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Cancer statistics for Asian American, Native Hawaiian, and Pacific Islander people, 2026

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ABSTRACT

Background: Cancer statistics for Asian American and Native Hawaiian and Pacific Islander (NHPI) people are usually aggregated, masking substantial variation within this heterogeneous population. Herein, the American Cancer Society reports cancer incidence and survival for 8 Asian American and 3 NHPI ethnic groups.

Methods: The authors used population-based cancer registry data from the National Cancer Institute's Surveillance, Epidemiology, and End Results program, for Asian American and NHPI ethnic groups from 2000 through 2022.

Results: During 2018–2022, overall cancer incidence ranged from 218.3 per 100,000 Kampuchean people to 474.5 per 100,000 Native Hawaiian people, which was 1.5 times higher than the rate for the aggregated Asian American and NHPI population (307.3 per 100,000). High incidence among Native Hawaiian people is largely driven by the highest rates of female breast, colorectal, and prostate cancers, whereas infection-related cancers were highest among Asian American ethnic groups. For example, liver and stomach cancer incidence is highest among Vietnamese (22.2 per 100,000) and Korean people (17.8 per 100,000), respectively, both of which were nearly twice that in Native Hawaiian people (12.9 and 9.6 per 100,000, respectively). Native Hawaiian and Samoan women are twice and 3 times as likely, respectively, to be diagnosed with uterine corpus cancer as aggregated Asian American and NHPI women or White women. Five-year relative survival ranges from 42% in Laotians to 74% in Asian Indians/Pakistanis, with largest differences for colorectal (43% in Laotians to 72% in Asian Indians/Pakistanis) and prostate (63% in Kampucheans to 97% in Japanese) cancers.

Conclusions: Wide variation in cancer risk within the Asian American and NHPI population highlights the critical need for disaggregated data to effectively target cancer prevention and control interventions.

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KEYWORDS

Asian American, cancer disparities, cancer incidence, data disaggregation, Native Hawaiian and Pacific Islander

INTRODUCTION

The Asian American population is the fastest-growing, single-race group in the United States and is expected to double by 2060, largely driven by international migration.¹ Most Asian Americans in the United States can trace their roots to more than 24 origin groups that differ in immigration patterns, acculturation levels, languages, exposures in country of origin, and social determinants of health.^{2,3} For example, Japanese people are about twice as likely to be native-born than Asian Indian people, whereas 75% of Asian Indian people in the United States have attained a bachelor's degree or higher, compared with 19% of Laotian people.⁴ Native Hawaiian and Pacific Islander (NHPI) people, who are often combined with Asian American people in health statistics reporting, were distinguished as a separate race by the Office of Management and Budget in 1997, in recognition of their distinct origins and the need for more accurate federal data to ensure equitable access to resources.⁵

Cancer incidence for all cancer sites combined is lower among the aggregated Asian American and NHPI population than among any other racial-ethnic group in the United States⁶ but varies substantially across ethnic groups within this population. For example, a previous study reported that overall cancer incidence rates in Samoan men were more than twice those in Asian Indian/Pakistani men.⁷ Reporting cancer statistics in aggregate for Asian American and NHPI people perpetuates the myth that these diverse populations uniformly experience favorable outcomes and obscures large health disparities within specific ethnic groups. In this report, we present cancer incidence trends during 2000–2022, as well as contemporary cancer incidence rates (2018–2022), stage at diagnosis (2018–2022), and survival (2015–2021), for disaggregated Asian American, Native Hawaiian, and Pacific Islander people in the United States. In keeping with the style of the American Cancer Society's *Facts & Figures* series, the results and discussion are consolidated into selected findings. Although data on cancer risk factors and screening are extremely limited for this population, we also include a section on cancer prevention and control for Asian American and NHPI populations.

MATERIALS AND METHODS**Data sources**

Population-based cancer incidence data were obtained from the National Cancer Institute's (NCI) Surveillance, Epidemiology, and End Results (SEER) Research Plus Limited Field specialized database for detailed Asian and Pacific Islander populations and served as the

source for 5-year average annual incidence rates and case distribution by stage at diagnosis (2018–2022), as well as long-term incidence trends during 2000–2022.⁸ These data were based on 21 SEER registries (excluding the Alaska Native tumor registry and the Seattle–Puget Sound registry) across 14 US States (California, Connecticut, Georgia, Hawaii, Idaho, Illinois, Iowa, Kentucky, Louisiana, New Jersey, New Mexico, New York, Texas, and Utah)⁸ and represented about 44% of the US population and 66% of the Asian American and NHPI population. Asian American ethnic groups in this database include Chinese, Filipino, Asian Indian/Pakistani, Vietnamese, Korean, Japanese, Kampuchean, and Laotian; whereas NHPI ethnic groups include Native Hawaiian, Guamanian/Chamorro, and Samoan people, regardless of Hispanic ethnicity. Under SEER coding rules, only the Native Hawaiian race was prioritized over other races among multiracial people of Hawaiian descent.⁹ We did not calculate incidence rates separately for the *other Asian and Asian, not otherwise specified* or *other Pacific Islander and Pacific Islander, not otherwise specified* categories because population estimates were not defined in the same way as case data. Data for non-Hispanic White (herein referred to as White) people were included as a comparison group.

Five-year relative survival from 2015 to 2021 was based on data from 21 SEER registries (Registries for Connecticut, Atlanta, San Francisco–Oakland, Hawaii, Iowa, New Mexico, Seattle–Puget Sound, Utah, Alaska Natives, rural and greater Georgia, San Jose–Monterey and greater California, Idaho, Kentucky, Los Angeles, Louisiana, New Jersey, New York, and Texas, excluding Illinois).¹⁰

Statistical analysis

All cancer cases were classified according to the *International Classification of Diseases for Oncology*.¹¹ The most common cancer types by ethnic group were identified based on the proportion of incident malignant cases relative to all cancers combined within each ethnic group, stratified by sex. Case distribution by stage at diagnosis was calculated as the proportion of incident malignant cases at each SEER stage (localized, regional, distant, and unknown) among all cases of a given cancer type within each ethnic group. Contemporary incidence was described in terms of five-year average annual incidence rates. To provide the most applicable implications for contemporary cancer prevention interventions, we characterized 5-year average annual incidence rates and case distribution by stage at diagnosis using most recent 5 years of data (2018–2022). All incidence rates were age-standardized to the 2000 US standard population (using 20 age groups) and expressed per 100,000 persons, as calculated by the NCI's SEER*Stat software (version 8.4.2).¹² Case counts fewer than 25 were suppressed. Population estimates during 2000–2022 for

disaggregated Asian American and NHPI populations were produced by Woods & Poole Economics Inc. under contract with the NCI using April 1, 2000, 2010, and 2020 decennial census data by country of origin, sex, and age. Detailed methodology developed by Woods & Poole Economics Inc. is described elsewhere.¹³ Temporal changes in cancer incidence were quantified using the NCI's Joinpoint Regression Program (version 6.0.1)¹⁴ and reported as the average annual percent change during the most recent 10 years of data (2013–2022) to reflect contemporary trends. Incidence trends were reported as increasing or decreasing if the average annual percent change was statistically significant based on a two-sided $p < .05$ and was otherwise reported as stable. Trend analyses excluded cancer incidence in 2020 because the Joinpoint regression program was not designed to accommodate the large drop in diagnoses resulting from pandemic-related disruptions to routine care.¹⁵

Relative survival is a measure of net survival that represents the probability of surviving cancer in the absence of other causes of death. It is calculated as the ratio of observed survival among people with cancer to expected survival in the absence of a cancer diagnosis among people of the same age, race, ethnicity, sex, and year. For this analysis, we used the Ederer II method to calculate expected survival,¹⁶ with vital status follow-up through 2022. Case counts fewer than 25 were suppressed.

SELECTED FINDINGS

Overall cancer incidence

Figure 1 presents incidence rates during 2018–2022 overall and for the four most common cancers in the United States by ethnic group and sex. Overall cancer incidence ranges from 218.3 per 100,000 in Kampuchean people to 474.5 per 100,000 in Native Hawaiian people; the rate in Native Hawaiian people is 1.5 times higher than that in the aggregated Asian American and NHPI population (307.3 per 100,000) and is similar to the rate in White people (477.8 per 100,000). Among women, incidence varies more than twofold across ethnic groups, ranging from 213.6 per 100,000 Laotian women to 507.4 per 100,000 Native Hawaiian women; the rate in Native Hawaiian women is 13% higher than that in White women (450.5 per 100,000). Incidence among men ranges from 218.0 per 100,000 among Kampuchean men to 447.8 per 100,000 among Native Hawaiian men, below the rate in White men (517.8 per 100,000).

