367	17.6	54	29.0	81
Colbert	525.0	1,808	93.1	327	54.4	186	98.1	361	22.8	76	32.2	106
Conecuh	496.0	435	91.5	84	47.4	43	94.3	89	20.0	19	29.4	25
Coosa	388.8	329	80.8	70	30.0	24	98.4	92	^	^	^	^
Covington	499.2	1,202	95.9	245	59.1	139	88.4	231	23.3	56	26.2	57
Crenshaw	568.5	487	109.6	99	69.4	58	120.0	111	22.1	20	23.0	17
Cullman	479.1	2,394	88.1	466	38.8	197	78.8	422	22.1	111	38.5	190
Dale	501.1	1,402	83.2	238	40.2	110	114.7	345	22.5	64	31.6	84
Dallas	563.5	1,269	93.5	216	66.7	148	164.5	397	14.8	34	11.9	25
DeKalb	427.7	1,772	76.0	316	42.5	178	91.2	410	15.2	64	22.8	88
Elmore	579.3	2,500	89.9	393	49.9	214	131.0	608	21.2	96	44.7	179
Escambia	495.5	1,107	101.7	233	57.5	125	93.1	220	13.8	30	19.2	41
Etowah	536.4	3,345	89.0	569	55.5	345	112.7	747	22.8	142	26.5	161
Fayette	498.5	553	71.8	87	64.5	71	118.0	142	21.4	23	16.2	16
Franklin	493.0	869	88.5	159	54.4	95	89.3	165	17.6	31	31.0	54
Geneva	504.3	890	104.9	190	33.0	54	104.4	199	23.2	43	41.6	70
Greene	502.8	275	93.8	52	57.0	30	159.4	92	^	^	^	^
Hale	515.3	473	84.0	80	43.0	41	145.1	140	16.2	16	^	^
Henry	548.7	663	88.3	109	38.7	42	136.0	182	23.0	26	38.6	45
Houston	521.8	3,112	73.5	445	51.0	297	128.9	826	23.9	143	32.9	187
Jackson	494.8	1,679	96.1	347	51.3	170	85.0	310	18.3	59	28.5	96
Jefferson	529.7	18,140	76.6	2,568	43.7	1,454	158.0	5,790	18.5	645	21.6	701
Lamar	527.1	514	95.7	96	66.0	60	108.7	119	^	^	32.5	27
Lauderdale	471.6	2,702	88.3	516	48.3	264	88.7	549	17.9	103	30.6	165
Lawrence	542.4	1,119	106.2	228	66.6	133	107.2	227	20.8	43	30.9	62
Lee	438.4	2,908	63.4	401	38.0	249	120.2	835	16.7	115	19.5	128
Limestone	513.5	2,638	78.4	402	45.0	233	107.2	590	16.9	95	35.0	164
Lowndes	645.5	405	104.3	67	80.7	49	188.1	125	^	^	^	^
Macon	559.0	639	82.6	103	68.8	77	193.8	225	20.1	24	^	^
Madison	455.3	8,649	65.9	1,243	41.8	778	95.6	1,964	16.8	328	29.9	542
Marengo	527.9	641	78.7	94	68.3	80	156.6	207	^	^	^	^
Marion	505.9	1,044	90.9	193	62.8	130	105.2	225	23.1	48	18.5	36
Marshall	501.1	2,699	91.3	502	45.0	234	90.2	527	20.4	112	25.8	133
Mobile	509.5	11,346	82.4	1,836	54.8	1,189	105.7	2,534	16.8	383	28.3	596
Monroe	479.0	652	72.7	107	60.1	77	107.9	157	12.1	16	17.0	22
Montgomery	518.6	5,738	71.2	780	50.6	545	149.0	1,739	18.8	211	25.5	268
Morgan	547.7	3,780	91.5	637	49.7	344	128.8	934	21.2	146	38.8	256
Perry	542.2	286	78.4	44	39.5	20	160.6	89	^	^	^	^
Pickens	481.6	615	80.2	105	50.8	64	113.0	153	19.0	23	14.9	19
Pike	522.5	839	80.6	129	45.1	69	130.1	230	24.1	40	33.1	51
Randolph	495.9	745	94.9	145	50.3	72	114.1	186	14.2	23	19.8	28
Russell	502.6	1,432	94.1	267	52.4	147	113.1	343	21.7	62	16.0	43
St. Clair	523.9	2,614	94.8	475	51.1	253	117.0	618	21.5	116	29.7	136
Shelby	469.6	5,132	56.6	590	39.3	430	138.5	1,632	18.4	208	27.5	295
Sumter	560.7	384	96.9	67	62.8	39	193.7	141	^	^	^	^
Talladega	527.0	2,526	97.2	473	61.7	281	109.8	570	24.4	118	23.1	103
Tallapoosa	551.2	1,554	91.2	267	47.4	132	120.3	377	17.8	50	27.1	70
Tuscaloosa	515.2	4,810	84.5	776	47.0	428	141.1	1,396	16.9	166	18.8	164
Walker	586.8	2,390	111.7	481	50.0	193	131.1	568	26.7	107	27.3	102
Washington	482.8	518	71.0	78	63.8	64	102.8	122	17.8	18	23.8	23
Wilcox	584.1	378	90.1	59	63.2	36	160.9	114	^	^	28.2	16
Winston	512.5	845	107.1	185	46.0	74	91.1	166	22.0	36	29.2	45

Rates are per 100,000 and age-adjusted to the 2000 U.S. (19 age groups) standard.
 Rates are for malignant cases only, except for All Sites, which contains in situ bladder cases.
 ^Statistic not displayed due to fewer than 15 cases.
 Source: Alabama Statewide Cancer Registry, 2023. Data Years: 2011-2020.

Table 5. Alabama Cancer Incidence Rates and Counts, by County, Females, All Races, 2011-2020 Combined														
	All Sites		Lung		Colorectal		Breast		Cervix		Oral		Melanoma	
	Rate	Count	Rate	Count	Rate	Count	Rate	Count	Rate	Count	Rate	Count	Rate	Count
Alabama	399.0	12534.0	49.8	16868	36.7	11698	121.8	37782	9.2	2353	6.9	2207	17.1	4990
Autauga	436.3	1470	58.2	206	43.0	144	133.4	459	9.5	27	6.1	20	24.1	77
Baldwin	406.2	5931	55.2	877	33.8	510	123.9	1800	10.4	111	8.9	130	24.9	333
Barbour	385.2	662	45.6	88	38.2	66	105.4	172	^	^	^	^	17.0	29
Bibb	430.3	581	64.9	96	30.2	43	141.0	188	^	^	^	^	^	^
Blount	391.9	1489	54.1	225	31.5	120	120.2	459	10.7	31	5.2	18	19.0	69
Bullock	442.3	270	49.1	33	27.0	20	148.8	83	^	^	^	^	^	^
Butler	389.9	562	41.0	66	35.3	54	152.3	205	^	^	^	^	13.1	18
Calhoun	411.7	3196	61.5	520	38.5	306	112.7	866	10.1	61	8.3	67	15.3	103
Chambers	430.4	1045	45.0	117	42.0	107	114.5	278	17.0	34	12.3	29	13.6	31
Cherokee	365.0	686	53.5	118	32.3	59	96.1	180	13.2	19	8.3	16	^	^
Chilton	375.3	1024	51.0	151	34.2	93	109.1	296	12.1	28	8.3	20	15.1	38
Choctaw	350.8	357	33.5	39	45.6	48	113.3	115	^	^	^	^	^	^
Clarke	414.6	729	47.5	89	57.0	99	143.7	250	^	^	^	^	17.6	29
Clay	435.7	409	62.1	67	48.8	44	132.5	120	^	^	^	^	19.2	16
Cleburne	384.4	396	59.3	66	35.0	38	105.9	107	^	^	^	^	^	^
Coffee	378.7	1247	49.9	180	27.9	91	115.1	372	8.8	22	7.2	26	18.1	56
Colbert	395.9	1561	49.5	220	40.4	164	120.4	466	12.1	34	7.5	31	16.5	61
Conecuh	405.0	374	44.8	49	40.6	39	138.0	123	^	^	^	^	^	^
Coosa	357.8	296	44.6	41	35.4	29	87.1	74	^	^	^	^	^	^
Covington	404.6	1142	66.2	202	40.7	118	114.1	315	^	^	7.2	21	20.2	54
Crenshaw	446.9	434	58.1	62	45.3	46	127.1	122	^	^	^	^	27.3	22
Cullman	403.8	2234	51.5	316	39.0	219	117.5	654	9.1	41	8.1	49	24.2	122
Dale	406.4	1284	64.7	224	38.1	120	123.6	383	10.3	25	8.2	27	17.6	53
Dallas	419.0	1144	44.2	130	49.2	139	142.3	374	15.3	33	5.9	18	11.5	28
DeKalb	342.9	1561	42.0	205	40.4	189	89.0	405	10.0	37	7.0	32	12.2	52
Elmore	425.3	2107	57.3	292	32.8	161	125.9	626	11.4	50	8.2	41	28.4	135
Escambia	381.0	941	52.0	141	38.4	98	106.3	258	^	^	8.4	21	17.1	40
Etowah	419.4	3030	60.9	482	37.1	273	109.8	781	13.9	75	8.2	61	17.6	117
Fayette	408.7	508	60.2	86	38.4	50	101.7	127	16.0	16	^	^	19.3	21
Franklin	392.3	783	55.1	118	37.2	78	111.3	222	^	^	^	^	17.8	31
Geneva	385.0	745	61.6	131	32.0	63	106.4	203	^	^	11.6	23	31.8	53
Greene	413.0	273	45.0	31	50.3	33	135.0	86	^	^	^	^	^	^
Hale	354.8	381	39.2	44	36.5	40	117.3	124	^	^	^	^	^	^
Henry	372.1	485	49.5	72	32.7	44	102.4	130	^	^	^	^	27.5	33
Houston	386.1	2709	50.1	381	33.7	237	114.1	789	10.2	62	7.9	55	22.9	156
Jackson	421.2	1562	60.0	248	40.7	150	116.8	429	11.6	30	5.4	20	21.5	67
Jefferson	396.1	16856	44.2	2002	33.6	1457	130.9	5463	8.1	286	5.7	254	12.4	484
Lamar	431.1	455	72.5	80	43.0	50	140.3	142	^	^	^	^	^	^
Lauderdale	383.6	2518	41.5	305	35.9	245	113.4	724	5.9	31	5.8	36	22.5	137
Lawrence	418.4	952	59.2	147	46.5	106	116.0	281	^	^	9.2	20	31.6	65
Lee	346.3	2682	39.6	309	29.2	226	107.1	832	8.3	60	7.2	56	12.7	94
Limestone	405.9	2261	49.0	292	31.1	178	123.3	686	8.7	43	6.6	38	22.6	120
Lowndes	435.6	311	41.2	33	44.9	34	125.0	88	^	^	^	^	^	^
Macon	377.6	521	37.4	59	46.4	66	114.1	153	^	^	^	^	^	^
Madison	417.4	9106	48.5	1112	35.0	767	132.6	2895	6.8	123	6.6	145	18.8	393
Marengo	386.2	538	40.2	61	43.9	67	129.8	171	^	^	^	^	^	^
Marion	401.0	879	50.8	126	33.8	72	123.4	265	^	^	7.8	16	15.9	30
Marshall	397.4	2410	58.0	383	40.3	248	101.1	616	10.9	52	7.6	48	18.3	103
Mobile	380.8	10288	51.1	1434	38.8	1040	117.2	3054	9.3	201	7.5	186	16.9	420
Monroe	388.2	601	44.5	78	49.0	81	136.6	203	^	^	^	^	10.9	17
Montgomery	394.7	5528	42.0	616	37.6	532	126.7	1736	9.8	117	5.2	75	12.3	168
Morgan	411.4	3216	53.9	462	40.3	314	119.4	926	8.9	53	8.3	69	20.3	142
Perry	359.5	249	23.5	18	49.2	35	115.7	77	^	^	^	^	^	^
Pickers	452.2	610	47.9	76	35.6	53	117.5	236	^	^	^	^	^	^
Pike	398.4	757	43.1	88	35.1	68	129.1	239	^	^	^	^	16.1	29
Randolph	379.6	624	47.5	88	43.8	72	99.1	159	14.2	17	^	^	13.0	19
Russell	395.6	1355	55.4	201	37.2	126	114.0	387	11.0	33	7.9	26	9.2	32
St. Clair	416.0	2305	59.2	357	35.6	196	126.4	702	10.0	46	5.7	30	19.9	105
Shelby	373.0	4673	42.4	542	33.1	411	125.2	1587	4.7	55	5.7	71	17.5	213
Sumter	380.0	330	35.7	32	44.7	38	128.7	111	^	^	^	^	^	^
Talladega	400.9	2160	50.1	296	34.5	194	117.4	622	10.9	52	8.6	46	12.0	60
Tallapoosa	429.5	1253	58.7	190	38.8	109	110.6	332	13.8	29	6.3	18	22.3	57
Tuscaloosa	388.9	4317	43.9	510	33.8	380	130.2	1419	9.5	93	6.2	71	10.4	113
Walker	462.7	2103	70.4	358	43.5	196	115.9	537	13.1	45	6.2	31	23.1	89
Washington	370.6	414	42.6	51	37.1	42	107.6	124	^	^	^	^	^	^
Wilcox	417.0	315	47.6	38	55.0	41	120.5	85	^	^	^	^	^	^
Winston	364.1	636	46.8	96	31.6	58	97.3	169	^	^	10.5	18	22.5	34

