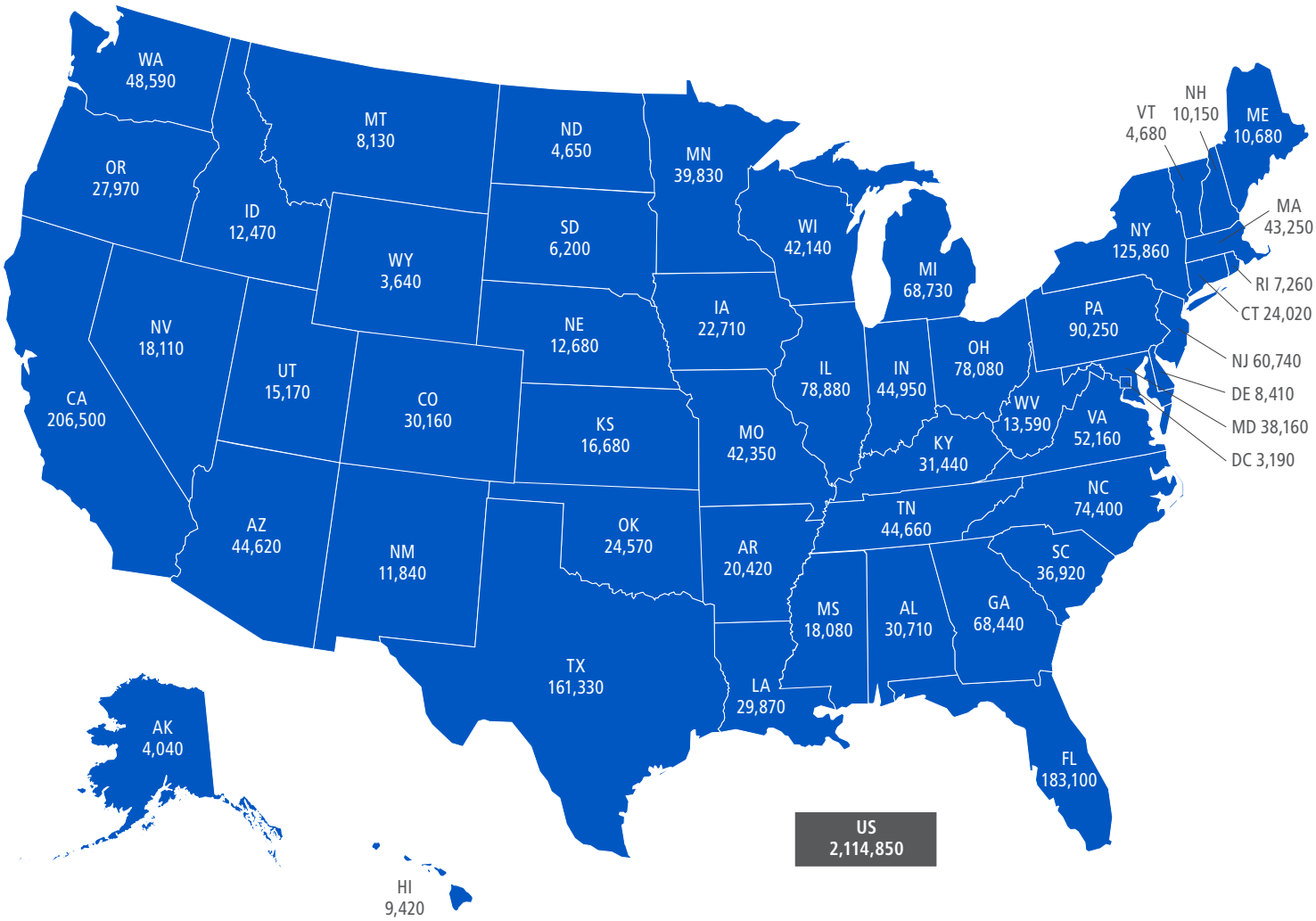
American Cancer Society®

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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Contents

This publication summarizes current scientific information about cancer.
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Suggested citation: American Cancer Society. *Cancer Facts & Figures 2026.* Atlanta: American Cancer Society; 2026.