Increasing overall cancer incidence in women versus declining or stable rates in men has resulted in a convergence in rates for men and women in several Asian American and NHPI ethnic groups over time (Figure 2), similar to patterns in the broader US population.⁶ For instance, cancer incidence increased by 0.3%–1.5% per year among Japanese, Native Hawaiian, and Chinese women from 2013 to 2022 but decreased or was stable among their male counterparts (Table 1), leading to higher contemporary incidence among women than among men. Contemporary rates are also higher in Asian Indian/Pakistani women than in men, reflecting a steeper increasing trend in women

(1.4% per year) compared with men (0.7% per year). Korean and Vietnamese men still have higher contemporary cancer incidence than their female counterparts, although the sex gap is narrowing (Figure 2). Overall variation in cancer incidence reflects differences between ethnic groups in exposure to risk factors, distribution of cancer types, as well as sociocultural and immigration patterns. For example, populations who have immigrated more recently are more likely to reflect risk factors in their country of origin. For more information, please refer to the sections below on specific cancer types.

Female breast

Breast cancer is the most commonly diagnosed cancer among women in every Asian American and NHPI ethnic group, accounting for up to 40% of all incident cancers among Asian Indian/Pakistani women (Table 2). During 2018–2022, breast cancer incidence rates varied nearly fourfold across ethnic groups, from 48.8 per 100,000 among Laotian women to 177.2 per 100,000 among Native Hawaiian women (Figure 1). Native Hawaiian women have breast cancer incidence 27% higher than that in White women (139.5 per 100,000), who have the highest rate in the United States when Asian American and NHPI women are combined.⁶ Breast cancer incidence in Japanese women is also slightly higher than in White women.

Breast cancer incidence rates are increasing in every Asian American and NHPI ethnic group except Samoan and Laotian women, among whom rates are stable. The average annual percent change during 2013–2022 ranged from about 1% per year in Native Hawaiian and Filipino women and 2% per year in Kampuchean, Japanese, and Asian Indian/Pakistani women to 3%–5% per year in Guamanian/Chamorro, Chinese, Vietnamese, and Korean women (Table 1). Differences in breast cancer incidence trends across ethnic groups reflect both increasing risk in countries of origin^{17–19} and lifestyle factors associated with westernization, such as delayed childbearing, nulliparity, and excess body weight,^{20–22} although contemporary risk factor data by ethnic group are limited. However, markedly steeper increases in incidence and distinct differences in breast cancer biology between Asian and non-Asian women suggest the potential for unique etiologic factors.²³

Variation in breast cancer screening uptake also contributes to differences in breast cancer incidence rates through the detection of prevalent asymptomatic disease. During 2015–2018, up-to-date breast cancer screening in women aged 45 years and older ranged from 55% among Asian Indian women to 69% among Filipino women,⁴ although more recent disaggregated screening data are limited. Variation in screening prevalence may partly reflect the impact of sociocultural factors, such as perception of susceptibility to breast cancer, as well as knowledge of the US health care system, which has been reported to influence preventive care utilization among Chinese and Asian Indian women.²⁴

Likely in part reflecting the prevalence of screening, the stage at diagnosis for breast cancer varies across ethnic groups. The proportion of localized stage diseases ranges from 62% among Asian

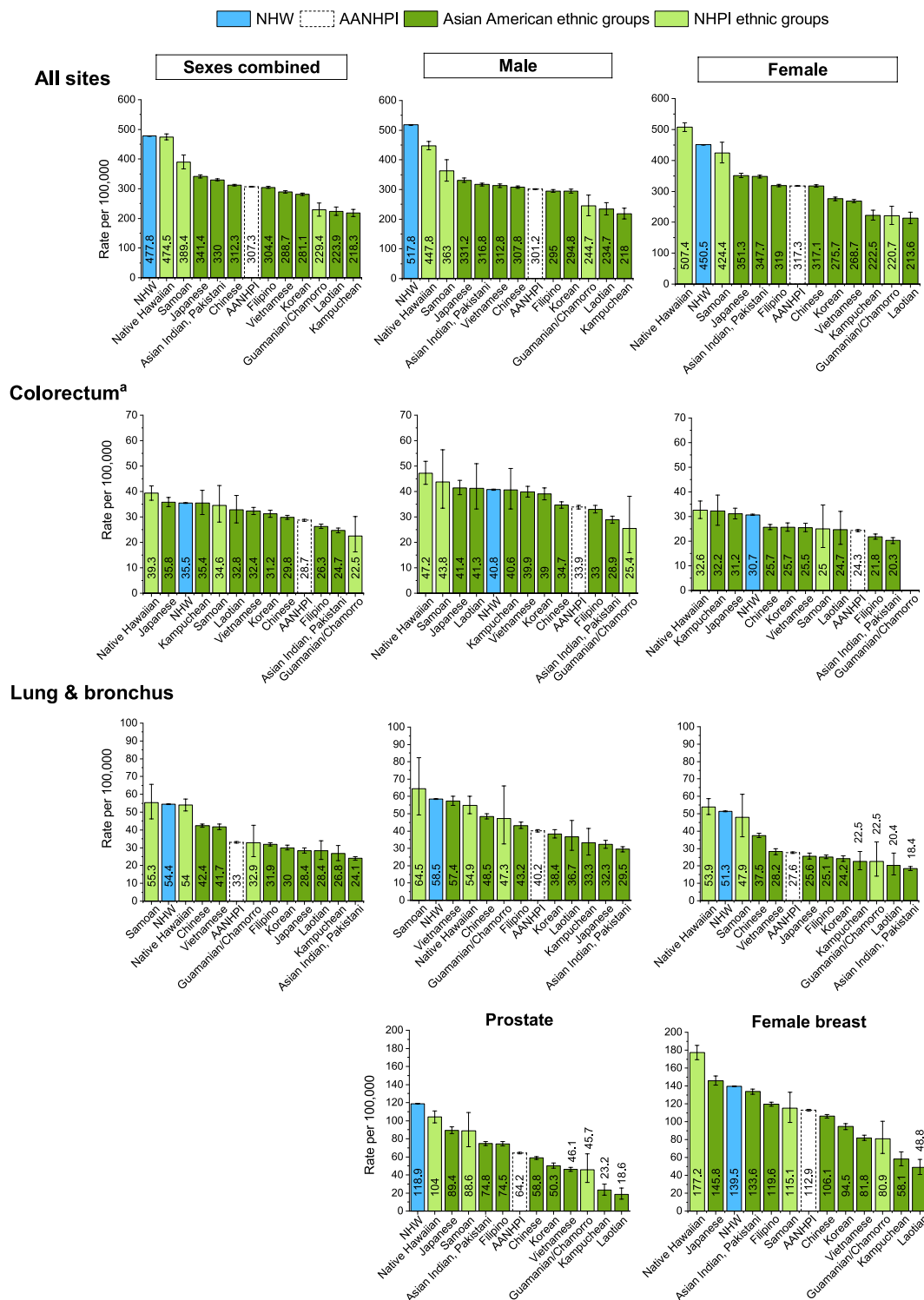


FIGURE 1 Contemporary incidence rates for selected cancers among Asian American, Native Hawaiian, and Pacific Islander people by sex and ethnic group, 2018–2022, United States. Incidence rates are age adjusted to the 2000 US standard population and suppressed for ethnic groups with fewer than 25 cases. AANHPI indicates Asian American, Native Hawaiian, and Pacific Islander; NHPI, Native Hawaiian and Pacific Islander; NHW, non-Hispanic White. ^aExcludes appendix.

Indian/Pakistani women to 72% among Japanese women (Figure 3). Similarly, 5-year relative survival also varies substantially across Asian American and NHPI ethnic groups, ranging from 71% among Samoan women to 95% among Japanese women (Figure 4).