Rates are per 100,000 and age-adjusted to the 2000 U.S. (19 age groups) standard.
 Rates are for malignant cases only, except for All Sites, which contains in situ bladder cases.
 ^Statistic not displayed due to fewer than 15 cases.

Source: Alabama Statewide Cancer Registry, 2023. Data Years: 2011-2020.

Table 6. Alabama Cancer Incidence Rates and Counts, by County, Males and Females, by Race, 2011-2020 Combined

	All Sites				Lung				Colorectal				Oral				Melanoma			
	White		Black		White		Black		White		Black		White		Black		White		Black	
	Rate	Count	Rate	Count	Rate	Count	Rate	Count	Rate	Count	Rate	Count	Rate	Count	Rate	Count	Rate	Count	Rate	Count
Alabama	444.4	20,694	443.9	58,503	66.5	31,767	56.1	7,365	40.5	18,124	48.5	6,188	13.8	6,285	8.6	1,182	27.9	11,894	1.0	117
Autauga	475.1	2,488	524.3	543	73.2	397	58.7	57	46.4	242	49.1	48	13.2	67	^	^	34.1	169	^	^
Baldwin	446.2	11,723	428.3	793	65.2	1,831	58.4	108	38.1	998	58.4	101	15.2	406	9.3	20	36.4	911	^	^
Barbour	459.8	941	418.0	559	73.0	159	51.3	69	34.5	68	51.9	64	19.1	38	15.4	19	30.9	62	^	^
Bibb	473.3	1,063	493.5	228	80.9	193	75.9	34	45.3	100	50.6	21	17.5	38	^	^	18.2	39	^	^
Blount	426.9	3,068	410.8	42	69.2	528	^	^	37.9	263	^	^	13.0	93	^	^	22.7	152	^	^
Bullock	435.3	178	466.6	388	71.1	30	66.3	57	^	^	41.1	35	^	^	^	^	^	^	^	^
Butler	430.4	721	434.8	435	62.5	116	48.7	51	37.8	66	57.4	56	16.0	27	^	^	25.8	41	^	^
Calhoun	474.5	5,640	444.1	1,056	80.3	1,008	58.1	134	45.6	54	51.9	121	17.5	208	10.1	25	23.9	261	^	^
Chambers	518.4	1,560	452.4	705	73.5	233	47.1	77	49.7	150	53.0	80	24.1	71	^	^	19.5	56	^	^
Cherokee	409.6	1,529	462.0	74	70.4	287	^	^	35.2	127	^	^	17.1	66	^	^	16.6	56	^	^
Chilton	415.6	2,001	446.3	209	62.5	317	70.1	31	41.2	194	40.4	19	12.4	58	^	^	19.3	90	^	^
Choctaw	397.1	477	450.0	352	49.6	68	42.1	36	46.7	55	70.0	53	^	^	^	^	21.0	26	^	^
Clarke	448.1	933	501.6	620	66.9	151	53.5	68	55.9	113	89.7	109	12.4	25	^	^	29.6	57	^	^
Clay	476.7	773	426.6	102	87.1	154	90.5	20	46.1	72	^	^	9.8	17	^	^	22.3	33	^	^
Cleburne	444.8	863	475.9	32	74.6	149	^	^	50.4	102	^	^	14.9	30	^	^	18.2	34	^	^
Coffee	430.9	2,208	403.7	395	66.3	358	63.4	62	32.3	162	31.3	29	13.2	70	^	^	27.5	135	^	^
Colbert	463.2	2,848	429.2	481	73.5	496	43.4	51	45.1	283	56.6	65	15.7	96	^	^	27.2	164	^	^
Conecuh	434.1	468	464.9	332	68.3	83	60.8	48	37.6	46	52.0	36	13.8	16	^	^	34.5	33	^	^
Coosa	367.0	444	379.6	174	68.3	91	43.2	20	27.2	31	49.1	21	^	^	^	^	^	^	^	^
Covington	438.9	2,072	471.3	247	78.3	404	76.9	40	48.6	228	52.4	28	15.7	74	^	^	24.5	107	^	^
Crenshaw	504.6	721	470.1	186	87.3	135	63.9	26	49.7	72	68.0	27	16.4	26	^	^	30.7	37	^	^
Cullman	433.5	4,524	272.2	29	67.9	760	^	^	39.4	414	^	^	15.1	159	^	^	30.9	310	^	^
Dale	452.2	2,203	428.6	423	76.8	398	51.4	52	38.5	183	47.9	44	15.9	80	^	^	29.3	137	^	^
Dallas	507.2	954	464.6	1,420	69.5	142	63.4	201	57.8	109	58.6	177	14.9	28	7.0	23	32.9	49	^	^
DeKalb	375.4	3,183	422.1	59	57.1	507	^	^	41.8	356	^	^	11.2	95	^	^	17.2	138	^	^
Etowah	488.8	3,824	499.3	686	72.0	591	75.0	91	39.7	305	50.3	68	14.7	119	^	^	42.2	312	^	^
Escambia	442.0	1,486	420.5	529	79.5	285	63.8	81	49.8	165	43.9	56	12.7	41	^	^	24.8	79	^	^
Etowah	468.6	5,534	449.1	743	74.4	938	62.8	104	44.8	530	47.9	76	15.0	180	9.0	17	24.5	275	^	^
Fayette	442.8	923	438.4	115	68.3	157	55.1	16	51.2	106	^	^	12.4	25	^	^	19.3	36	^	^
Franklin	435.2	1,571	306.4	52	72.3	271	^	^	45.4	166	^	^	11.3	42	^	^	24.6	84	^	^
Geneva	443.0	1,497	395.2	124	81.8	293	77.0	25	33.3	109	^	^	17.3	61	^	^	39.0	121	^	^
Greene	494.0	143	433.4	398	88.9	29	57.6	54	^	^	57.9	51	^	^	^	^	^	^	^	^
Hale	412.1	392	425.5	449	63.1	65	53.9	58	41.9	42	36.0	38	^	^	^	^	^	^	^	^
Henry	445.7	835	479.2	297	68.0	142	60.4	38	37.7	67	31.6	19	12.8	25	^	^	41.7	76	^	^
Houston	444.9	4,560	443.8	1,188	61.2	669	52.9	145	39.4	400	49.5	128	16.9	172	8.9	24	34.6	340	^	^
Jackson	451.1	3,080	377.3	85	78.5	578	^	^	45.1	304	^	^	11.8	76	^	^	25.2	161	^	^
Jefferson	443.2	20,775	454.8	13,550	59.1	2,893	55.2	1,642	34.0	1,593	43.7	1,257	12.9	615	8.9	270	26.5	1,164	0.7	18
Lamar	471.7	873	479.6	93	85.6	164	^	^	53.6	102	^	^	10.4	21	^	^	25.0	40	^	^
Lauderdale	473.4	4,722	453.6	439	62.3	780	54.9	57	39.7	446	63.1	60	12.0	133	^	^	27.7	294	^	^
Lawrence	498.5	1,801	480.6	254	90.0	349	39.1	24	55.5	200	79.3	39	16.6	59	^	^	36.7	126	^	^
Lee	374.3	4,079	421.1	1,333	49.1	537	56.1	163	29.6	320	43.4	129	12.4	137	9.6	31	20.8	219	^	^
Limestone	451.8	4,245	424.2	547	64.1	629	52.4	63	37.4	352	39.6	48	12.4	124	^	^	31.6	281	^	^
Lowndes	553.7	247	513.2	457	67.7	37	67.5	62	53.7	25	63.9	57	^	^	^	^	52.5	18	^	^
Madison	461.4	294	446.3	895	83.9	48	50.9	114	^	^	63.1	128	^	^	11.6	23	^	^	^	^
Madison	433.5	13,821	405.8	3,233	57.7	1,920	51.7	396	37.3	1,171	43.4	333	12.6	406	6.2	54	30.3	928	^	^
Marengo	434.3	615	446.2	536	61.9	96	50.8	60	49.6	70	59.8	75	^	^	^	^	20.3	25	^	^
Marion	443.8	1,848	454.3	63	69.3	311	^	^	47.8	196	^	^	15.7	63	^	^	17.7	66	^	^
Marshall	437.4	4,923	457.2	85	72.6	868	^	^	42.7	468	^	^	14.1	158	^	^	21.7	235	^	^
Mobile	448.0	14,744	435.2	6,516	67.5	2,327	59.4	901	44.9	1,463	50.8	733	13.0	428	8.9	138	31.7	994	1.3	17
Monroe	420.0	783	435.3	458	60.7	127	53.7	58	44.9	85	68.3	71	^	^	^	^	20.0	35	^	^
Montgomery	445.9	5,667	437.9	5,287	56.7	779	51.8	609	41.8	534	44.3	525	12.4	157	8.8	114	35.6	421	^	^
Morgan	467.9	6,239	475.1	646	71.4	1,013	65.7	82	43.0	566	61.5	81	15.0	199	^	^	31.6	396	^	^
Perry	394.9	200	438.3	322	53.8	30	40.8	31	39.4	21	47.1	34	^	^	^	^	^	^	^	^
Pickens	423.1	727	501.9	481	60.5	115	63.3	66	36.4	64	54.7	53	12.1	20	^	^	19.4	32	^	^
Pike	446.0	1,065	446.1	496	57.1	148	61.5	68	33.0	80	47.3	52	15.9	39	^	^	34.6	79	^	^
Randolph	422.9	1,123	452.5	231	70.7	201	61.1	31	44.9	117	55.4	27	11.1	31	^	^	19.2	45	^	^
Russell	466.2	1,744	391.9	995	88.4	351	46.4	113	42.1	154	46.3	115	16.8	62	8.5	22	21.2	74	^	^
St. Clair	460.8	4,511	412.6	318	76.5	787	59.9	41	42.8	415	36.8	26	13.6	137	^	^	25.9	237	^	^
Shelby	412.2	8,710	425.7	847	49.3	1,046	41.8	70	35.6	741	43.6	75	11.8	254	6.2	16	24.6	505	^	^
Sumter	441.0	205	456.0	500	56.1	30	61.1	68	38.1	19	58.2	58	^	^	^	^	^	^	^	^
Talladega	463.2	3,446	425.1	1,165	75.8	611	59.9	157	46.6	343	47.8	125	18.2	132	11.4	31	22.8	159	^	^
Tallapoosa	471.6	2,134	526.6	661	75.9	369	70.2	87	39.2	173	59.0	68	12.0	52	^	^	32.2	127	^	^
Tuscaloosa	429.7	6,434	454.7	2,501	61.6	954	60.4	326	37.1	550	45.8	243	11.7	182	8.1	49	18.7	271	^	^
Walker	513.6	4,231	543.8	221	90.1	805	80.6	32	45.9	363	60.5	25	15.9	134	^	^	26.2	190	^	^
Washington	446.9	700	439.0	222	61.3	102	52.5	27	53.4	81	42.8	22	14.2	22	^	^	26.3	37	^	^
Wilcox	477.6	253	483.1	431	65.3	40	59.8	56	39.4	22	63.8	53	^	^	^	^	46.0	21	^	^
Winston	427.4	1,455	^	^	74.1	276	^	^	38.6	131	^	^	15.7	53	^	^	24.8	78	^	^