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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.

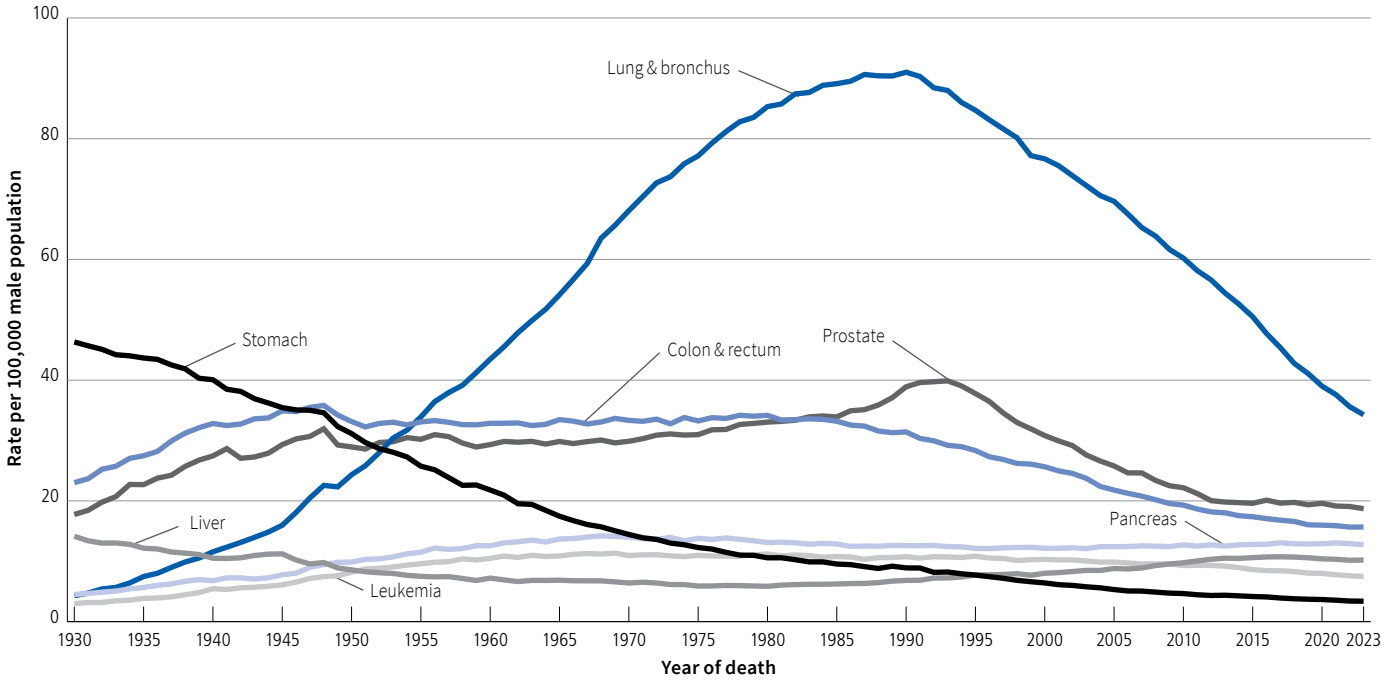
How Is Cancer Staged?

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.

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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