Colorectum

Colorectal cancer is the third most commonly diagnosed cancer in men and women in the United States overall⁶ but is the most

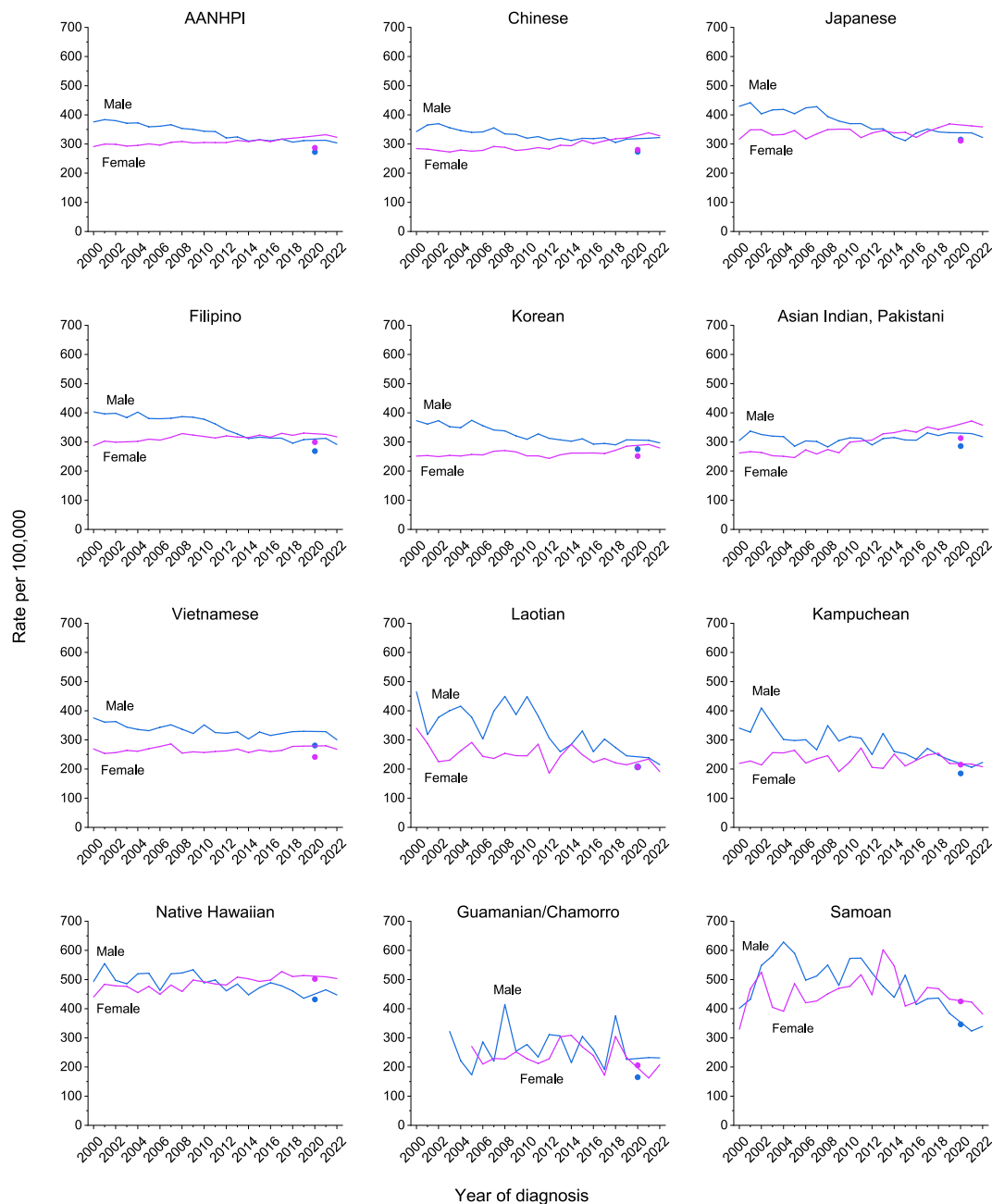


FIGURE 2 Incidence trends for all cancers combined among Asian American, Native Hawaiian, and Pacific Islander people by sex and ethnic group, 2000–2022, United States. Incidence rates are age adjusted to the 2000 US standard population and suppressed for ethnic groups with fewer than 25 cases. Data for 2020 are shown separate from the trend lines. AANHPI indicates Asian American, Native Hawaiian, and Pacific Islander.

common cancer in Laotian and Kampuchean men and ranks second in their female counterparts (after breast cancer), as well as in Japanese and Korean men and women and Asian Indian/Pakistani men (Table 2). During 2018–2022, colorectal cancer incidence ranged from 22.5 per 100,000 among Guamanian/Chamorro people to 39.3 per 100,000 among Native Hawaiian people, whose rates are 37% higher than those of the aggregate Asian American and NHI population (28.7 per 100,000) and 11% higher than those of

White people (35.5 per 100,000; Figure 1). Over the past decade, colorectal cancer incidence rates have been declining among Filipino, Native Hawaiian, and Korean people at a steeper pace (1.3%–1.8% per year) than the general US population (0.9% per year).²⁵ Conversely, incidence is stable among most ethnic groups, with the exception of Asian Indian/Pakistani people, among whom rates are increasing by about 1% per year (Table 1). Similar to the overall US population,²⁵ colorectal cancer incidence rates among

TABLE 1 Ten-year (2013–2022) average annual percent change in incidence rates among Asian American, Native Hawaiian, and Pacific Islander people for four major cancers, United States.

	Sexes combined		Men		Women	
	AAPC, %	95% Confidence interval, %	AAPC, %	95% Confidence interval, %	AAPC, %	95% Confidence interval, %
All sites						
Non-Hispanic White	−0.3 ^a	−0.4, −0.2	−0.2	−0.6, 0.3	−0.1	−1.0, 0.7
AANHPI	0.1	0.1, −0.2	−0.5 ^a	−0.9, −0.1	0.5 ^a	0.4, 0.6
Chinese	0.8 ^a	0.5, 1.2	0.1	−0.5, 0.7	1.5 ^a	1.1, 1.9
Japanese	0.4	−0.3, 1.2	−0.2	−1.2, 0.8	0.3 ^a	0.0, 0.6
Filipino	−0.3	−0.7, 0.2	−1.0 ^a	−1.7, −0.4	0.1	−0.1, 0.3
Korean	0.5	−0.2, 1.2	−0.3	−1.0, 0.5	1.5 ^a	1.0, 2.0
Asian Indian, Pakistani	1.4 ^a	1.1, 1.7	0.7 ^a	0.3, 1.1	1.4 ^a	0.8, 2.0
Vietnamese	−0.2	−0.4, 0.0	−0.6 ^a	−0.8, −0.3	0.2	−0.0, 0.4
Laotian	−2.0 ^a	−2.7, −1.3	−4.4 ^a	−6.3, −2.5	−1.2 ^a	−2.0, −0.4
Kampuchean	−1.2 ^a	−1.7, −0.7	−2.2 ^a	−2.9, −1.6	−0.3	−1.0, 0.4
Native Hawaiian	−0.0	−0.2, 0.2	−0.7 ^a	−1.0, −0.4	0.5 ^a	0.3, 0.7
Samoa	−3.6 ^a	−5.0, −2.1	−4.4 ^a	−6.6, −2.2	−2.9 ^a	−5.4, −0.4
Guamanian/Chamorro	−3.1	−7.2, 1.2	0.2	−1.4, 1.9	−3.8	−8.4, 1.0
Breast						
Non-Hispanic White	—		—		0.5 ^a	0.4, 0.7
AANHPI	—		—		2.2 ^a	1.8, 2.7
Chinese	—		—		3.4 ^a	2.6, 4.3
Japanese	—		—		2.0 ^a	1.3, 2.7
Filipino	—		—		1.3 ^a	1.0, 1.5
Korean	—		—		4.8 ^a	3.5, 6.1
Asian Indian, Pakistani	—		—		2.4 ^a	1.7, 3.1
Vietnamese	—		—		3.6 ^a	2.4, 4.8
Laotian	—		—		1.1	−1.1, 3.5
Kampuchean	—		—		1.8 ^a	0.2, 3.4
Native Hawaiian	—		—		0.7 ^a	0.2, 1.1
Samoa	—		—		0.3	−1.2, 1.8
Guamanian/Chamorro	—		—		2.6 ^a	0.4, 4.8
Colon and rectum ^b						
Non-Hispanic White	−0.9 ^a	−1.2, −0.6	−1.0 ^a	−1.2, −0.7	−1.0 ^a	−1.2, −0.7
AANHPI	−1.2 ^a	−1.8, −0.5	−1.1 ^a	−1.9, −0.4	−1.0 ^a	−1.7, −0.3
Chinese	−0.8	−1.7, 0.1	−1.3 ^a	−1.8, −0.9	−0.3	−1.8, 1.3
Japanese	−1.2	−2.5, 0.1	−3.0 ^a	−3.5, −2.5	−2.5 ^a	−3.0, −2.0

TABLE 1 (Continued)