Table 7. Alabama Cancer Incidence Rates and Counts, by County, Males by Race, 2011-2020 Combined												
	All Sites				Lung				Colorectal			
	White		Black		White		Black		White		Black	
	Rate	Count	Rate	Count	Rate	Count	Rate	Count	Rate	Count	Rate	Count
Alabama	499.8	105,794	538.2	30,405	82.6	17,848	83.0	4,564	47.0	9,718	58.0	3,109
Autauga	519.9	1,278	686.6	312	85.4	210	97.8	41	48.9	120	71.0	31
Baldwin	492.7	6,266	482.2	399	75.4	1,003	82.7	66	44.0	542	69.0	52
Barbour	524.8	524	564.8	320	92.6	93	83.7	47	32.1	31	74.8	36
Bibb	533.9	577	588.5	134	94.1	104	128.1	27	62.6	66	^	^
Blount	480.5	1,630	367.4	18	87.5	308	^	^	46.8	149	^	^
Bullock	415.7	93	551.9	206	77.5	18	94.0	36	^	^	56.1	18
Butler	505.7	386	485.4	212	83.4	66	75.8	35	48.3	39	71.3	29
Calhoun	554.6	3,003	547.5	549	101.0	556	74.9	69	56.1	296	66.2	66
Chambers	605.6	869	561.8	371	95.4	141	77.3	53	60.7	84	59.5	41
Cherokee	473.0	877	450.8	37	91.2	175	^	^	40.0	72	^	^
Chilton	475.4	1,085	544.1	118	77.6	181	76.2	17	49.6	109	^	^
Choctaw	475.8	280	558.1	194	66.1	42	60.9	23	58.3	33	87.0	28
Clarke	503.1	505	606.7	320	74.4	80	94.8	50	66.9	67	109.1	56
Clay	533.6	421	461.3	50	115.2	95	^	^	46.0	36	^	^
Cleburne	521.7	486	546.7	16	90.6	84	^	^	70.8	67	^	^
Coffee	489.0	1,181	498.8	215	83.0	204	93.8	39	37.4	89	^	^
Colbert	522.4	1,523	506.9	251	98.1	293	65.2	33	51.9	150	68.0	34
Conecuh	460.4	254	545.7	173	86.9	50	97.2	32	39.3	25	61.1	18
Coosa	368.7	226	449.3	99	83.9	55	^	^	^	^	^	^
Covington	492.4	1,071	582.4	125	95.8	223	105.9	21	59.5	125	^	^
Crenshaw	580.0	388	518.5	90	113.0	81	105.0	18	66.8	45	^	^
Cullman	476.8	2,332	319.0	17	88.4	449	^	^	39.6	197	^	^
Dale	497.9	1,164	526.7	218	85.1	205	71.2	30	38.5	87	43.5	21
Dallas	548.4	499	564.6	741	77.3	73	103.1	141	67.8	60	70.8	88
DeKalb	421.0	1,680	556.1	37	76.5	307	^	^	42.9	173	^	^
Elmore	554.3	2,031	662.7	396	85.8	329	126.9	63	47.3	171	68.4	42
Escambia	510.8	804	489.1	283	102.3	168	106.8	59	61.4	92	50.6	31
Etowah	532.3	2,914	555.7	377	89.5	508	84.6	56	53.1	293	76.0	45
Fayette	483.9	477	510.2	59	72.5	78	^	^	67.7	66	^	^
Franklin	494.6	821	365.7	31	91.1	154	^	^	55.8	92	^	^
Geneva	504.7	808	543.5	76	103.9	171	126.7	17	33.2	50	^	^
Greene	591.8	81	457.5	188	132.4	19	79.5	33	^	^	66.3	25
Hale	456.1	210	556.0	252	81.5	40	87.6	40	39.3	19	45.0	21
Henry	513.1	468	665.3	181	86.7	84	86.1	24	39.4	33	^	^
Houston	508.3	2,406	574.1	666	73.0	353	70.1	84	46.8	218	69.5	76
Jackson	497.0	1,601	403.5	43	98.9	339	^	^	53.5	168	^	^
Jefferson	505.7	10,780	556.9	7,018	74.4	1,581	79.8	962	40.0	829	48.9	590
Lamar	530.0	469	499.4	44	98.0	89	^	^	68.1	57	^	^
Lauderdale	464.7	2,454	529.7	221	88.0	473	96.5	43	45.5	231	87.5	33
Lawrence	560.1	973	628.1	141	118.4	213	^	^	62.9	108	123.0	25
Lee	414.8	2,132	537.7	691	59.1	296	86.5	100	33.6	169	51.6	67
Limestone	508.5	2,273	525.5	306	78.3	353	89.3	48	44.6	202	52.9	25
Lowndes	629.3	147	634.0	248	85.5	23	109.9	44	^	^	85.6	34
Macon	508.6	138	561.2	484	84.1	25	81.9	78	^	^	76.4	67
Madison	450.8	6,789	437.5	1,500	66.2	1,006	68.5	222	41.2	604	47.9	158
Marengo	448.4	305	588.2	313	74.5	51	83.2	43	58.2	37	82.2	43
Marion	504.0	998	492.3	37	91.8	188	^	^	62.7	125	^	^
Marshall	499.4	2,596	542.9	46	93.1	497	^	^	44.7	223	^	^
Mobile	504.6	7,768	525.9	3,350	81.2	1,258	86.6	563	52.8	792	62.1	375
Monroe	446.3	400	547.2	245	65.3	63	91.3	44	44.3	40	91.6	35
Montgomery	505.5	2937	514.2	2,604	71.1	425	72.9	354	50.5	286	51.2	249
Morgan	544.0	3,389	583.9	328	92.6	587	100.9	49	48.5	301	64.3	37
Perry	505.3	111	544.0	165	82.1	21	75.9	23	^	^	^	^
Pickens	446.5	383	540.7	224	77.0	69	89.3	36	41.0	35	73.0	29
Pike	511.5	572	535.7	253	77.5	88	90.4	41	41.5	44	49.4	23
Randolph	482.9	614	551.1	122	96.1	125	84.2	19	48.1	60	^	^
Russell	503.9	874	498.0	533	102.8	185	82.3	80	48.5	82	56.4	63
St. Clair	520.9	2,391	502.4	181	96.7	448	70.5	26	52.0	236	^	^
Shelby	463.0	4,570	557.1	436	56.5	538	69.5	47	38.8	383	49.3	33
Sumter	545.7	115	556.4	261	78.7	19	103.2	48	^	^	71.0	28
Talladega	519.7	1,833	528.0	648	97.6	361	101.2	111	60.5	202	66.1	74
Tallapoosa	531.0	1,187	628.1	353	89.7	208	104.9	58	45.3	102	60.3	30
Tuscaloosa	486.1	3,380	569.4	1,290	82.2	569	94.5	204	43.9	300	58.0	121
Walker	581.9	2,247	663.6	114	113.0	463	111.5	17	49.9	182	^	^
Washington	500.3	385	526.2	127	74.8	60	73.7	18	71.5	51	^	^
Wilcox	567.0	141	573.4	231	91.6	24	85.0	35	^	^	79.9	28
Winston	510.6	829	^	^	105.9	181	^	^	46.0	73	^	^

Rates are per 100,000 and age-adjusted to the 2000 U.S. (19 age groups) standard.
 Rates are for malignant cases only, except for All Sites, which contains in situ bladder cases.
 ^Statistic not displayed due to fewer than 15 cases.

Source: Alabama Statewide Cancer Registry, 2023. Data Years: 2011-2020.

