Cancer Incidence and Mortality in Nebraska: 2022

The Nebraska Cancer Registry contains a wealth of information, not all of which is included in this report:

What types of data are available?

- Demographic: age at diagnosis, sex, race/ethnicity, county of residence
- Medical history: date of diagnosis, primary site, cell type, stage of disease at diagnosis
- Therapy: surgery, radiation therapy, chemotherapy, immunotherapy, hormone therapy
- Follow up: length of survival, cause of death

Who may request data from the Nebraska Cancer Registry?

- Medical Researchers
- Health Planners
- Market Researchers
- Health Care Facility Administrators
- Physicians
- Nurses
- Health Care Facility Cancer Committees
- Oncology Conference Planners and Speakers
- Patient Care Evaluators
- Pharmaceutical Companies
- Government Officials
- Members of the Public
- Students

How do I make a request?

Contact the Office of Health Data at the
Nebraska Department of Health and Human Services
Division of Public Health
P.O. Box 95026, Lincoln, NE 68509-5026
DHHS.PublicRecords@nebraska.gov
Phone (402)471-8298, Monday-Friday between 8 AM and 5 PM

Please note: Statutes and regulations may restrict or affect the ability of the department' to release requested information.

NEBRASKA CANCER REGISTRY
2022 ANNUAL REPORT

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EXECUTIVE SUMMARY

The Cancer Incidence and Mortality in Nebraska annual report for 2022 provides a comprehensive overview of the impact of cancer in Nebraska. The purpose of the report is to present the most recent statistics that describe cancer incidence and mortality in Nebraska, for the entire state; in-depth analyses of selected cancer sites; and comparisons of trends between Nebraska and the United States. Findings from the report include:

- ***Overall Cancer Incidence:*** In 2022, there were 10,220 diagnoses of cancer among Nebraska residents. This number is lower than the number of cancers that were diagnosed in 2021 (10,300).

- ***Cancer Incidence by Sex:*** In 2022, prostate, lung, and colorectal cancers were the most frequently diagnosed cases among Nebraska men, while breast, lung, and colorectal cancers were the most frequently diagnosed cases among Nebraska women. Taken together, these cancers accounted for approximately half (47.8%) of all cancer cases diagnosed among Nebraska residents in 2022.

- ***Cancer Incidence by Age:*** During the past five years (2018-2022), more than half (58.2%) of all cancers in Nebraska occurred among people 65 years of age and older. Less than 1% were diagnosed among children and adolescents.

- ***Cancer Incidence Rate by Site:*** During the past five years (2018-2022), cancers of the lung and bronchus, and liver were diagnosed significantly less often among Nebraska residents when compared to the U.S., while prostate, colorectal, thyroid, and kidney and renal pelvis cancers were diagnosed significantly more often. Kidney and renal pelvis cancer, as well as melanoma of the skin, show an upward trend from 2018 to 2022.

- ***Cancer Incidence Rate by Race:*** During the past decade (2013-2022), African Americans in Nebraska were significantly more likely to be diagnosed with kidney, liver, lung, myeloma, pancreatic, and prostate cancers than were whites. Liver cancer diagnoses were also significantly more frequent among Native Americans and Asian American/Pacific Islanders compared to whites.

- ***Overall Cancer Mortality:*** In 2022, 3,392 Nebraska residents died from cancer, which is a slight decrease from the 2021 cancer death total of 3,493. Cancer was the second leading cause of death in Nebraska in 2022 after heart disease.

- ***Cancer Mortality Rate by Site:*** During the past five years (2018-2022), deaths from cancers of liver occurred significantly less often among Nebraska residents when compared to the U.S. as a whole. Lung cancer was the leading cause of cancer mortality in Nebraska in 2022, accounting for 22% of all cancer deaths, followed by colorectal cancer.

- ***Cancer Incidence by County:*** Below are the Nebraska counties where cancer incidence during 2018-2022 was significantly different ($p<.05$) from the state. (NOTE: counties with fewer than 20 cases are not included.)