	Sexes combined		Men		Women	
	AAPC, %	95% Confidence interval, %	AAPC, %	95% Confidence interval, %	AAPC, %	95% Confidence interval, %
Filipino	−1.3 ^a	−2.3, −0.3	−2.2 ^a	−2.6, −1.8	−2.5 ^a	−3.1, −1.9
Korean	−1.8 ^a	−2.3, −1.3	−1.7 ^a	−2.4, −1.1	−2.0 ^a	−2.7, −1.3
Asian Indian, Pakistani	0.7 ^a	0.2, 1.1	0.7 ^a	0.2, 1.2	0.5	−0.2, 1.2
Vietnamese	−0.3	−0.7, 0.1	0.4	−0.3, 1.0	−1.2 ^a	−1.8, −0.6
Laotian	0.6	−1.1, 2.3	1.6	−0.9, 4.1	−0.2	−2.4, 2.1
Kampuchean	0.2	−1.1, 1.5	0.9	−0.9, 2.7	−0.2	−1.9, 1.6
Native Hawaiian	−1.4 ^a	−2.2, −0.6	−1.7 ^a	−2.7, −0.7	−1.2 ^a	−2.3, −0.0
Samoa	0.0	−2.4, 2.5	1.2	−1.3, 3.8	−1.5	−4.7, 1.9
Guamanian/ Chamorro	−9.6	−24.4, 8.1	2.4	−2.1, 7.1	^c	
Lung and bronchus						
Non-Hispanic White	−2.3 ^a	−3.1, −1.5	−3.1 ^a	−3.9, −2.3	−1.6 ^a	−2.5, −0.8
AANHPI	−1.4 ^a	−2.7, −0.1	−1.6 ^a	−1.8, −1.5	−0.6	−2.3, 1.0
Chinese	0.0	−1.1, 1.1	−0.5 ^a	−0.8, −0.2	0.9	−2.0, 3.9
Japanese	−1.8 ^a	−2.4, −1.2	−2.8 ^a	−3.5, −2.0	−1.6 ^a	−2.5, −0.6
Filipino	−2.0 ^a	−2.5, −1.6	−3.2 ^a	−4.2, −2.2	−0.9 ^a	−1.5, −0.2
Korean	−0.8 ^a	−1.3, −0.4	−1.7 ^a	−2.5, −0.9	−0.0	−0.6, 0.5
Asian Indian, Pakistani	1.1 ^a	0.5, 1.7	0.3	−0.5, 1.2	2.3 ^a	1.5, 3.1
Vietnamese	−0.6 ^a	−0.9, −0.2	−0.5 ^a	−1.1, −0.0	−0.5	−1.2, 0.2
Laotian	−2.1 ^a	−3.4, −0.8	−2.5 ^a	−4.5, −0.5	2.2	−1.5, 6.1
Kampuchean	−2.1 ^a	−3.6, −0.6	−3.2 ^a	−5.5, −0.9	−0.3	−2.6, 2.0
Native Hawaiian	−2.9 ^a	−4.7, −1.0	−2.3 ^a	−3.2, −1.4	−0.9 ^a	−1.6, −0.2
Samoa	−1.0	−2.3, 0.3	−2.3 ^a	−3.6, −0.9	0.7	−1.2, 2.7
Guamanian/ Chamorro	0.1	−2.7, 3.1	1.4	−2.0, 4.9	^c	
Prostate						
Non-Hispanic White	—		1.5 ^a	0.1, 2.9	—	
AANHPI	—		1.5 ^a	0.5, 2.5	—	
Chinese	—		2.7 ^a	1.3, 4.0	—	
Japanese	—		2.5	−0.4, 5.5	—	
Filipino	—		0.6	−1.0, 2.1	—	
Korean	—		3.6 ^a	1.7, 5.5	—	
Asian Indian, Pakistani	—		1.3 ^a	0.4, 2.1	—	
Vietnamese	—		1.4	−0.2, 3.1	—	
Laotian	—		−6.3 ^a	−9.6, −2.8	—	

(Continues)

TABLE 1 (Continued)

	Sexes combined		Men		Women	
	AAPC, %	95% Confidence interval, %	AAPC, %	95% Confidence interval, %	AAPC, %	95% Confidence interval, %
Kampuchean	—		−3.9 ^a	−5.9, −2.0	—	
Native Hawaiian	—		3.4 ^a	0.9, 6.0	—	
Samoan	—		−7.0 ^a	−9.1, −4.9	—	
Guamanian/ Chamorro	—		−4.6 ^a	−6.9, −2.1	—	

Note: The average annual percent change during 2013–2022 is based on incidence rates during 2000–2022. Incidence rates were age adjusted to the 2000 US standard population and analyzed by the Joinpoint Regression Program, version 6.0.1 (National Cancer Institute), allowing up to two joinpoints.

Abbreviations: AANHPI, Asian American, Native Hawaiian, and Pacific Islander; AAPC, average annual percent change.

^aThe AAPC is significantly different from zero ($p < .05$).

^bExcludes appendix.

^cCould not analyze this group because of sparse data.

those younger than 50 years are increasing by about 2% per year in Native Hawaiian and Asian Indian/Pakistani people, whereas the rates are stable for other Asian American and other Pacific Islander ethnic groups (data not shown).

Differences in colorectal cancer incidence patterns across ethnic groups may reflect variation in underlying risk factors, including excess body weight and dietary patterns, as well as uptake of screening. In general, NHPI people have a higher prevalence of established risk factors (e.g., excess body weight, lack of physical activity) than many Asian American ethnic groups, which may contribute to higher colorectal cancer incidence.^{26,27} Although the prevalence of excess body weight among Asian Americans is relatively low, it varies widely across ethnic groups. For example, in 2018, the prevalence of excess body weight ranged from 31% in Chinese people to 57% in Asian Indian people.⁴ In addition, the risk of Asian American people developing cancer at a lower body mass index than White people is an area of ongoing research. Up-to-date colorectal cancer screening is generally low among Asian American people, with wide variation across ethnic groups. For example, during 2015–2018, the prevalence of colorectal cancer screening ranged from 44% in Asian Indian people to 51% in Chinese people, compared with 57% among their White counterparts,⁴ although there is a lack of contemporary screening data by ethnic group.

Stage at diagnosis for colorectal cancer varies across ethnic groups, with a lower proportion of localized-stage disease among Native Hawaiian (32%) and Vietnamese (33%) people compared with 36% in Filipino people (Figure 3). Similarly, 5-year relative colorectal cancer survival varies widely across ethnic groups, ranging from 43% in Laotian people and 47% in Samoan people compared with 72% in Asian Indian/Pakistani people (Figure 4). Wide variation in survival across Asian American and NHPI ethnic groups may partly reflect differences in stage at diagnosis and access to high-quality cancer care.^{28,29}

Lung & bronchus

Lung cancer is the most common cancer among Vietnamese men and ranks second or third among men and women of almost every other ethnic group (Table 2). Contemporary lung cancer incidence ranges from 24.1 per 100,000 among Asian Indian/Pakistani people to 55.3 per 100,000 among Samoan people, with rates among Samoan and Native Hawaiian people (54.0 per 100,000) comparable to those of White people (54.4 per 100,000; Figure 1). Native Hawaiian women have nearly twice the incidence rates of the aggregated Asian American and NHPI female population (Figure 1), likely reflecting higher smoking prevalence than in some Asian ethnic groups.³⁰

In the United States, declines in lung cancer incidence have been faster among men than women, likely because women started smoking later than men and were slower to quit.^{6,31} Sex-specific patterns similar to those of the general US population were observed over the past decade in Japanese, Filipino, and Native Hawaiian people, with steeper declines in incidence among men than women (Table 1). Prior studies have reported that smoking behaviors among Japanese and NHPI populations more closely resemble those of the general US population than those of other Asian American ethnic groups,³² although disaggregated historical smoking data are unavailable. In contrast, incidence rates were stable among Chinese, Korean, Vietnamese, Laotian, Kampuchean, and Samoan women, whereas rates declined among their male counterparts. Notably, Asian Indian/Pakistani women experienced a 2.3% per year increase in lung cancer incidence, whereas rates in men were stable.

Non-smoking-related risk factors, such as secondhand tobacco smoke and cooking oil fumes, are important for lung cancer in Asia and may be relevant in Asian American women in the United States.³³ A recent multicenter study indicated that, among women who never smoked, lung cancer incidence rates were higher among women from every Asian American and NHPI ethnic group (except

TABLE 2 The five most common cancer types among Asian American, Native Hawaiian, and Pacific Islander people by sex and ethnic group, 2018–2022, United States.