Table 7. (Continued) - Alabama Cancer Incidence Rates and Counts, by County, Males by Race, 2011-2020 Combined

	Prostate				Oral				Melanoma			
	White		Black		White		Black		White		Black	
	Rate	Count	Rate	Count	Rate	Count	Rate	Count	Rate	Count	Rate	Count
Alabama	100.3	22,814	188.0	11,132	21.0	4,499	13.8	817	34.5	7,004	0.9	48
Autauga	99.5	25.8	229.3	133	19.9	49	^	^	38.8	92	^	^
Baldwin	83.5	1151	137.2	114	22.2	287	^	^	47.2	581	^	^
Barbour	117.0	126	222.0	133	28.5	29	^	^	32.7	33	^	^
Bibb	102.8	120	128.3	35	29.9	32	^	^	25.0	24	^	^
Blount	90.5	330	^	^	221	76	^	^	26.8	84	^	^
Bullock	73.4	17	188.5	77	^	^	^	^	^	^	^	^
Butler	96.6	82	184.5	84	23.8	19	^	^	32.8	23	^	^
Calhoun	118.7	679	210.1	212	26.7	148	171	20	29.7	158	^	^
Chambers	108.5	172	232.1	160	33.3	48	^	^	20.1	29	^	^
Cherokee	87.4	182	^	^	27.6	52	^	^	21.0	41	^	^
Chilton	102.1	242	190.6	43	17.3	41	^	^	22.8	52	^	^
Choctaw	113.4	72	231.2	85	^	^	^	^	26.0	16	^	^
Clarke	100.8	10.8	164.4	93	21.1	20	^	^	30.5	31	^	^
Clay	113.3	91	153.7	18	^	^	^	^	22.7	17	^	^
Cleburne	96.5	98	^	^	23.4	22	^	^	27.0	25	^	^
Coffee	108.0	272	188.7	87	18.2	46	^	^	33.6	79	^	^
Colbert	80.7	253	177.3	90	23.9	67	^	^	37.1	104	^	^
Conecuh	63.8	39	137.5	47	^	^	^	^	48.9	25	^	^
Coosa	81.4	56	150.6	35	^	^	^	^	^	^	^	^
Covington	80.4	189	166.4	41	25.8	56	^	^	28.6	56	^	^
Crenshaw	107.9	77	155.9	31	28.4	20	^	^	30.6	17	^	^
Cullman	74.3	391	^	^	22.4	110	^	^	38.9	188	^	^
Dale	102.4	257	187.7	82	23.5	57	^	^	37.5	84	^	^
Dallas	111.4	118	198.4	260	18.5	17	11.3	16	29.0	23	^	^
DeKalb	87.2	378	^	^	15.8	64	^	^	23.6	88	^	^
Simone	104.7	412	231.4	147	20.6	80	^	^	51.8	178	^	^
Escambia	77.3	131	146.4	84	15.9	24	^	^	25.3	39	^	^
Etowah	100.9	590	194.4	138	23.7	129	^	^	29.5	158	^	^
Fayette	101.9	110	167.7	20	21.3	21	^	^	18.3	16	^	^
Franklin	83.4	145	^	^	18.0	30	^	^	32.2	53	^	^
Geneva	96.0	167	226.1	32	23.9	40	^	^	45.8	70	^	^
Greene	119.2	17	165.7	72	^	^	^	^	^	^	^	^
Hale	95.3	47	124.0	84	^	^	^	^	^	^	^	^
Henry	101.2	103	245.7	77	23.0	20	^	^	46.5	43	^	^
Houston	110.2	566	205.2	250	26.2	124	144	17	40.9	186	^	^
Jackson	77.3	268	176.3	21	18.9	58	^	^	29.1	94	^	^
Jefferson	123.1	2,809	216.9	2,899	20.2	438	15.4	196	33.4	691	^	^
Lamar	102.4	102	175.9	16	^	^	^	^	36.0	27	^	^
Lauderdale	84.0	482	133.9	55	18.6	98	^	^	32.8	162	^	^
Lawrence	100.9	180	190.2	44	22.3	39	^	^	37.1	62	^	^
Lee	100.9	544	204.5	266	18.0	96	128	16	25.0	128	^	^
Limestone	95.3	469	171.4	105	17.9	87	^	^	40.0	164	^	^
Lowndes	127.6	33	203.1	82	^	^	^	^	^	^	^	^
Macon	141.6	40	199.9	134	^	^	18.7	16	^	^	^	^
Madison	79.2	1,299	128.9	470	18.8	289	84	33	37.1	538	^	^
Marengo	107.2	80	191.6	107	^	^	^	^	^	^	^	^
Marion	101.2	208	^	^	23.7	47	^	^	19.4	36	^	^
Marshall	86.5	489	185.6	16	21.0	110	^	^	26.6	132	^	^
Mobile	85.4	1433	154.4	1,032	18.0	284	14.2	92	39.4	583	^	^
Monroe	79.0	77	167.3	77	^	^	^	^	23.5	20	^	^
Montgomery	106.3	663	180.1	947	21.1	120	15.1	82	47.3	264	^	^
Morgan	119.3	782	206.7	123	22.2	137	^	^	42.7	255	^	^
Perry	73.6	20	200.4	61	^	^	^	^	^	^	^	^
Pickers	76.0	69	179.9	79	21.5	17	^	^	21.9	19	^	^
Pike	113.7	141	167.2	84	26.8	31	^	^	46.9	51	^	^
Sandwich	95.1	132	221.9	53	15.4	21	^	^	23.2	27	^	^
Russell	87.7	162	150.0	173	28.2	47	^	^	26.8	43	^	^
St. Clair	110.4	538	205.3	73	22.3	110	^	^	31.9	134	^	^
Shelby	130.5	1,394	230.2	200	18.8	191	^	^	30.3	293	^	^
Sumter	146.8	33	209.4	103	^	^	^	^	^	^	^	^
Talladega	93.1	358	151.6	201	27.4	95	16.3	22	30.1	100	^	^
Tallapoosa	104.1	262	180.2	110	18.0	38	^	^	34.5	70	^	^
Tuscaloosa	109.6	807	204.7	489	17.1	125	14.4	36	24.3	161	^	^
Walker	124.9	514	227.5	40	27.4	104	^	^	28.9	102	^	^
Washington	81.1	70	188.4	51	21.1	16	^	^	33.2	23	^	^
Wilcox	110.2	33	184.4	77	^	^	^	^	^	^	^	^
Winston	88.9	159	^	^	22.4	36	^	^	29.7	45	^	^

Rates are per 100,000 and age-adjusted to the 2000 U.S. (19 Age Groups) standard.
 Rates are for malignant cases only, except for All Sites, which contains insitu bladder cases.
 ^Statistic not displayed due to fewer than 15 cases.
 Source: Alabama Statewide Cancer Registry, 2023. Data Years: 2011-2020.

Table 8. Alabama Cancer Incidence Rates and Counts, by County, Females by Race, 2011-2020 Combined																
	All Sites				Lung				Colorectal				Breast			
	White		Black		White		Black		White		Black		White		Black	
	Rate	Count	Rate	Count	Rate	Count	Rate	Count	Rate	Count	Rate	Count	Rate	Count	Rate	Count
Alabama	405.0	94,850	379.5	28,098	54.0	13,919	37.3	2,791	35.1	8,406	41.7	3,072	119.4	27,666	126.8	9,418
Autauga	441.4	1,210	400.7	231	63.7	187	31.3	16	44.3	122	32.0	17	127.9	359	154.6	93
Baldwin	408.4	5,457	390.6	394	56.5	828	40.2	42	32.6	466	50.5	49	125.2	1,664	115.9	118
Barbour	419.8	417	338.5	239	57.3	66	29.6	22	37.3	37	39.0	28	102.9	99	107.0	72
Bibb	429.5	486	448.6	94	70.6	89	^	^	29.3	35	^	^	133.2	149	184.8	39
Blount	385.7	1,438	465.9	24	54.1	220	^	^	30.8	114	^	^	115.7	437	^	^
Bullock	516.6	85	423.8	182	^	^	45.8	21	^	^	32.4	17	155.6	21	151.5	61
Butler	392.5	335	396.5	223	49.3	50	29.0	16	29.7	27	45.9	27	139.8	110	168.8	93
Calhoun	422.0	2,637	376.9	507	65.4	452	47.9	65	38.1	246	41.0	55	111.2	697	114.5	155
Chambers	452.2	691	383.4	334	56.6	92	25.6	24	41.0	66	44.2	39	110.9	173	118.1	101
Cherokee	358.9	652	476.5	37	53.0	112	^	^	32.0	55	^	^	90.3	164	^	^
Chilton	373.3	916	367.3	91	50.7	136	^	^	34.9	85	^	^	107.4	263	116.6	28
Choctaw	332.9	197	371.2	158	36.5	26	^	^	35.7	22	56.3	25	95.6	57	137.8	58
Clarke	404.0	429	430.9	300	61.6	71	24.7	18	46.4	46	75.1	53	130.4	139	159.0	111
Clay	441.2	352	402.8	52	63.7	59	^	^	47.8	36	^	^	133.0	103	^	^
Cleburne	387.7	377	434.8	16	60.6	65	^	^	34.0	35	^	^	107.2	104	^	^
Coffee	388.3	1,027	341.4	180	53.5	154	41.5	23	28.1	73	^	^	113.9	297	122.9	63
Colbert	404.1	1,325	372.7	230	54.5	202	26.0	18	39.8	133	47.7	31	116.2	375	148.8	90
Conecuh	417.6	214	407.9	159	51.0	33	35.1	16	36.4	21	47.3	18	138.4	71	138.1	51
Coosa	371.5	218	315.1	75	55.4	36	^	^	33.2	20	^	^	83.9	48	91.9	24
Covington	401.0	1,001	40.31	122	66.1	181	65.8	19	40.2	103	^	^	114.6	277	108.4	33
Crenshaw	448.4	333	433.8	96	66.7	54	^	^	34.4	27	72.7	17	125.1	90	142.4	32
Cullman	404.1	2192	^	^	51.7	311	^	^	39.5	217	^	^	117.7	641	^	^
Dale	416.5	1,039	364.3	205	70.0	193	37.2	22	37.9	96	47.0	23	121.8	299	121.7	71
Dallas	480.7	455	393.2	679	63.7	69	33.6	60	49.4	49	50.8	89	138.6	130	141.8	242
DeKalb	342.0	1,503	313.8	22	42.1	200	^	^	40.3	183	^	^	89.0	393	^	^
Elmore	438.6	1,793	382.1	290	60.3	262	42.4	28	32.9	134	35.9	26	128.3	526	118.3	94
Escambia	390.7	682	382.7	246	60.8	117	33.0	22	40.2	73	37.9	25	97.4	170	128.5	81
Etowah	423.9	2,620	384.5	366	62.5	430	50.4	48	38.2	237	31.1	31	105.6	647	127.8	123
Fayette	409.1	446	386.7	56	63.4	79	^	^	36.2	41	^	^	97.8	110	125.5	16
Franklin	396.6	750	268.3	21	57.6	117	^	^	37.1	74	^	^	114.4	215	^	^
Geneva	396.4	689	284.5	48	63.8	122	^	^	33.5	59	^	^	108.7	188	^	^
Greene	398.2	62	416.3	210	^	^	42.1	21	^	^	51.3	26	^	^	148.2	72
Hale	383.6	182	334.4	197	49.0	25	30.1	18	44.7	23	28.7	17	108.6	53	124.6	71
Henry	388.1	367	339.9	116	54.2	58	^	^	35.8	34	^	^	106.8	98	95.8	32
Houston	401.4	2154	346.7	522	52.7	316	39.4	61	33.7	182	35.0	52	117.0	619	109.3	163
Jackson	421.3	1,479	371.7	42	61.1	239	^	^	38.1	136	^	^	116.7	405	^	^
Jefferson	400.6	9,995	385.9	6,532	47.9	1,312	38.8	680	29.0	764	40.0	667	131.2	3,180	128.8	2,190
Lamar	425.8	404	477.8	49	76.8	75	^	^	43.5	45	^	^	138.7	128	^	^
Lauderdale	380.6	2,289	399.6	218	42.8	287	^	^	34.9	215	45.4	27	110.7	645	132.9	70
Lawrence	445.3	828	369.4	113	66.2	136	^	^	49.3	92	^	^	120.1	221	122.8	36
Lee	344.3	1,947	351.4	642	41.1	241	36.6	63	26.3	151	36.4	62	107.2	609	105.0	198
Limestone	410.4	1,972	358.2	241	52.9	276	^	^	30.1	150	33.1	23	119.9	576	135.7	92
Lowndes	484.4	100	42.21	209	^	^	35.4	18	^	^	44.8	23	139.2	30	119.6	58
Macon	415.3	106	365.3	41	83.5	23	27.6	36	^	^	52.4	61	100.9	26	117.5	127
Madison	426.1	7,032	384.9	1,733	51.3	94	39.6	174	34.0	567	40.0	175	130.8	2,158	135.1	624
Marengo	428.4	310	335.1	223	52.0	44	26.9	17	41.8	33	42.4	32	144.3	94	116.5	76
Marion	400.3	850	451.0	26	51.4	123	^	^	34.7	71	^	^	119.1	250	^	^
Marshall	396.3	2,327	415.2	39	57.5	371	^	^	41.1	245	^	^	100.6	594	^	^
Mobile	407.3	6,926	373.1	3,166	56.9	1,069	40.3	348	38.0	671	42.9	358	118.3	1,994	119.2	1,015
Monroe	405.9	383	363.9	213	57.7	64	^	^	46.5	45	56.6	36	145.2	130	124.2	72
Montgomery	407.7	2,730	387.6	2,683	46.4	354	37.7	255	34.4	248	39.4	276	124.2	793	128.7	902
Morgan	412.9	2,850	409.8	318	55.4	426	44.5	33	38.8	265	59.3	44	119.8	814	120.2	100
Perry	299.1	89	367.4	157	^	^	^	^	^	^	57.0	25	62.3	18	135.6	59
Pickers	417.7	344	484.4	257	46.7	46	48.6	30	34.0	29	41.3	24	154.7	125	212.7	106
Pike	397.5	493	383.1	243	41.9	60	42.8	27	25.9	36	46.3	29	125.7	149	129.3	84
Randolph	379.4	509	387.6	109	49.6	76	^	^	42.1	57	^	^	95.1	125	113.6	32
Russell	443.0	870	326.1	462	77.5	166	23.9	33	37.0	72	38.3	52	114.6	220	108.3	160
St. Clair	416.1	2,120	343.1	137	60.5	339	^	^	34.9	179	^	^	125.5	637	111.1	49
Shelby	374.0	4,140	344.4	41	44.0	508	23.8	23	32.2	358	40.2	42	125.4	1,401	117.5	152
Sumter	365.2	90	386.8	239	^	^	31.5	20	^	^	50.3	30	139.0	36	124.1	75
Talladega	422.0	1,613	349.3	517	57.7	250	30.8	46	34.9	141	34.2	51	114.6	434	122.4	182
Tallapoosa	424.2	947	450.4	298	64.4	161	44.2	29	34.1	71	58.2	38	102.7	246	122.1	82
Tuscaloosa	390.8	3,054	379.9	1,211	45.7	385	38.3	122	31.3	250	38.3	122	127.4	979	133.1	426
Walker	463.7	1,984	469.3	107	71.2	342	^	^	42.9	181	^	^	116.6	507	126.4	30
Washington	400.5	315	372.4	95	49.7	42	^	^	38.1	30	^	^	120.6	98	96.4	26
Wilcox	423.3	112	411.5	200	50.0	16	40.9	21	^	^	53.9	25	111.8	26	125.9	59
Winston	364.4	626	^	^	47.2	95	^	^	32.1	58	^	^	98.0	167	^	^