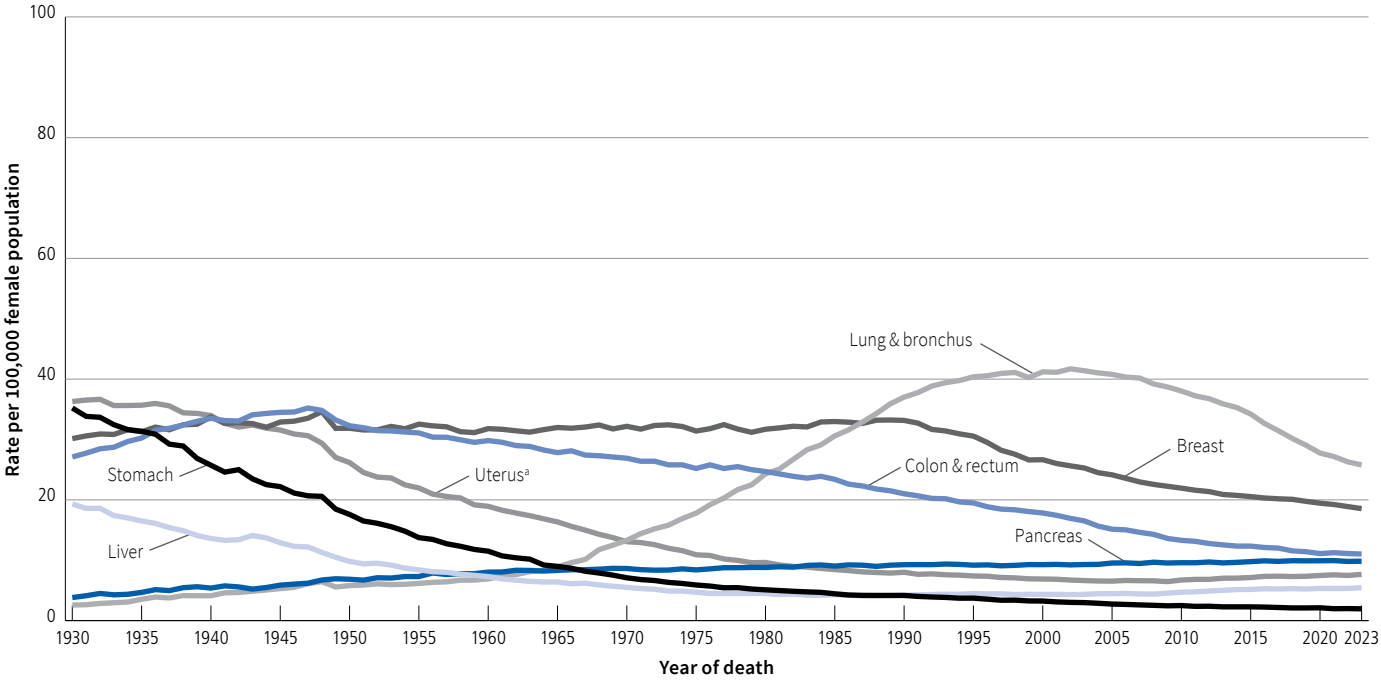
This section provides information on the occurrence, risk factors, symptoms, early detection, and treatment for the most common types of cancer and may have limited relevance for specific subtypes. Incidence trends are based on population-based registry data for cases diagnosed from 1998 through 2022 (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. [a]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.

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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[a]	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. [a]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	[a]	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	[a]	260
Dist. of Columbia	3,190	590	230	80	330	90	100	450	100	[a]	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	[a]	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	3,200	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	[a]	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	[a]	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	[a]	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	[a]	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	[a]	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	[a]	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	[a]	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. [a]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[a]	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	[b]	60	90	[b]	[b]	210	[b]	80	70	[b]
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	[b]	80	80	30	40	150	[b]	70	70	[b]
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	[b]
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	[b]	70	110	60	50	270	[b]	120	70	[b]
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	[b]	90	150	80	50	380	60	160	100	[b]
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	[b]
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	[b]	80	130	[b]	50	210	[b]	110	70	[b]
United States	**626,140**	**18,350**	**42,140**	**55,230**	**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. [a]Includes intrahepatic bile duct. [b]Fewer 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

	All sites		Breast	Colon & rectum[a]		Liver & intrahepatic bile duct		Lung & bronchus		Prostate	Uterine cervix[b]	Uterine corpus[b]
State	**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[e]	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. [a]Excludes appendix. [b]Adjusted for hysterectomy prevalence. [c]From 2016 to 2020. [d]From 2017 to 2021. [e]Not adjusted for delays in case reporting. [f]Excludes 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