Significantly lower ▼		*Significantly higher ▲*	
County	***Primary Sites***	***County***	***Primary Sites***
Adams	Kidney & renal pelvis, Melanoma of skin	Antelope	Prostate, Colon & rectum
Antelope	Melanoma of skin	Boone	Colon & rectum
Cheyenne	Lung & bronchus	Buffalo	Melanoma of skin
Dakota	Prostate		
Dawes	Prostate	Clay	Female breast, Prostate, Colon & rectum
Dawson	Lung & bronchus, Melanoma of skin	Colfax	Colon & rectum, Female breast, Prostate, Urinary Bladder, NHL, Thyroid, Kidney & renal pelvis
Hall	Female breast, Prostate	Douglas	Female breast Lung & bronchus Melanoma of skin Prostate
Lancaster	Melanoma of skin, Prostate		
Madison	Lung & bronchus, Kidney & renal pelvis	Howard	Female breast, NHL, Prostate
		Jefferson	Female breast
Phelps	Prostate	Keith	Urinary Bladder
Platte	Lung & bronchus,		
Richardson	Female breast	Hitchcock	Colon & rectum, Female breast, Prostate, Melanoma of skin
Saunders	Prostate		
Seward	Prostate	Sarpy	Melanoma of skin
		Washington	Female breast, Thyroid, Melanoma of skin

Annual *Report Special Topic: Early-onset colorectal cancer (EOCRC)*

During the most recent past five years (2018–2022), EOCRC accounted for 533 new cases and 94 deaths among Nebraska residents, representing a 15.1% increase in incident cases and a 9.3% increase in deaths compared with the previous five-year period (2013-2017), which recorded 463 new cases and 86 deaths.

From 2013 to 2022, an overall upward trend in EOCRC incidence was largely driven by increases observed among males. A large proportion of EOCRC cases were diagnosed at regional and localized stages. These findings suggest the need to consider early screening strategies which may facilitate detection of cases at earlier stages and support improved prevention and outcomes.

INTRODUCTION

This publication represents the 36th annual statistical summary of the Nebraska Cancer Registry (NCR) since it began collecting data in 1987. The purpose of this report is to present the registry's most recent data to the citizens of the State of Nebraska. Most of the data covers cancer diagnoses and cancer deaths that occurred between January 1, 2022, and December 31, 2022, as well as during the past five years (January 1, 2018-December 31, 2022).

The NCR was founded in 1986, when the Nebraska Unicameral authorized funding for a state cancer registry using a portion of funds generated by the state's cigarette tax. The establishment of the registry successfully combined the efforts of many Nebraska physicians, legislators, concerned citizens, and the Nebraska Medical Foundation, all of whom had worked for years toward this goal. The Nebraska Medical Foundation also helped establish the registry with financial assistance. Since 1994, the NCR has received additional funding from the Centers for Disease Control and Prevention (CDC).

The NCR is managed by the Nebraska Department of Health and Human Services (DHHS) in Lincoln. However, registry data is collected and edited by NCR data collection staff under contract with Westat, a management services company that provides research services to government agencies and businesses. Analysis of registry data and preparation of the annual statistical report are the responsibilities of DHHS.

The purpose of the registry is to gather data that describes how many Nebraska residents are diagnosed with cancer, what types of cancer they have, how far the disease has advanced at the time of diagnosis, what types of treatment they receive, and how long they survive after diagnosis. These data are put to a variety of uses both inside and outside of DHHS. Within DHHS, they are used to identify high-risk populations and long-term disease trends, to compare Nebraska's cancer experience with the rest of the nation, to investigate reports of possible cancer clusters, and to help plan and evaluate cancer control programs. Outside of DHHS, the registry provides data upon request for research studies and public information and has provided data to the North American Association of Central Cancer Registries (NAACCR), the National Cancer Institute (NCI), the American Cancer Society (ACS), CDC, and the University of Nebraska Medical Center, among others. The NCR also contributes its data to several national cancer incidence databases. In recognition of the accuracy and completeness of the data collected, NAACCR has awarded the NCR its gold standard certificate of data quality for 27 years, from 1995 to 2022.