Rates are per 100,000 and age-adjusted to the 2000 U.S. (19 age groups) standard.
 Rates are for malignant cases only, except for All Sites, which contains in situ bladder cases.
 ^ Statistic not displayed due to fewer than 15 cases.

Source: Alabama Statewide Cancer Registry, 2023. Data Years: 2011-2020.

Table 8. (Continued) Alabama Cancer Incidence Rates and Counts, by County, Females by Race, 2011-2020 Combined

	Cervix				Oral				Melanoma			
	White		Black		White		Black		White		Black	
	Rate	Count	Rate	Count	Rate	Count	Rate	Count	Rate	Count	Rate	Count
Alabama	9.1	1,605	9.8	682	7.5	1,786	4.8	365	23.2	4,890	1.0	69
Autauga	10.5	23	^	^	7.0	18	^	^	30.6	77	^	^
Baldwin	9.2	87	15.8	16	8.9	119	^	^	27.3	330	^	^
Barbour	^	^	^	^	^	^	^	^	30.5	29	^	^
Bibb	^	^	^	^	^	^	^	^	^	^	^	^
Bibb	10.2	29	^	^	5.0	17	^	^	19.3	68	^	^
Bullock	^	^	^	^	^	^	^	^	^	^	^	^
Butler	^	^	^	^	^	^	^	^	23.2	18	^	^
Calhoun	10.9	49	^	^	9.2	60	^	^	19.7	103	^	^
Chambers	17.9	20	^	^	15.8	23	^	^	19.3	27	^	^
Cherokee	13.9	19	^	^	^	^	^	^	^	^	^	^
Chilton	11.7	24	^	^	8.2	17	^	^	16.9	38	^	^
Choctaw	^	^	^	^	^	^	^	^	^	^	^	^
Clarke	^	^	^	^	^	^	^	^	29.2	26	^	^
Clay	^	^	^	^	^	^	^	^	22.7	16	^	^
Clayborne	^	^	^	^	^	^	^	^	^	^	^	^
Coffee	10.1	20	^	^	8.1	24	^	^	23.0	56	^	^
Colbert	12.1	27	^	^	8.6	29	^	^	19.7	60	^	^
Conecuh	^	^	^	^	^	^	^	^	^	^	^	^
Cook	^	^	^	^	^	^	^	^	^	^	^	^
Covington	^	^	^	^	7.2	18	^	^	21.7	51	^	^
Crenshaw	^	^	^	^	^	^	^	^	33.7	20	^	^
Cullman	8.6	39	^	^	8.3	49	^	^	24.8	122	^	^
Dale	10.8	20	^	^	8.7	23	^	^	22.7	53	^	^
Dallas	^	^	15.7	23	^	^	^	^	36.7	26	^	^
DeKalb	10.2	36	^	^	7.1	31	^	^	12.3	50	^	^
Elmore	11.5	38	^	^	9.5	39	^	^	35.3	134	^	^
Escambia	^	^	^	^	9.5	17	^	^	25.0	40	^	^
Etowah	14.2	60	^	^	8.0	51	^	^	20.9	117	^	^
Fayette	^	^	^	^	^	^	^	^	21.4	20	^	^
Franklin	^	^	^	^	^	^	^	^	19.0	31	^	^
Geneva	^	^	^	^	12.1	21	^	^	34.2	51	^	^
Greene	^	^	^	^	^	^	^	^	^	^	^	^
Hale	^	^	^	^	^	^	^	^	^	^	^	^
Henry	^	^	^	^	^	^	^	^	38.5	33	^	^
Houston	9.8	43	12.6	19	9.2	48	^	^	30.5	154	^	^
Jackson	12.4	30	^	^	5.2	18	^	^	22.9	67	^	^
Jefferson	8.0	145	8.5	132	6.5	177	4.3	74	22.1	473	^	^
Lamar	^	^	^	^	^	^	^	^	^	^	^	^
Lauderdale	5.8	27	^	^	6.3	35	^	^	24.6	132	^	^
Lawrence	^	^	^	^	11.1	20	^	^	38.4	64	^	^
Lee	8.1	39	10.0	19	7.5	41	^	^	17.2	91	^	^
Limestone	8.9	37	^	^	7.4	37	^	^	26.2	117	^	^
Lowndes	^	^	^	^	^	^	^	^	^	^	^	^
Macon	^	^	^	^	^	^	^	^	^	^	^	^
Madison	7.0	87	7.3	33	7.0	117	4.5	21	25.6	390	^	^
Marengo	^	^	^	^	^	^	^	^	^	^	^	^
Marion	^	^	^	^	8.1	16	^	^	16.5	30	^	^
Marshall	11.2	51	^	^	7.9	48	^	^	19.0	103	^	^
Mobile	8.6	110	10.8	85	8.5	144	5.2	46	26.5	411	^	^
Monroe	^	^	^	^	^	^	^	^	^	^	^	^
Montgomery	7.2	33	12.2	81	4.9	37	4.2	32	27.3	157	^	^
Morgan	8.4	42	^	^	8.3	62	^	^	23.2	140	^	^
Perry	^	^	^	^	^	^	^	^	^	^	^	^
Pickens	^	^	^	^	^	^	^	^	^	^	^	^
Rile	^	^	^	^	^	^	^	^	25.3	28	^	^
Randolph	^	^	^	^	^	^	^	^	15.6	18	^	^
Russell	11.3	19	^	^	^	^	^	^	16.5	31	^	^
St. Clair	10.9	45	^	^	5.5	27	^	^	21.6	103	^	^
Shelby	4.7	46	^	^	5.9	63	^	^	20.2	212	^	^
Sumter	^	^	^	^	^	^	^	^	^	^	^	^
Talladega	12.9	41	^	^	9.9	37	^	^	17.1	59	^	^
Tallapoosa	12.6	19	^	^	^	^	^	^	30.8	57	^	^
Tuscaloosa	9.0	58	10.7	34	7.0	57	^	^	14.9	110	^	^
Walker	12.6	40	^	^	6.4	30	^	^	24.6	88	^	^
Washington	^	^	^	^	^	^	^	^	^	^	^	^
Wilcox	^	^	^	^	^	^	^	^	^	^	^	^
Winston	^	^	^	^	10.0	17	^	^	22.3	33	^	^

Rates are per 100,000 and age-adjusted to the 2000 U.S. (19 Age Groups) standard.
 Rates are for malignant cases only, except for All Sites, which contains in situ bladder cases.
 ^Statistic not displayed due to fewer than 15 cases.
 Source: Alabama Statewide Cancer Registry, 2023. Data Years: 2011-2020.