Ethnic group	First	%	Second	%	Third	%	Fourth	%	Fifth	%
Men										
Asian American										
Chinese	Prostate	20	Lung & bronchus	16	Colon & rectum	11	Liver	6	Non-Hodgkin lymphoma	5
Japanese	Prostate	29	Colon & rectum	12	Lung & bronchus	10	Urinary Bladder	6	Non-Hodgkin lymphoma	5
Filipino	Prostate	27	Lung & bronchus	14	Colon & rectum	11	Non-Hodgkin lymphoma	6	Kidney & renal pelvis	5
Korean	Prostate	17	Colon & rectum	13	Lung & bronchus	13	Stomach	9	Urinary bladder	6
Asian Indian/Pakistani	Prostate	23	Colon & rectum	10	Lung & bronchus	9	Oral cavity & pharynx	6	Non-Hodgkin lymphoma	6
Vietnamese	Lung & bronchus	18	Prostate	15	Colon & rectum	13	Liver	12	Non-Hodgkin lymphoma	5
Laotian	Colon & rectum	18	Lung & bronchus	15	Liver	13	Prostate	8	Oral cavity & pharynx	5
Kampuchean	Colon & rectum	19	Liver	14	Lung & bronchus	14	Prostate	11	Non-Hodgkin lymphoma	6
NHPI										
Native Hawaiian	Prostate	24	Lung & bronchus	12	Colon & rectum	11	Liver	5	Non-Hodgkin lymphoma	5
Samoaan	Prostate	21	Lung & bronchus	15	Colon & rectum	14	Liver	6	Stomach	5
Guamanian/Chamorro	Prostate	18	Lung & bronchus	16	Colon & rectum	11	^a		^a	
Women										
Asian American										
Chinese	Breast	33	Lung & bronchus	12	Colon & rectum	8	Thyroid	6	Uterine corpus	6
Japanese	Breast	37	Colon & rectum	10	Lung & bronchus	9	Uterine corpus	6	Pancreas	5
Filipino	Breast	38	Uterine corpus	10	Lung & bronchus	8	Thyroid	7	Colon & rectum	7
Korean	Breast	34	Colon & rectum	10	Lung & bronchus	9	Thyroid	6	Uterine corpus	5
Asian Indian/Pakistani	Breast	40	Uterine corpus	8	Thyroid	8	Colon & rectum	5	Lung & bronchus	5
Vietnamese	Breast	31	Lung & bronchus	10	Colon & rectum	10	Thyroid	7	Uterine corpus	6
Laotian	Breast	26	Colon & rectum	11	Lung & bronchus	9	Liver	6	Uterine corpus	5
Kampuchean	Breast	28	Colon & rectum	14	Lung & bronchus	9	Uterine corpus	5	Liver	5
NHPI										
Native Hawaiian	Breast	35	Uterine corpus	12	Lung & bronchus	10	Colon & rectum	6	Thyroid	5
Samoaan	Breast	28	Uterine corpus	21	Lung & bronchus	10	Colon & rectum	5	Pancreas	4

(Continues)

TABLE 2 (Continued)

Ethnic group	First	%	Second	%	Third	%	Fourth	%	Fifth	%
Guamanian/ Chamorro	Breast	37	Lung & bronchus	10	^a		^a		^a	

Note: Liver includes the intrahepatic bile duct. Colon and rectum excludes appendix. Percentages are rounded to the nearest whole number.

Abbreviation: NHPI, Native Hawaiian and Pacific Islander.

^aData for <25 cases are suppressed.

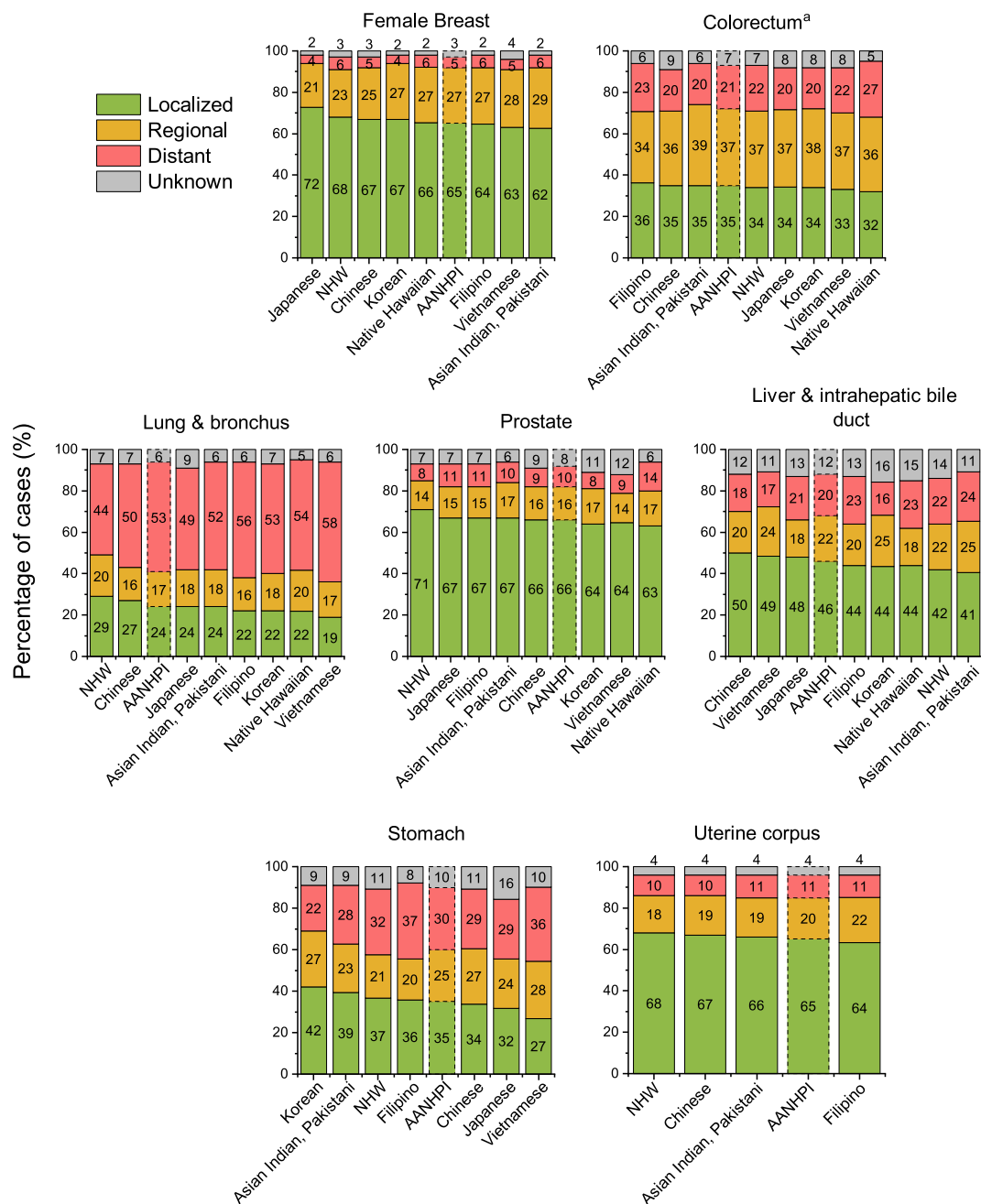


FIGURE 3 Stage distribution (%) for selected cancers among Asian American, Native Hawaiian, and Pacific Islander people by ethnic group, 2018–2022, United States. Stage distribution by sex is not shown because of sparse data, and ethnic groups with fewer than 25 cases are suppressed. Percentages are rounded to the nearest whole number and may not sum to 100%. AANHPI indicates Asian American, Native Hawaiian, and Pacific Islander; NHW, non-Hispanic White. ^aExcludes appendix.