	All sites		Breast	Colon & rectum		Liver & intrahepatic bile duct		Lung & bronchus		Pancreas		Prostate
State	**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[a]	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[b]	**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. [a]From 2018 to 2022 and were obtained from statecancerprofiles.cancer.gov. [b]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[a]

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 300)	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 592)	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. [a]Excludes 2020. [b]Excludes basal and squamous cell skin cancers and in situ carcinoma except urinary bladder. [c]For non-Hispanic White individuals only. [d]Not 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	39	37
Breast (female)	75	87	92	76	89	94	62	75	84
Colon & rectum	50	61	65	50	62	65	45	54	59
Colon[a]	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[b]	76[b]	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[b,c]	86[b]	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. [a]Excludes appendix. [b]The standard error is between 5 and 10 percentage points. [c]From 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[a]	65	91	74	15	Oral cavity & pharynx	69	88	69	37
Colon[a]	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[b]	22	38	13	3	Urinary bladder[c]	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.

[a]Excludes appendix. [b]Includes intrahepatic bile duct. [c]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.

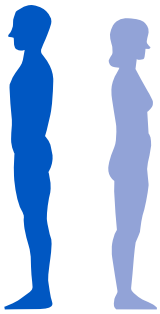
Kidney and Renal Pelvis

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

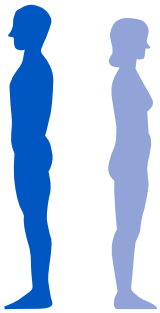
Estimated New Cases

Male			Female		
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

Male			Female		
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 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 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 overdetection.

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 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. Ssee 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[a]	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. [a]To 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. [b]Excludes appendix. [c]Adjusted 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]

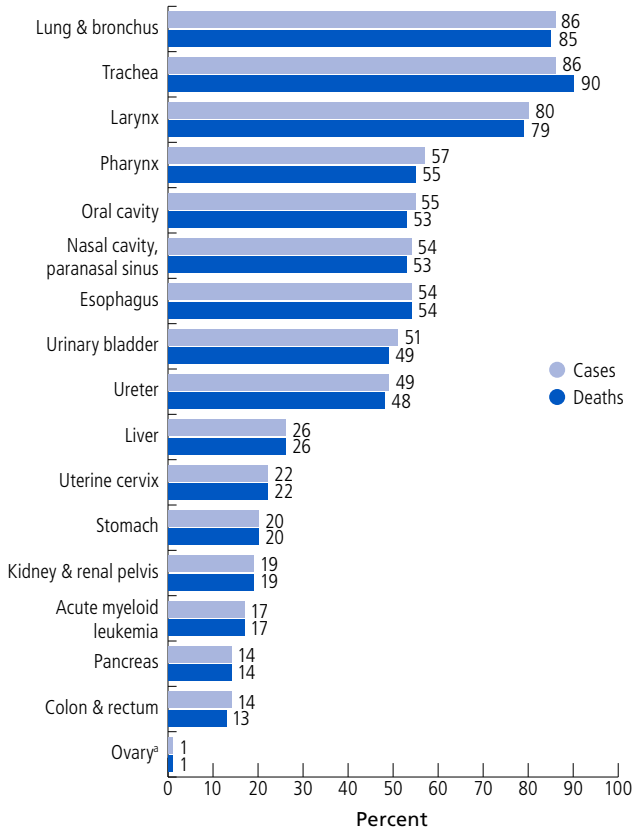
Cigarettes

- 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.[3, 8]
- 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.[3, 9]

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



[a]Limited to mucinous type.