Table 9. Alabama Cancer Mortality Rates and Counts, by Site, Race, and Sex, 2011-2020 Combined

	Male and Female						Male					
	All Races		White		Black		All Races		White		Black	
	Rate	Count	Rate	Count	Rate	Count	Rate	Count	Rate	Count	Rate	Count
All Malignant Cancers	173.7	108,558	170.6	79,066	190.2	23,749	218.7	56,814	213.1	43,852	250.7	12,607
Oral Cavity and Pharynx	2.9	1,722	2.8	1,324	2.9	386	4.7	1,276	4.6	973	5.5	297
Digestive System	43.3	25,968	40.6	18,829	54.7	6,870	56.5	15,068	53.3	11,160	71.5	3,772
Esophagus	3.8	2,344	3.9	1,818	3.8	508	6.9	1,885	7.0	1,496	6.7	375
Stomach	3.1	1,843	2.4	1,082	5.9	723	4.2	1,083	3.2	646	8.4	422
Small Intestine	0.3	195	0.3	127	0.5	67	0.4	100	0.4	69	0.6	31
Colon and Rectum	15.5	9,094	14.3	6,503	20.6	2,525	19.1	4,939	17.6	3,600	25.9	1,308
Colon Excluding Rectum	12.9	7,583	11.8	5,359	17.8	2,168	15.8	4,062	14.5	2,934	22.2	1,104
Rectum and Rectosigmoid Junction	2.6	1,511	2.5	1,144	2.8	357	3.3	877	3.2	666	3.8	204
Anus, Anal Canal, and Anorectum	0.4	205	0.3	155	0.4	49	0.4	90	0.3	59	0.6	31
Liver and Intrahepatic Bile Duct	7.1	4,362	6.9	3,250	7.6	1,042	10.4	2,910	10.0	2,170	11.8	698
Gallbladder	0.5	291	0.4	194	0.8	92	0.4	108	0.4	74	0.7	32
Pancreas	11.6	7,025	11.1	5,222	14.0	1,740	13.7	3,653	13.3	2,814	15.5	810
Other Digestive Organs	0.3	172	0.3	117	0.4	52	0.4	109	0.4	74	0.7	34
Respiratory System	50.3	30,749	51.8	24,689	46.0	5,884	68.9	18,500	68.4	14,533	73.4	3,884
Larynx	1.2	744	1.1	516	1.7	225	2.2	610	1.9	414	3.5	195
Lung and Bronchus	48.7	29,818	50.4	24,029	44.0	5,616	66.2	17,767	66.0	14,026	69.4	3,659
Bones and Joints	0.7	386	0.7	290	0.7	92	0.9	231	0.9	173	1.0	54
Soft Tissue Including Heart	1.2	680	1.2	494	1.4	179	1.5	366	1.5	281	1.5	81
Skin Excluding Basal and Squamous	3.4	1,971	4.2	1,868	0.8	98	5.3	1,311	6.3	1,253	1.1	56
Melanoma of the Skin	2.4	1,388	3.0	1,336	0.4	50	3.6	906	4.4	882	0.5	23
Other Non-Epithelial Skin	1.0	583	1.2	532	0.4	48	1.7	405	1.9	371	0.6	33
Breast	12.0	6,963	10.8	4,863	16.2	2,054	0.3	69	0.3	51	0.4	17
Female Genital System	*	*	*	*	*	*	*	*	*	*	*	*
Cervix Uteri	*	*	*	*	*	*	*	*	*	*	*	*
Corpus and Uterus, NOS	*	*	*	*	*	*	*	*	*	*	*	*
Corpus Uteri	*	*	*	*	*	*	*	*	*	*	*	*
Uterus, NOS	*	*	*	*	*	*	*	*	*	*	*	*
Ovary	*	*	*	*	*	*	*	*	*	*	*	*
Vagina	*	*	*	*	*	*	*	*	*	*	*	*
Vulva	*	*	*	*	*	*	*	*	*	*	*	*
Other Female Genital Organs	*	*	*	*	*	*	*	*	*	*	*	*
Male Genital System	*	*	*	*	*	*	21.9	5,112	17.6	3,310	43.5	1,778
Prostate	*	*	*	*	*	*	21.4	4,976	17.1	3,205	42.9	1,750
Testis	*	*	*	*	*	*	0.2	57	0.3	44	0.2	10
Penis	*	*	*	*	*	*	0.2	62	0.3	52	0.2	10
Other Male Genital Organs	*	*	*	*	*	*	0.1	17	^	^	^	^
Urinary System	8.3	4,893	8.6	4,004	7.2	869	13.6	3,368	14.2	2,835	10.6	518
Urinary Bladder	4.3	2,484	4.6	2,102	3.3	375	7.5	1,795	8.2	1,572	4.8	217
Kidney and Renal Pelvis	3.8	2,289	3.9	1,808	3.7	468	5.7	1,506	5.8	1,207	5.6	290
Ureter	0.1	41	0.1	33	^	^	0.1	21	0.1	18	^	^
Other Urinary Organs	0.1	79	0.1	61	0.2	18	0.2	46	0.2	38	^	^
Eye and Orbit	0.1	40	0.1	35	^	^	0.1	24	0.1	21	^	^
Brain and Other Nervous System	5.0	2,924	5.6	2,490	3.2	421	6.0	1,611	6.7	1,380	3.7	224
Endocrine System	0.7	406	0.7	306	0.8	98	0.8	195	0.8	162	0.7	33
Thyroid	0.4	253	0.4	197	0.4	54	0.5	115	0.5	102	0.3	13
Other Endocrine Including Thymus	0.3	153	0.3	109	0.4	44	0.3	80	0.3	60	0.4	20
Lymphoma	5.6	3,239	5.9	2,713	4.1	500	7.4	1,826	7.8	1,544	5.4	271
Hodgkin Lymphoma	0.3	176	0.3	134	0.3	42	0.4	107	0.4	77	0.5	30
Non-Hodgkin Lymphoma	5.3	3,063	5.6	2,579	3.8	458	7.0	1,719	7.4	1,467	4.9	241
Myeloma	3.6	2,128	3.0	1,382	6.1	734	4.6	1,167	4.1	809	7.3	352
Leukemia	6.6	3,803	7.0	3,145	5.1	628	8.9	2,195	9.5	1,850	6.6	327
Lymphocytic Leukemia	1.6	902	1.7	754	1.2	146	2.1	509	2.3	431	1.6	76
Acute Lymphocytic Leukemia	0.4	205	0.4	172	0.2	32	0.4	106	0.5	93	0.2	12
Chronic Lymphocytic Leukemia	1.0	576	1.0	481	0.8	94	1.4	336	1.5	283	1.1	52
Myeloid and Monocytic Leukemia	3.1	1,802	3.3	1,479	2.4	305	4.2	1,048	4.4	884	3.0	155
Acute Myeloid Leukemia	2.5	1,438	2.6	1,181	1.9	243	3.2	830	3.4	698	2.5	126
Chronic Myeloid Leukemia	0.3	157	0.3	127	0.2	29	0.4	86	0.4	75	0.2	10
Other Leukemia	1.9	1,099	2.0	912	1.5	177	2.7	638	2.8	535	2.0	96
Miscellaneous Malignant Cancer	13.0	7,757	12.8	5,932	14.2	1,769	17.3	4,495	17.1	3,517	18.4	940

Rates are per 100,000 and age-adjusted to the 2000 U.S. (19 age groups) standard. *Statistic not displayed because it is not applicable. ^Statistic not displayed due to fewer than 10 deaths. Source: Alabama Statewide Cancer Registry, 2023. Data Years: 2011-2020.

Table 9. Alabama Cancer Mortality Rates and Counts, by Site, Race, and Sex, 2011-2020 Combined

	Female					
	All Races		White		Black	
	Rate	Count	Rate	Count	Rate	Count
All Malignant Cancers	141.2	46,744	139.0	35,214	152.3	11,142
Oral Cavity and Pharynx	1.3	446	1.4	351	1.1	89
Digestive System	32.7	10,900	30.1	7,669	42.6	3,098
Esophagus	1.4	459	1.2	322	1.8	133
Stomach	2.3	760	1.7	436	4.2	301
Small Intestine	0.3	95	0.2	58	0.5	36
Colon and Rectum	12.6	4,155	11.6	2,903	16.9	1,217
Colon Excluding Rectum	10.7	3,521	9.6	2,425	14.8	1,064
Rectum and Rectosigmoid Junction	2.0	634	2.0	478	2.1	153
Anus, Anal Canal, and Anorectum	0.3	115	0.4	96	0.2	18
Liver and Intrahepatic Bile Duct	4.3	1,452	4.2	1,080	4.6	344
Gallbladder	0.5	183	0.5	120	0.8	60
Pancreas	10.0	3,372	9.3	2,408	12.8	930
Other Digestive Organs	0.2	63	0.2	43	0.3	18
Respiratory System	36.1	12,249	39.0	10,156	27.2	2,000
Larynx	0.4	134	0.4	102	0.4	30
Lung and Bronchus	35.5	12,051	38.4	10,003	26.6	1,957
Bones and Joints	0.5	155	0.5	117	0.5	38
Soft Tissue Including Heart	1.1	314	1.0	213	1.3	98
Skin Excluding Basal and Squamous	2.1	660	2.6	615	0.5	42
Melanoma of the Skin	1.5	482	2.0	454	0.3	27
Other Non-Epithelial Skin	0.5	178	0.6	161	0.2	15
Breast	21.3	6,894	19.4	4,812	27.4	2,037
Female Genital System	14.9	4,817	13.9	3,392	18.8	1,385
Cervix Uteri	3.3	946	2.9	594	4.8	345
Corpus and Uterus, NOS	3.6	1,223	2.8	723	6.6	493
Corpus Uteri	2.1	691	1.7	430	3.5	257
Uterus, NOS	1.6	532	1.1	293	3.1	236
Ovary	7.0	2,318	7.2	1,818	6.5	476
Vagina	0.3	87	0.2	61	0.4	26
Vulva	0.5	180	0.6	157	0.3	21
Other Female Genital Organs	0.2	63	0.2	39	0.3	24
Male Genital System	*	*	*	*	*	*
Prostate	*	*	*	*	*	*
Testis	*	*	*	*	*	*
Penis	*	*	*	*	*	*
Other Male Genital Organs	*	*	*	*	*	*
Urinary System	4.5	1,525	4.5	1,169	4.9	351
Urinary Bladder	2.0	689	2.0	530	2.3	158
Kidney and Renal Pelvis	2.3	783	2.3	601	2.4	178
Ureter	0.1	20	0.1	15	^	^
Other Urinary Organs	0.1	33	0.1	23	0.1	10
Eye and Orbit	0.0	16	0.1	14	^	^
Brain and Other Nervous System	4.1	1,313	4.6	1,110	2.7	197
Endocrine System	0.7	211	0.6	144	0.9	65
Thyroid	0.4	138	0.4	95	0.5	41
Other Endocrine Including Thymus	0.3	73	0.2	49	0.3	24
Lymphoma	4.2	1,413	4.5	1,169	3.2	229
Hodgkin Lymphoma	0.2	69	0.2	57	0.2	12
Non-Hodgkin Lymphoma	4.0	1,344	4.2	1,112	3.1	217
Myeloma	2.8	961	2.2	573	5.4	382
Leukemia	5.0	1,608	5.3	1,295	4.2	301
Lymphocytic Leukemia	1.2	393	1.3	323	1.0	70
Acute Lymphocytic Leukemia	0.4	99	0.4	79	0.3	20
Chronic Lymphocytic Leukemia	0.7	240	0.7	198	0.6	42
Myeloid and Monocytic Leukemia	2.4	754	2.4	595	2.1	150
Acute Myeloid Leukemia	1.9	608	2.0	483	1.6	117
Chronic Myeloid Leukemia	0.2	71	0.2	52	0.3	19
Other Leukemia	1.4	461	1.5	377	1.1	81
Miscellaneous Malignant Cancer	9.8	3,262	9.4	2,415	11.5	829

Rates are per 100,000 and age-adjusted to the 2000 U.S. (19 age groups) standard. *Statistic not displayed because is not applicable. ^Statistic not displayed due to fewer than 10 deaths. Source: Alabama Statewide Cancer Registry, 2023. Data Years: 2011-2020.