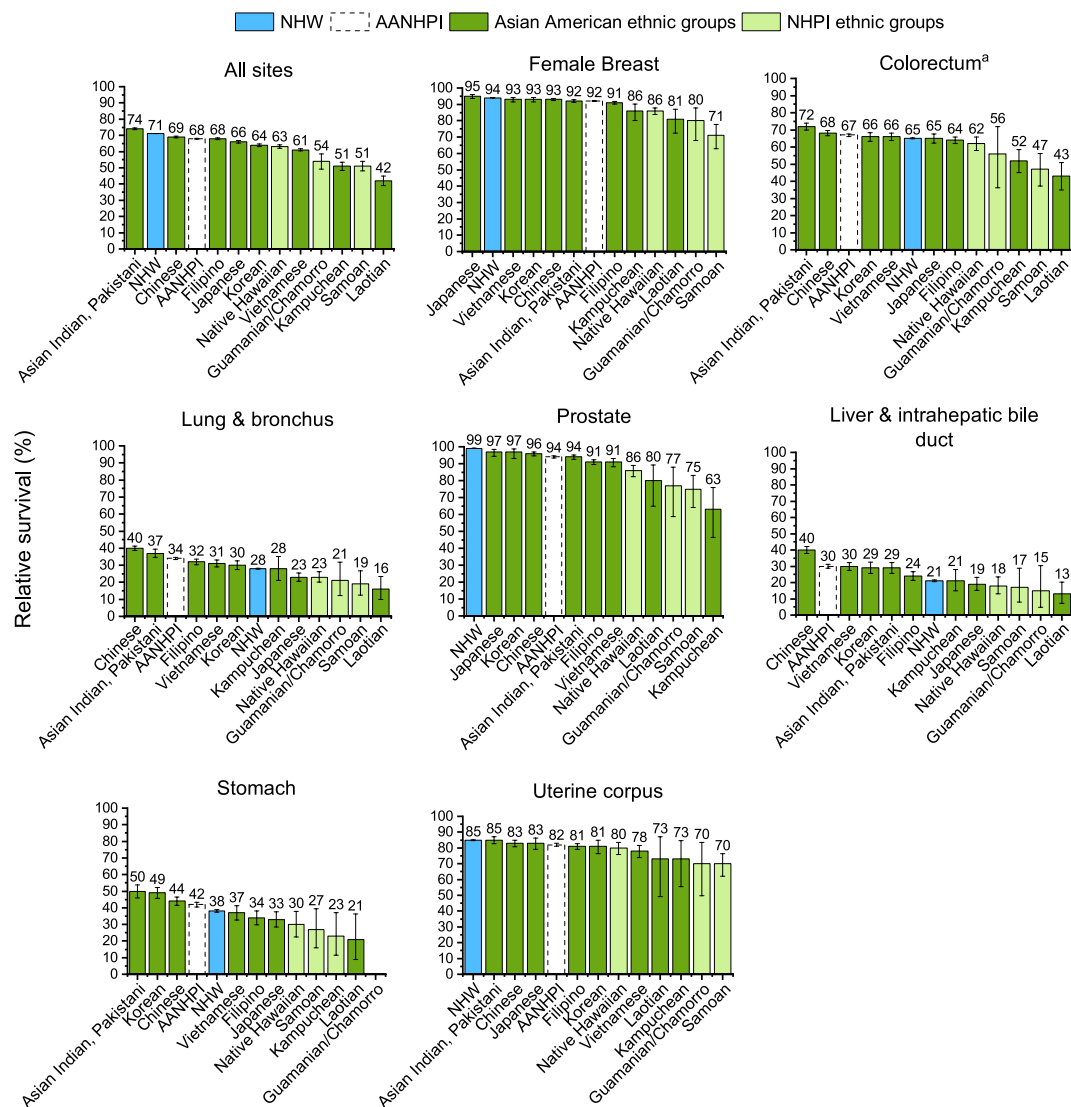


FIGURE 4 Five-year relative survival (%) for selected cancers among Asian American, Native Hawaiian, and Pacific Islander people by ethnic group, 2015–2021, United States. Relative survival is based on cases diagnosed from 2015 to 2021, all followed through 2022, and is not shown by sex due to sparse data. Ethnic groups with fewer than 25 cases are suppressed. Percentages are rounded to the nearest whole number. AANHPI indicates Asian American, Native Hawaiian, and Pacific Islander; NHPI, Native Hawaiian and Pacific Islander; NHW, non-Hispanic White. ^aExcludes appendix.

Japanese women) compared with White women, ranging from 66% higher among Native Hawaiian women to about 120% higher among Chinese women.³⁴ However, lung cancer risk factors among people in the United States who have never smoked remain poorly understood and require more research.

Stage at diagnosis and survival for lung cancer varies widely by ethnic group. For example, the proportion of localized-stage disease among Asian Americans ranges from 19% among Vietnamese people to 27% among Chinese people (Figure 3). Similarly, 5-year relative survival ranges from 16% among Laotian people to 40% among Chinese people (Figure 4). However, Native Hawaiian people have a lower proportion of localized-stage lung cancer (22%) and worse survival (23%) compared with most Asian American ethnic groups (Figures 3

and 4). Comparison of survival between racial-ethnic groups should be interpreted with caution because higher survival with a relatively poor stage distribution may be caused by differences in tumor biology (EGFR prevalence), lifestyle factors, and overestimation because of loss to follow-up or delays in treatment initiation.^{35–38}

Prostate

Prostate cancer is the leading cancer among men in every Asian American and NHPI ethnic group except Vietnamese men, in whom it ranks second (after lung cancer), and Kampuchean and Laotian men, in whom it ranks fourth (after colorectal, lung, and liver cancers).

(Table 2). Prostate cancer incidence ranges from 18.6 per 100,000 among Laotian men to 104 per 100,000 among Native Hawaiian men, all below those of White men (118.9 per 100,000; Figure 1). Factors that contribute to these differences in prostate cancer incidence rates across population groups likely include genetic ancestry, which confers differential risk across ethnic groups,^{39,40} and prostate-specific antigen (PSA) test use, which elevates incidence rates through the detection of asymptomatic disease.⁴¹ PSA testing prevalence likely differs across Asian American and NHPI ethnic groups because of variations in health care access and cultural belief systems,⁴⁰ although disaggregated screening data are unavailable.

Historically, temporal changes in the use of PSA screening have caused erratic trends in prostate cancer incidence rates,^{41,42} although the extent to which PSA testing contributes to contemporary trends is unclear. Prostate cancer incidence rates increased over the past decade among Chinese, Korean, Asian Indian/Pakistani, and Native Hawaiian men (Table 1), consistent with incidence trends in the overall US male population.⁶ In contrast, incidence declined among Samoan (7.0% per year), Laotian (6.3% per year), Guamanian/Chamorro (4.6% per year), and Kampuchean men (3.9% per year), whereas rates were stable among Japanese, Filipino, and Vietnamese men.

Although prostate cancer has a generally favorable prognosis, Native Hawaiian men as well as men in all of the Asian American ethnic groups (for which data are presented) have a lower proportion of localized-stage disease compared with White people (63%–67% vs. 71%, respectively; Figure 3). Similarly, 5-year relative survival ranges from 63% among Kampuchean men to 97% among Japanese men compared with 99% among White men (Figure 4). Lower survival in part likely reflects later stage diagnosis. However, NHPI men are 29% (hazard ratio, 1.29; 95% confidence interval, 1.14–1.46) more likely than White men to die after a prostate cancer diagnosis, even after controlling for stage at diagnosis, comorbidities (which are higher), and socioeconomic differences.⁴³ Persistent deficits in early detection and survival are particularly concerning given the rising prostate cancer incidence in Chinese, Korean, Asian Indian/Pakistani, and Native Hawaiian men. Early detection through PSA testing is associated with earlier stage at diagnosis and reduced prostate cancer mortality⁴⁴; however, prevalence among Asian men overall was among the lowest of any racial and ethnic group in 2023 (26% vs. 41% among White men).⁴⁵ Community-based prostate cancer screening and education programs targeting specific ethnic groups may effectively improve knowledge about prostate cancer and, consequently, promote screening behaviors among Asian American men.⁴⁶

Liver & intrahepatic bile duct

Liver cancer ranks 11th among US men overall⁶ but second and third among Kampuchean and Laotian men, respectively, accounting for about 14% of all incident cancer cases among these two groups (Table 2). Liver cancer also ranks in the top five cancer types among Chinese, Vietnamese, Native Hawaiian, and Samoan men as well as

among Laotian and Kampuchean women. Contemporary incidence (2018–2022) ranges from 7.6 per 100,000 among Japanese people to 22.2 per 100,000 among Vietnamese people, whose rates are approximately three times higher than those of White people (7.6 per 100,000; Figure 5).

During 2013–2022, liver cancer incidence was stable among Native Hawaiian and Samoan people but declined among every Asian ethnic group except Asian Indian/Pakistani people, among whom rates increased by 1.8% per year (Table 3). These differences partly reflect variation in underlying etiologies. For example, hepatocellular carcinoma among Southeast Asian and East Asian populations is most commonly associated with chronic hepatitis B virus (HBV) and hepatitis C virus (HCV) infection,⁴⁷ and declining rates among these groups may reflect therapeutic advances such as direct-acting antivirals introduced in 2013,⁴⁸ universal infant HBV vaccination programs in Asian countries,⁴⁹ and viral hepatitis screening recommendations in the United States.^{50,51} Despite opportunities for cancer prevention through viral hepatitis screening and antiviral therapies, awareness of liver cancer and the prevalence of screening for HBV and HCV are low.^{47,52–54} In contrast, metabolic dysfunction–associated steatotic liver disease is the leading cause of hepatocellular carcinoma in Filipino, NHPI, and South Asian people.⁴⁷

There is also heterogeneity in disease presentation and survival across Asian American ethnic groups. For example, the proportion of localized-stage liver cancer ranges from 41% among Asian Indian/Pakistani people to 50% among Chinese people (Figure 3). Similarly, 5-year relative survival ranges from 13% in Laotian people to 40% among Chinese people (Figure 4). In contrast, 5-year survival within NHPI people only ranges from 15% in Guamanian/Chamorro people to 18% among Native Hawaiian people.