Data 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.[3, 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.[3, 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.[3, 14]

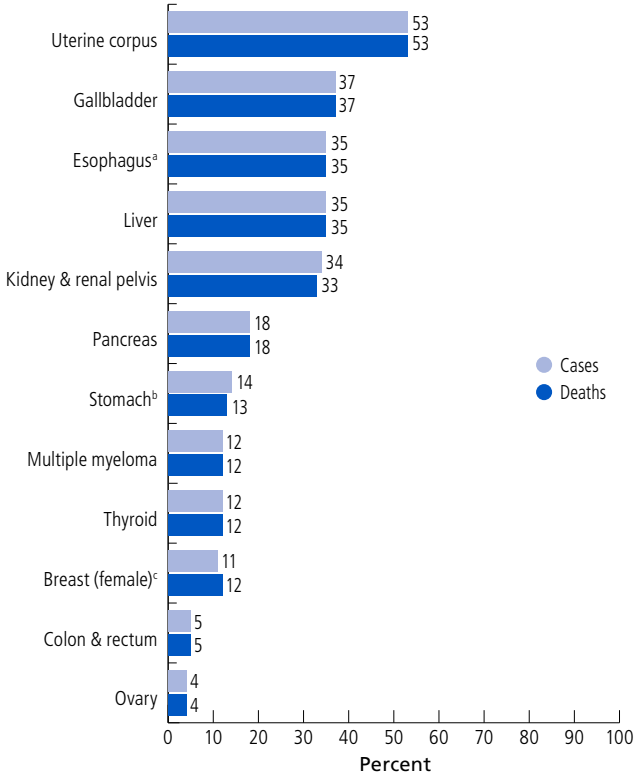
Nutrition and Physical Activity

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/m^2 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



[a]Limited to adenocarcinomas. [b]Limited to cancers of the cardia. [c]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/m^2) 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/m^2) 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 ≥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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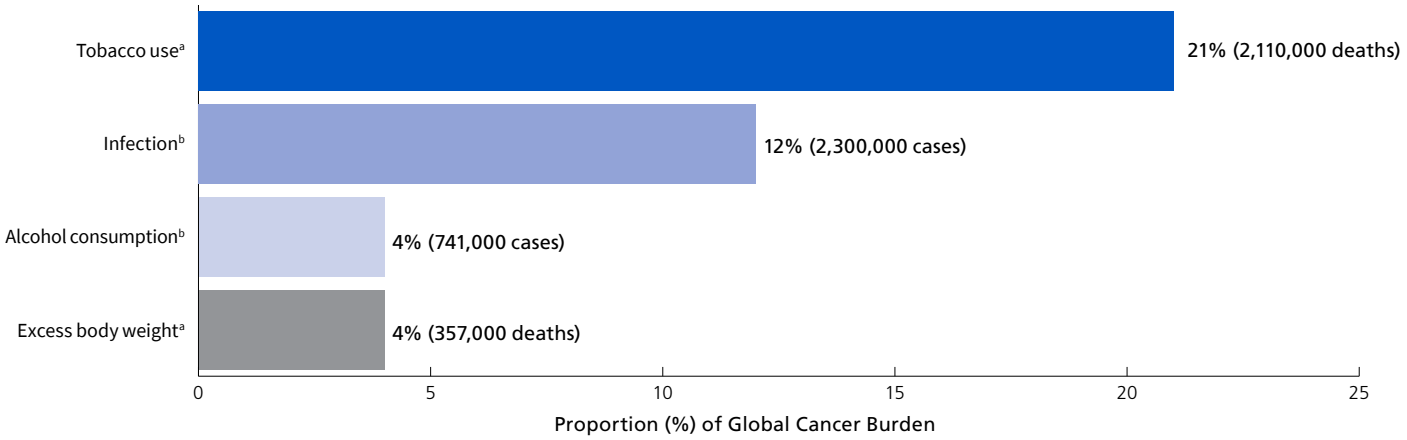
The Global Cancer Burden

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



[a]Derived from 2021 cancer mortality estimates. [b]Derived 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.[3]

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American Cancer Society Recommendations for the Early Detection of Cancer in Average-risk Asymptomatic People[a]

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[b]	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[c]	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[d]	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. [a]All individuals should become familiar with the potential benefits, limitations, and harms associated with cancer screening. [b]Guidelines apply to all individuals with a cervix, including those with HPV vaccination. [c]All positive tests (other than colonoscopy) should be followed up with a colonoscopy. [d]Guideline 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.

Cancer Facts & Figures is an annual publication of the American Cancer Society, Atlanta, Georgia.

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No. 500826

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