Table 10. Trends in Alabama Cancer Mortality Rates, Selected Sites, 2016–2020

Females									
Breast	P-Value	0.2414			Cervix	P-Value	0.9089		
	Rate/Trend	Std. Error	Lower CI	Upper CI		Rate/Trend	Std. Error	Lower CI	Upper CI
Total PC	-5.2				Total PC	9.4			
Total APC	-1.5		-4.7	1.8	Total APC	0.5		-10.8	13.1
2016 Rate	21.0	0.8	19.4	22.7	2016 Rate	3.1	0.3	2.4	3.8
2017 Rate	21.2	0.8	19.6	22.9	2017 Rate	3.1	0.3	2.4	3.8
2018 Rate	21.9	0.8	20.3	23.6	2018 Rate	3.4	0.4	2.8	4.2
2019 Rate	20.3	0.8	18.8	21.9	2019 Rate	2.6	0.3	2.1	3.3
2020 Rate	19.9	0.8	18.4	21.5	2020 Rate	3.3	0.4	2.7	4.1
Males					Males and Females				
Prostate	P-Value	0.4595			All Sites	P-Value	0.0275		
	Rate/Trend	Std. Error	Lower CI	Upper CI		Rate/Trend	Std. Error	Lower CI	Upper CI
Total PC	-6.5				Total PC	-7.5			
Total APC	-1.3		-6.0	3.6	Total APC	-2.1*		-3.7	-0.4
2016 Rate	21.4	1.0	19.6	23.4	2016 Rate	174.1	1.7	170.7	177.5
2017 Rate	19.3	0.9	17.5	21.1	2017 Rate	169.5	1.7	166.2	172.9
2018 Rate	21.1	0.9	19.2	23.0	2018 Rate	170.1	1.7	166.8	173.5
2019 Rate	19.4	0.9	17.7	21.3	2019 Rate	160.2	1.6	157.1	163.4
2020 Rate	20.0	0.9	18.3	21.9	2020 Rate	161.0	1.6	157.9	164.2
Males and Females									
Colorectal	P-Value	0.2161			Lung	P-Value	0.0028		
	Rate/Trend	Std. Error	Lower CI	Upper CI		Rate/Trend	Std. Error	Lower CI	Upper CI
Total PC	-4.7				Total PC	-17.5			
Total APC	-2.3		-6.7	2.4	Total APC	-4.8*		-6.4	-3.2
2016 Rate	14.7	0.5	13.7	15.7	2016 Rate	49.1	0.9	47.3	50.9
2017 Rate	15.8	0.5	14.8	16.9	2017 Rate	46.6	0.9	44.9	48.3
2018 Rate	15.1	0.5	14.1	16.1	2018 Rate	45.6	0.9	43.9	47.3
2019 Rate	13.9	0.5	13.0	14.9	2019 Rate	41.7	0.8	40.1	43.3
2020 Rate	14.0	0.5	13.1	15.0	2020 Rate	40.5	0.8	39.0	42.1
Melanoma	P-Value	0.2370			Oral	P-Value	0.9073		
	Rate/Trend	Std. Error	Lower CI	Upper CI		Rate/Trend	Std. Error	Lower CI	Upper CI
Total PC	-7.0				Total PC	-3.4			
Total APC	-3.0		-9.0	3.5	Total APC	0.2		-3.9	4.4
2016 Rate	2.4	0.2	2.0	2.8	2016 Rate	3.1	0.2	2.7	3.6
2017 Rate	2.3	0.2	1.9	2.7	2017 Rate	2.8	0.2	2.4	3.3
2018 Rate	2.1	0.2	1.8	2.6	2018 Rate	3.0	0.2	2.5	3.5
2019 Rate	1.9	0.2	1.6	2.3	2019 Rate	3.1	0.2	2.7	3.6
2020 Rate	2.2	0.2	1.8	2.6	2020 Rate	3.0	0.2	2.6	3.5

Rates are per 100,000 and age-adjusted to the 2000 U.S. (19 age groups) standard; CI are 95 percent for rates and trends. Percent changes (PC) were calculated using 1 year for each end point; APCs were calculated using the weighted least squares method. *The APC is significantly different from zero ($p < 0.05$).

Source: Alabama Statewide Cancer Registry, 2023. Data Years: 2016–2020.

Table 11. Alabama and U.S. Cancer Incidence Rates, by Site, Race, and Sex, 2011-2020

	Males and Females					
	Alabama			United States		
	All Races	White	Black	All Races	White	Black
All Sites	447.0#	444.4^	443.9^	442.0	453.9	450.4
Lung and Bronchus	63.9#	66.5#	56.1	50.8	52.3	55.7
Colon and Rectum	42.3#	40.5#	48.5#	37.9	37.5	44.3
Melanoma of the Skin	21.3^	27.9	1.0	23.4	28.3	1.0
	Males					
	Alabama			United States		
	All Races	White	Black	All Races	White	Black
All Sites	513.2#	499.8#	538.2#	484.0	493.3	528.3
Lung and Bronchus	82.2#	82.6#	83.0#	58.4	58.8	72.5
Colon and Rectum	49.2#	47.0#	58.0#	43.3	42.7	51.5
Melanoma of the Skin	27.4^	34.5^	0.9	30.3	36.1	1.1
Prostate	122.6#	100.3^	188.0#	112.8	107.0	180.9
	Females					
	Alabama			United States		
	All Races	White	Black	All Races	White	Black
All Sites	399.0^	405.0^	379.5^	414.0	428.2	397.1
Lung and Bronchus	49.8#	54.0#	37.3^	45.0	47.5	44.1
Colon and Rectum	36.7#	35.1#	41.7#	33.2	33.0	39.1
Melanoma of the Skin	17.1^	23.2	1.0	18.3	22.5	0.9
Breast	121.8^	119.4^	126.8	126.8	129.1	126.7
Cervix	9.2#	9.1#	9.8#	7.4	7.5	8.4

Rates are per 100,000 and age-adjusted to the 2000 U.S. (19 age groups) standard.

All rates are for malignant cases only, except the rates for All Sites, which includes bladder cancer *in situ*.

The incidence rate for Alabama is significantly higher than the incidence rate for the U.S. ($p < 0.05$).

^ The incidence rate for Alabama is significantly lower than the incidence rate for the U.S. ($p < 0.05$).

Source: Alabama Data: Alabama Statewide Cancer Registry, 2023. Data Years: 2011-2020.

Source: U.S. Data: SEER Research Data, 17 Registries Nov. 2022 Submission. Data Years: 2011-2020.

Table 12. Alabama and U.S. Cancer Mortality Rates, by Site, Race, and Sex, 2011-2020						
	Males and Females					
	Alabama			United States		
	All Races	White	Black	All Races	White	Black
All Sites	173.7#	170.6#	190.2#	160.3	161.3	182.2
Lung and Bronchus	48.7#	50.4#	44.0#	38.9	39.7	40.6
Colon and Rectum	15.5#	14.3#	20.6#	13.7	13.4	18.0
Melanoma of the Skin	2.4	3.0#	0.4	2.3	2.7	0.3
	Males					
	Alabama			United States		
	All Races	White	Black	All Races	White	Black
All Sites	218.7#	213.1#	250.7#	191.4	192.1	226.6
Lung and Bronchus	66.2#	66.0#	69.4#	47.5	47.7	56.2
Colon and Rectum	19.1#	17.6#	25.9#	16.3	15.9	22.6
Melanoma of the Skin	3.6	4.4	0.5	3.4	4.0	0.4
Prostate	21.4#	17.1^	42.9#	19.0	17.8	37.6
	Females					
	Alabama			United States		
	All Races	White	Black	All Races	White	Black
All Sites	141.2#	139.0	152.3	137.5	138.4	154.6
Lung and Bronchus	35.5#	38.4#	26.6^	32.2	33.5	29.9
Colon and Rectum	12.6#	11.6	16.9#	11.5	11.3	14.8
Melanoma of the Skin	1.5	2.0	0.3	1.5	1.7	0.3
Breast	21.3#	19.4	27.4	20.2	19.8	27.6
Cervix	3.3#	2.9#	4.8#	2.2	2.1	3.4

Rates are per 100,000 and age-adjusted to the 2000 U.S. (19 age groups) standard.

The mortality rate for Alabama is significantly higher than the rate for the U.S. ($p < 0.05$).

^ The mortality rate for Alabama is significantly lower than the rate for the U.S. ($p < 0.05$).

Source: Alabama Data: Alabama Statewide Cancer Registry, 2023. Data Years: 2011-2020.

Source U.S. Data: CDC WONDER, 2023. Data Years: 2011-2020.

Health Risk and Cancer Screening Behaviors Tables

Table 13. Percentage of Tobacco Use, Adults, Alabama and the U.S., 2021

Current Cigarette Smoking	Alabama	United States
Total Adults	17.5	14.4
Male Adults	19.1	15.9
Female Adults	15.6	13.1
Low Education	34.2	27.0
White	18.0	13.6
Black	17.3	16.8

Source: Behavioral Risk Factor Surveillance System, Centers for Disease Control and Prevention.

Table 14. Percentage of Colorectal Cancer Screening, Adults 50-75 Years Old, Alabama and the U.S., 2020

Met USPSTF Recommendation	Alabama	United States
Total Adults	76.2	73.5
Male Adults	74.7	72.4
Female Adults	78.8	75.8
Low Education	72.7	63.4
White	77.7	75.4
Black	75.0	74.6

Source: Behavioral Risk Factor Surveillance System, Centers for Disease Control and Prevention.