Stomach

Contemporary stomach cancer incidence rates (2018–2022) range from 4.7 per 100,000 in Filipino people to 17.8 per 100,000 in Korean people (Figure 5). Rates in Chinese (12 per 100,000), Samoan (16.4 per 100,000), and Korean people (17.8 per 100,000), are approximately two to three times those in White people (5.6 per 100,000). Disproportionately high stomach cancer incidence among several Asian American and NHPI ethnic groups likely reflects, in part, a higher prevalence of *Helicobacter pylori* (*H. pylori*) infection and dietary patterns characterized by high salt and preserved food intake.^{55,56} *H. pylori* infection is the strongest risk factor for stomach cancer, increasing risk by about sixfold and accounting for about 90% of noncardia gastric cancer cases worldwide.⁵⁷ Although global reductions in *H. pylori* infection have driven declines in stomach cancer incidence in many countries, seroprevalence is still substantially higher in many Asian countries than in the United States.⁵⁶ In the United States, stomach cancer incidence rates have risen since 2019 because the World Health Organization revised the classification of gastrointestinal stromal tumors from nonmalignant to malignant; thus they are newly reportable.⁵⁸ This artifact is not yet reflected in

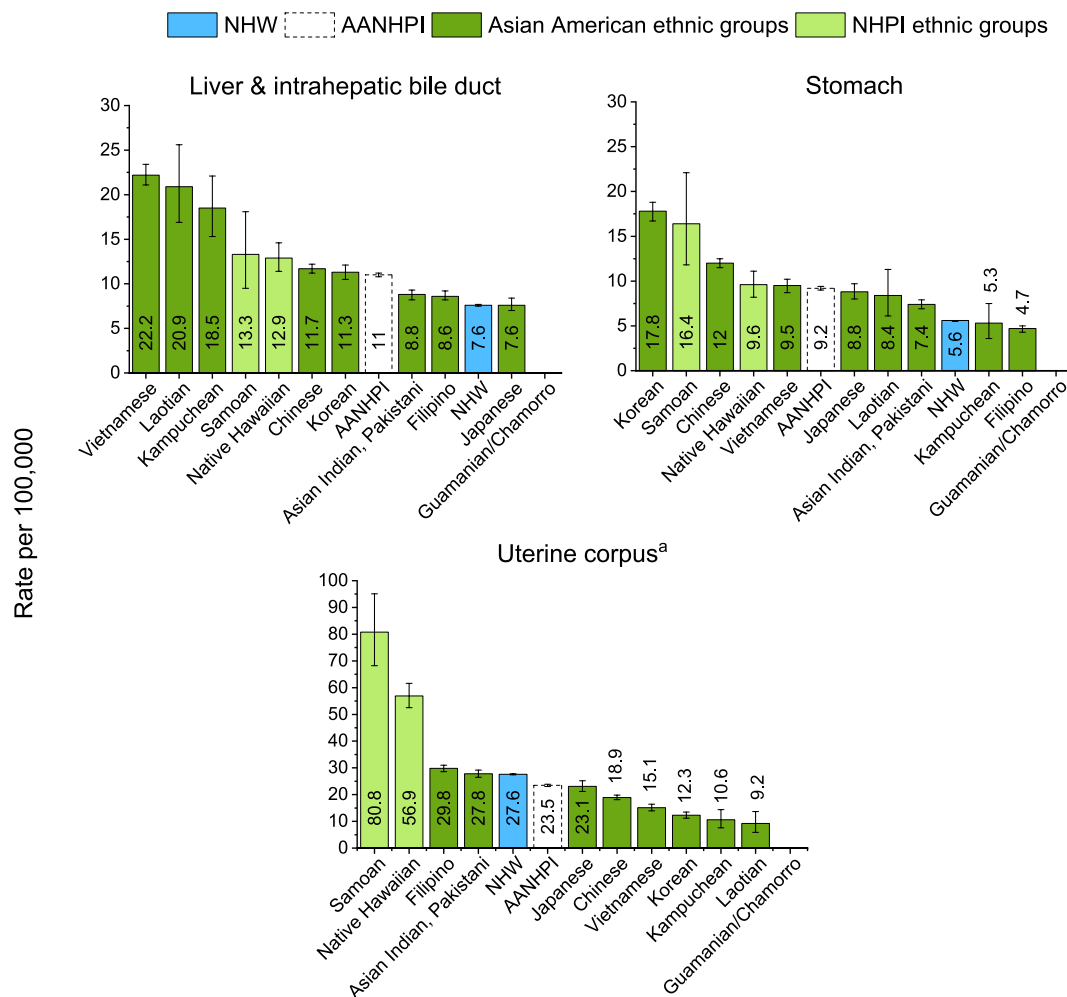


FIGURE 5 Contemporary incidence rates of liver, stomach, and uterine corpus cancers among Asian American, Native Hawaiian, and Pacific Islander people by ethnic group, 2018–2022, United States. Incidence rates are age adjusted to the 2000 US standard population and not shown by sex for liver and stomach cancers because of sparse data. Ethnic groups with fewer than 25 cases are suppressed. AANHPI indicates Asian American, Native Hawaiian, and Pacific Islander; NHPI, Native Hawaiian and Pacific Islander; NHW, non-Hispanic White. ^aNot adjusted for hysterectomy prevalence.

the average annual percent change in stomach cancer incidence over the past decade (2013–2022), as indicated in Table 3, during which rates have declined among all Asian American and NHPI ethnic groups in the United States except Japanese and Asian Indian/Pakistani people, among whom rates were stable.

Korean and Asian Indian/Pakistani people have the highest proportion of localized stomach cancer diagnoses (42% and 39%, respectively; Figure 3), and the highest 5-year relative survival (49% and 50%, respectively; Figure 4). Vietnamese people are most likely to be diagnosed with advanced-stage disease (distant stage, 36%), although 5-year relative survival is similar to that of White people (37% vs. 38%; Figures 3 and 4). Elevated stomach cancer incidence, later stage diagnoses, and low survival among some Asian American ethnic groups may warrant evaluation of targeted endoscopic screening in the United States⁵⁹; however, the potential scalability of such an evaluation across the United States remains uncertain.

Uterine corpus

Uterine corpus cancer ranks fourth in US women overall⁶ but is the second most commonly diagnosed cancer among Filipino, Asian Indian/Pakistani, Native Hawaiian, and Samoan women (Table 2). Samoan women have the highest incidence (80.8 per 100,000) across ethnic groups, with rates approximately three times those among aggregated Asian American and NHPI women (23.5 per 100,000) and White women (27.6 per 100,000; Figure 5). Over the past decade (2013–2022), uterine corpus cancer incidence declined in Samoan women and stabilized in Laotian and Guamanian/Chamorro women, similar to White women (Table 3). In contrast, incidence increased among Japanese, Chinese, Vietnamese, Filipino, Native Hawaiian, Asian Indian/Pakistani, and Korean women by about 1%–4% per year (Table 3), similar to increases among all racially/ethnically minoritized women in the United States.⁶

TABLE 3 Ten-year (2013–2022) average annual percent change in incidence rates for liver, stomach, and uterine corpus cancers in the Asian American, Native Hawaiian, and Pacific Islander people, United States.

	AAPC, %	95% Confidence interval, %
Liver and intrahepatic bile duct		
Non-Hispanic White	0.7 ^a	0.2, 1.2
AANHPI	–2.9 ^a	–3.8, –2.0
Chinese	–2.5 ^a	–3.0, –1.9
Japanese	–1.2 ^a	–1.8, –0.6
Filipino	–2.2 ^a	–3.9, –0.5
Korean	–3.4 ^a	–4.0, –2.8
Asian Indian, Pakistani	1.8 ^a	0.9, 2.6
Vietnamese	–3.9 ^a	–5.6, –2.1
Laotian	–3.9 ^a	–5.8, –2.0
Kampuchean	–7.6 ^a	–12.6, –2.0
Native Hawaiian	–3.5	–7.6, 0.7
Samoa	–2.2	–5.0, 0.7
Guamanian/Chamorro ^b		
Stomach		
Non-Hispanic White	0.6	–0.9, 2.0
AANHPI	–1.7 ^a	–3.0, –0.3
Chinese	–0.9 ^a	–1.3, –0.4
Japanese	–1.5	–9.4, 7.0
Filipino	–2.2 ^a	–2.9, –1.5
Korean	–3.4 ^a	–3.9, –3.0
Asian Indian, Pakistani	–0.5	–1.5, 0.6
Vietnamese	–2.9 ^a	–3.6, –2.1
Laotian	–4.4 ^a	–7.0, –1.7
Kampuchean	–3.5 ^a	–6.7, –0.2
Native Hawaiian	–2.2 ^a	–3.4, –0.9
Samoa	–2.8 ^a	–5.6, –0.0
Guamanian/Chamorro ^b		
Uterine corpus ^c		
Non-Hispanic White	0.2	–0.2, 0.5
AANHPI	2.2 ^a	2.0, 2.4
Chinese	2.1 ^a	1.6, 2.7
Japanese	0.6 ^a	0.0, 1.2
Filipino	2.5 ^a	2.1, 2.9
Korean	3.7 ^a	2.9, 4.4
Asian Indian, Pakistani	3.3 ^a	2.6, 3.9
Vietnamese	2.1 ^a	1.2, 3.1
Laotian	–10.4	–19.9, 0.3
Kampuchean ^b		

TABLE 3 (Continued)

	AAPC, %	95% Confidence interval, %
Native Hawaiian	2.7 ^a	1.8, 3.6
Samoa	–5.7 ^a	–10.9, –0.1
Guamanian/Chamorro	–11.8	–22.6, 0.4

Note: The average annual percent change during 2013–2022 is based on incidence rates during 2000–2022. Incidence rates were age adjusted to the 2000 US standard population and analyzed by the Joinpoint Regression Program, version 6.0.1 (National Cancer Institute), allowing up to two joinpoints. Trends by sex are not shown due to sparse data.

Abbreviations: AANHPI, Asian American, Native Hawaiian, and Pacific Islander; AAPC, average annual percent change.

^aThe AAPC is significantly different from zero ($p < .05$).

^bCould not analyze this group because of sparse data.

^cNot adjusted for hysterectomy prevalence.

More than one half of all uterine corpus cancers in the United States are attributed to excess body weight,⁶⁰ and the particularly high incidence among Samoan and Native Hawaiian women may reflect the elevated prevalence of obesity in these populations.^{61,62} Although obesity is lower in the Asian American population compared with the White population, in 2018, the prevalence of excess body weight (body mass index, ≥ 25 kg/m²) varied nearly twofold within Asian ethnic groups, ranging from 31% in Chinese people to 57% among Asian Indian people.⁴ Recent research suggests that uterine cancer may occur at a lower body mass index in Asian American women than the standard obesity cutoff point (body mass index, ≥ 30 kg/m²) in the United States,^{63–65} although more recent disaggregated risk factor data are limited.

Five-year relative survival for uterine corpus cancer ranges from 70% in Samoan women to 85% in Asian Indian/Pakistani women (Figure 4). Research indicates that, despite controlling for adherence to treatment, stage at diagnosis, histology, and tumor grade, NHPI women have worse endometrial cancer survival compared with White women.⁶⁶ Poor survival in combination with high incidence is reflected in uterine corpus cancer mortality rates among NHPI women that are approximately three times higher than those in White women.⁴ Despite generally higher survival among East and South Asian ethnic groups than among NHPI ethnic groups, there is variation in clinical characteristics and histologic subtypes. e.g., Filipino and Korean women are more likely than Japanese women to present with non-endometrioid histology, which generally has worse survival.⁶⁷

Cancer prevention and control

Studies among Asian American and NHPI populations consistently demonstrate that health care use across ethnic groups is influenced by structural barriers (e.g., socioeconomic status, access to health insurance and care), immigration-related factors (e.g., time spent in the United States), and cultural factors (e.g., beliefs toward preventive care, languages spoken) within this population.^{68–71} For example,

the likelihood of being uninsured is higher among NHPI (12%) and Korean (10%) people compared with Japanese people (3%) in the United States.⁶⁸ Spending less than or equal to 40% of life in the United States was associated with three times the odds of non-adherence to colorectal carcinoma screening among South Asians in California compared with those who had spent 61% or more of their lives in the United States.⁷¹

Language-concordant and culturally appropriate interventions tailored to specific ethnic groups rather than the aggregated Asian American and NHPI population have been particularly effective. For example, overall cancer screening increased in Chinese people when interventions were physician-led versus lay-person-led, individual-based versus group-based, and in-person rather than remote, or self-learning.⁷² In contrast, community-based interventions are generally received well among Korean, Vietnamese, and Native Hawaiian people. For example, in a Korean church-based community in the Philadelphia–New Jersey region, a cluster randomized controlled trial reported that 70% of participants who received interactive colorectal cancer-specific group education, patient navigation assistance, provision of fecal immunochemical test kits, and physician engagement compared with 16% of controls who received general health education, communication with physician, and standard printed colorectal cancer guidelines.⁷³ Similarly, a community-based social network approach improved colon health knowledge in greater than 90% of Native Hawaiian men (Kāne) participants of the No Ke Ola Pono o Nā Kāne (For the Good Health of Men) project.⁷⁴ In a community-based, randomized controlled trial among Vietnamese American people in the Pennsylvania–New Jersey–New York City region, 88% of participants who received a multilevel HBV screening intervention (interactive group education, navigation services, and the engagement of community leadership and health care providers in advocacy and referrals) reported receipt of HBV screening compared with 4.6% of controls who received general cancer education and standard printed materials.⁵³ A recent pilot study in the greater Washington, District of Columbia, metropolitan area, using *Kakao Talk*, a popular South Korean social media application, to disseminate the *Let's talk about liver cancer* program among Korean people, reported increases in postintervention knowledge of HBV infection, testing, and liver cancer prevention.⁷⁵ Despite limited studies, community-based education has also been suggested to improve cancer knowledge and risk awareness among Asian Indian people, one of the most populous Asian ethnic groups in the United States.⁷⁶

Limitations

This study offers essential information on the growing Asian American and NHPI populations across different ethnic groups in the United States, which is necessary to shape current cancer policies, health interventions, and future research. Nevertheless, these ecologic data have several limitations. Inherent to small populations, a challenge with reporting cancer statistics for disaggregated Asian

American and NHPI ethnic groups is the sparsity of data. In addition, approximately 9% of Asian American and 26% of NHPI cancer cases were classified as *other Asian or Asian, not otherwise specified* and *other Pacific Islander or Pacific Islander, not otherwise specified*, respectively; as such, the incidence rates for individual ethnic groups may be slightly underestimated. Although Hispanic ethnicity could not be distinguished for Asian American and NHPI ethnic groups, only 2% of Asian Americans and Pacific Islanders combined are of Hispanic ethnicity, based on the standard SEER Program 21-registry data set.⁷⁷ Incidence rates in the most recent years may be underestimated because rates could not be adjusted for delays in cancer reporting.⁷⁸ Although the entire multiracial Native Hawaiian population was included in this analysis according to SEER coding rules,⁹ some multiracial individuals from Asian American and Pacific Islander ethnic groups may have been inadvertently excluded. Finally, although 66% of the Asian American and NHPI populations are covered across 21 registries included in the SEER specialized incidence database used in this study, our results cannot be generalized to all Asian American and NHPI populations in the United States.

CONCLUSION

This study clearly demonstrates that aggregated cancer occurrence information obscures substantial variation within Asian American and NHPI ethnic groups. Native Hawaiian people have the highest overall cancer incidence—twice that of Kampuchean people and more than 50% higher than the Asian American and NHPI aggregated rate—driven by the highest incidence of female breast, colorectal, and prostate cancers. Similarly, incidence is approximately twofold higher than the aggregated rate for both stomach cancer in Korean people and liver cancer in Vietnamese, Laotian, and Kampuchean people. Native Hawaiian and Samoan women have a particularly disproportionate incidence of uterine corpus cancer, approximately twice and 3 times that of the aggregated Asian American and NHPI rate, respectively. There is also wide variation in stage at diagnosis and survival across ethnic groups, with Native Hawaiian people generally being diagnosed at advanced stages and experiencing poor survival. Given demonstrated differences in the efficacy of cancer interventions depending on delivery through individual-based, physician-led, or community-clinical linkage-based approaches, addressing the cancer burden within Asian American and NHPI ethnic groups will require sustained investment in population-specific data collection and understanding of the sociocultural factors that shape health care utilization. Successful cancer prevention and control strategies must be tailored to specific ethnic groups rather than a one-size-fits-all approach.

AUTHOR CONTRIBUTIONS

Nikita Sandeep Wagle: Conceptualization; investigation; writing—original draft; writing—review and editing; formal analysis; visualization; methodology; validation; project administration. **Angela**

N. Giaquinto: Writing—review and editing; formal analysis; validation. **Mandi Yu:** Data curation; writing—review and editing. **Hyuna Sung:** Writing—review and editing. **Tyler B. Kratzer:** Writing—review and editing; validation. **Kekoa Tapparra:** Writing—review and editing. **Jessica Star:** Formal analysis; writing—review and editing. **Ahmedin Jemal:** Writing—review and editing. **Rebecca L. Siegel:** Conceptualization; investigation; writing—review and editing; methodology; validation; project administration; supervision.

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CONFLICT OF INTEREST STATEMENT

Kekoa Tapparra reports personal/consulting fees from Genentech outside the submitted work. The remaining authors disclosed no conflicts of interest.

Nikita Sandeep Wagle, Angela N. Giaquinto, Tyler B. Kratzer, Hyuna Sung, Ahmedin Jemal, and Rebecca L. Siegel are employed by the American Cancer Society, which receives grants from private and corporate foundations, including foundations associated with companies in the health sector, for research outside the submitted work. The authors declare no conflicts of interest related to this study. The findings and conclusions in this report are those of the authors and do not necessarily represent the official position of the National Cancer Institute.

DATA AVAILABILITY STATEMENT

Data used in this study are not publicly available and cannot be shared by the authors due to the terms of data access agreement. Access to the source data may be obtained from <https://seer.cancer.gov/data/specialized/available-databases/apitrends-request/> upon approval and signed data access agreement with the National Cancer Institute's Surveillance, Epidemiology, and End Results program.

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