Table 15. Percentage of Breast Cancer Screening, Women 50 and Older, Alabama and the U.S., 2020

Mammogram in the Past 2 Years	Alabama	United States
50 years and older	78.0	78.0
Low Education	68.5	71.2
White	75.8	77.7
Black	87.0	84.1

Source: Behavioral Risk Factor Surveillance System, Centers for Disease Control and Prevention.

Table 16. Percentage of Prostate Cancer Screening, Men 40 and Older, Alabama and the U.S., 2020

PSA within the Past 2 Years	Alabama	United States
40-49 Years Old	10.2	6.9
50-59 Years Old	35.8	26.4
60-64 Years Old	56.4	40.4
65 Years and Older	55.3	49.8
Low Education	20.9	16.2
White	39.8	35.0
Black	36.6	27.5

Source: Behavioral Risk Factor Surveillance System, Centers for Disease Control and Prevention.

Table 17. Percentage of Cervical Cancer Screening, Women 21-65, Alabama and the U.S., 2020		
Pap Test within the Past 3 Years	Alabama	United States
Total 21-65	79.2	77.6
Low Education	66.7	68.7
White	76.4	78.0
Black	85.5	84.2

Source: Behavioral Risk Factor Surveillance System, Centers for Disease Control and Prevention.

Table 18. Percentage of Fruit and Vegetable Intake, Adults 18 and Older, Alabama and the U.S., 2021		
Consuming Vegetables Less than One Time Daily	Alabama	United States
Total Adults	20.5	19.7
Male Adults	22.9	22.2
Female Adults	18.4	17.4
Low Education	27.8	30.1
White	17.4	17.6
Black	27.2	26.4
Consuming Fruit Less than One Time Daily	Alabama	United States
Total Adults	46.1	40.9
Male Adults	47.0	43.5
Female Adults	44.7	37.8
Low Education	44.4	44.0
White	49.3	41.0
Black	37.4	39.4

Source: Behavioral Risk Factor Surveillance System, Centers for Disease Control and Prevention.

Table 19. Percentage of Physical Activity, Adults 18 and Older, Alabama and the U.S., 2021		
Participated in ≥ 150 Minutes Aerobic Physical Activity per Week	Alabama	United States
Total	70.2	77.2
Male	73.1	78.7
Female	64.3	73.8
Low Education	53.1	58.6
White	69.1	78.4
Black	64.8	72.0

Source: Behavioral Risk Factor Surveillance System, Centers for Disease Control and Prevention.

Table 20. Percentage of Overweight and Obese*, Adults 18 and Older, Alabama and the U.S., 2021		
Overweight and Obese	Alabama	United States
Total	71.4	68.3
Male	74.3	72.5
Female	69.3	64.2
Low Education	73.6	68.8
White	70.2	67.4
Black	76.1	74.2

Source: Behavioral Risk Factor Surveillance System, Centers for Disease Control and Prevention. *BMI 25 and over.

Sources

1. American Cancer Society. *Cancer Facts & Figures 2023*. Atlanta: American Cancer Society; 2023.
2. Alabama Statewide Cancer Registry (ASCR), 2023. Data Years: 2011-2020 (Incidence) and ASCR and Alabama Center for Health Statistics, 2023. Data Years: 2011-2020 (Mortality). Alabama Department of Public Health.
3. Surveillance, Epidemiology, and End Results (SEER) Program SEER*Stat Database: Incidence - SEER Research Data, 17 Registries, Nov. 2022 Submission. www.seer.cancer.gov Data Years: 2011-2020.
4. Centers for Disease Control and Prevention (CDC), National Center for Health Statistics, National Vital Statistics System, 2023. wonder.cdc.gov. Data Years: 2011-2020.
5. Behavioral Risk Factor Surveillance System, 2023. Centers for Disease Control and Prevention.

Technical Notes

International Classification of Diseases codes used for this report were based on the North American Association of Central Cancer Registries (NAACCR) list for incidence and mortality. The International Classification of Diseases for Oncology (ICDO), Third Edition (2000) was used for incidence data. The International Classification of Diseases, Tenth Revision, Clinical Modification (2003) was used for mortality data. The 95 percent confidence intervals were calculated for incidence and mortality data and used to determine the level of significance when comparing two rates. If the confidence intervals overlapped, it was determined that no difference existed between the two rates.

Materials & Methods

Population Estimates

The population estimates for the denominators of incidence and mortality rates are race-specific (all races, white, black) and sex-specific county population estimates. The county population estimates were incorporated into the National Cancer Institute's (NCI) SEER*Stat software to calculate cancer incidence and mortality rates. The SEER*Stat population estimates are a slight modification of the annual time series of July 1 county population estimates (by age, sex, and race) produced by the Population Estimates Program of the U.S. Bureau of the Census with support from NCI through an interagency agreement.

Data Sources

Data from cancer registries, health information departments, histopathologic laboratories, and physician offices were reported to the ASCR as of January 15, 2021. For cancer cases diagnosed during 2009-2018, the ASCR considered as reportable all incident cases with a behavior code of 3 (invasive, primary site only) in the ICDO Third Edition, except for *in situ* cancer of the bladder which was included. Basal and squamous cell carcinomas of the skin were excluded, except for those on the skin of the genital organs. The primary source of cancer incidence data is medical records. Staff at health care facilities abstract cancer incidence data from patients' medical records, enter the data into the facility's own cancer registry if it has one, and send the data to the ASCR. All reporting sources collect data using uniform data items and codes as documented by the NAACCR. This uniformity means that data items collected by all reporting sources are comparable. For this report, information on primary cancer sites was coded according to the appropriate ICDO edition and was grouped according to revised SEER recodes dated March 19, 2013, which define standard groupings of primary cancer sites. The SEER/World Health Organization 2008 recodes were used to ensure consistent site-type definitions over time and consistency with other published cancer incidence and mortality data. Invalid site codes were excluded from the analysis.

Age-Adjusted Incidence Rates

Because the occurrence of many cancers increases with age and because the age distribution of a population (i.e., the number of people in particular age categories) can change over time and can be different in different geographic areas, researchers age adjust incidence rates so that they can make a valid comparison between one year's rates and those of another year or between one geographic area's rates and those of another area. Age adjusting the rates ensures that differences in incidence from one year to another or from one geographic area to another are not due to differences in age distribution. The standard population used to age adjust the rates for this report is the 2000 U.S. standard population, in accordance with a 1998 Department of Health and Human Services recommendation. The 2000 U.S. standard population is based on the proportion of the 2000 population in specific age groups. The proportions of the 2000 population in these age groups serve as weights for calculating age-adjusted incidence rates.

Age-Adjusted Mortality Rates

Mortality data for Alabama was obtained from the Alabama Department of Public Health Center for Health Statistics, and age-adjusted rates were calculated using the 2000 U.S. standard population. Prior to the release of *Alabama Cancer Facts & Figures 2007*, cancer deaths of Alabama residents that occurred outside of the state were omitted from the rates. Beginning with *Alabama Cancer Facts & Figures 2007*, these deaths were included in the rate calculations.

APC

APC is a summary statistic that represents the average rate of change in a rate over a defined time period and is used to measure trends over time. The APC is calculated by fitting a least squares regression line to the natural logarithm of the rates using the calendar year as a regressor variable.

Interpreting the Data

Published age-adjusted cancer incidence and mortality rates for years before 1999 were calculated using standard populations other than the 2000 U.S. standard population. Beginning with the publication of data for the 1999 diagnosis year, or year of death, cancer incidence and mortality rates were age adjusted to the 2000 U.S. standard population. This change was motivated by a need to standardize age-adjustment procedures across publications and to update the calculation of age-adjusted rates to more closely reflect the current age distribution of the U.S. population and the current burden of cancer. Because of the aging of the U.S. population, the 2000 U.S. standard population gives more weight to older age categories than did previous standard populations. Caution should be used when comparing the data published here with cancer incidence and mortality rates adjusted to standard populations other than the 2000 U.S. standard population. Geographic variation in incidence and mortality rates may be the result of regional differences in the exposure of the population to known or unknown risk factors. Differences may arise because of differences in

sociodemographic characteristics of the populations (e.g., age, race, or ethnicity, geographic region, urban, or rural residence), screening use, health-related behaviors (e.g., behaviors related to tobacco use, diet, physical activity), exposure to cancer-causing agents, or factors related to registry operations (e.g., completeness, timeliness, specificity in coding cancer sites). Work continues to ensure the reporting of high-quality data. Please note that differences in registry database completeness and data quality do influence the estimated cancer incidence rates. Because 2016 cases were estimated to be 97 percent complete at the time of this publication, some rates, especially all sites combined, may vary slightly from the "true" or final rates for the Alabama population. The rates presented here have not been adjusted for completeness differences across the database. The ASCR may update the previous years' data as cancer registries submit data for the new diagnosis year and additional cases from the previous diagnosis years. Users of cancer incidence data should be mindful of this issue for all data used in their comparisons. Race information reported to the ASCR is not self-reported by the patient. Information on race is abstracted from medical records, coded according to standard procedures, and grouped into standard race groupings. In this *Alabama Cancer Facts & Figures* report, cancer incidence and mortality data are presented for all races combined and for white and black populations in Alabama.

Acknowledgments

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Filed Electronically at: shpda.online@shpda.alabama.gov

November 24, 2025

Ms. Emily T. Marsal
Executive Director
State Health Planning and Development Agency
100 North Union Street, Suite 870
Montgomery, Alabama 36104

Re: Letter of Intent for the Expansion of East Alabama Medical Center's Spencer Cancer Center

Dear Ms. Marsal:

Pursuant to Section 410-1-7-.05 of the State Health Planning and Development Agency's Certificate of Need Rules and Regulations, this letter is to inform you of the intent of East Alabama Medical Center ("EAMC") to file a certificate of need application to expand its Spencer Cancer Center which is located at 2501 Village Professional Drive in Opelika, Lee County. The expansion will include an additional 30,050 square feet to the current facility. The expansion allows for the addition of twenty-two (22) new infusion bays, space for an additional PET/CT, and clinic space for an additional gynecological oncologist, two breast surgeons, and additional medical oncologists. In addition to the expansion, this project involves renovating 2,255 square feet of existing space to provide increased capacity in the lab, pharmacy and walk-in clinical.

EAMC estimates that the proposed project will involve the following costs:

Total Cost of Construction:	\$28,700,000
Equipment Costs:	\$ 5,500,000
First Year New Annual Operating Expenses:	\$15,100,000

The proposed project does not involve the acquisition or conversion of beds, nor does it involve the acquisition of stock or assets of any other entity. EAMC plans to file its formal certificate of need application within the time allowed by law and regulation, and in accordance with Rule 410-1-7-.05 of the Alabama Certificate of Need Program Rules and Regulations.

In addition to this letter of intent, the \$250 filing fee has been paid on the State Health Planning and Development Agency's electronic payment portal. Please contact Marcilla Gross at (334) 528-5825 should you or your staff have any questions.

Sincerely,



Laura Grill
President/CEO

cc: Marcilla Gross, Chief Compliance & Regulatory Affairs Officer