All individual records in the cancer registry are kept in strict confidence as prescribed by both state and federal law. The NCR follows all the privacy safeguards in the Health Insurance Portability and Accountability Act (HIPAA), although some of the procedural requirements do not apply to the registry.

DHHS welcomes inquiries about cancer from the public for aggregate statistics or general information from the registry. To obtain cancer data or information about the registry not included in this report, please refer to the instructions provided inside the front cover.

An electronic copy of this report is available on the DHHS website at
http://dhhs.ne.gov/Pages/Cancer-Registry.aspx

METHODOLOGY

Data Collection and Management

The NCR gathers data on Nebraska residents diagnosed and treated for invasive and in situ tumors. The registry does not include benign tumors (except for benign brain and other nervous system tumors, which became reportable as of January 1, 2004), benign polyps, and basal cell and squamous cell carcinomas of the skin. Information gathered from each case includes the patient's name, address, birth date, race, sex, social security number, date of diagnosis, primary site of the cancer (coded according to the International Classification of Diseases for Oncology, 3rd edition [ICD-O-3]), stage of disease at diagnosis, facility where the initial diagnosis was made, basis of staging, method of diagnostic confirmation, histological type (also classified according to the ICDO-3), and initial treatment. The registry does not actively collect follow-up information on registered cases, but many facilities provide it, and it includes the date of last contact with the patient, status of disease, type of additional treatment, and quality of survival. The registry collects information from every hospital in the state where cancer patients are diagnosed and/or treated on an inpatient basis. The registry also includes Nebraska residents who are diagnosed with and/or treated for cancer out of state, as well as cases identified through pathology laboratories, outpatient treatment facilities, physician offices, and death certificates. Death of registered cases is ascertained using death certificates available from DHHS and from the National Death Index.

Nebraska cancer mortality data are obtained from death certificates on file with DHHS. Mortality data are available for every Nebraska resident who dies from cancer, whether death occurs in or outside of Nebraska. The mortality data presented in this report is limited to those deaths where cancer is listed as the underlying (i.e., primary) cause of death. Causes of death are coded according to the Tenth Edition of the International Classification of Disease (ICD-10).

The U.S. cancer incidence data presented in this report were compiled by CDC's National Program of Cancer Registries (NPCR) and NCI's Surveillance, Epidemiology, and End Results (SEER) Program. NPCR provides support for cancer registries in 46 states (including Nebraska), the District of Columbia, and some U.S. territories, and covers 97% of the total U.S. population. The mortality data presented in this report were compiled by the National Center for Health Statistics (NCHS) and include all U.S. resident cancer deaths. Incidence data from NPCR and mortality data from NCHS are available through 2021.

Confidentiality

All data obtained by the NCR from the medical records of individual patients is held in strict confidence by DHHS. As specified in state statute, researchers may obtain case specific and/or patient-identifiable information from the registry by submitting a written application that describes how the data will be used for scientific study. In situations where contact with a patient or patient's family is proposed, the applicant must substantiate the need for any such contact and submit approval from an Institutional Review Board. In addition, before any individual's name can be given to a researcher, the registry must obtain permission from the individual that they are willing to be a research subject. Upon favorable review by DHHS, the applicant must also agree to maintain confidentiality.

Nebraska Department of Health and Human Services/Cancer Registry and security of the data throughout the course of the study, to destroy or return the registry data at the end of the study and to present material to the registry prior to publication to ensure that no identifiable information is released.

Aggregate data (i.e., statistical information) from the registry are considered open to the public and are available upon request. Details on how to obtain such data are provided inside the front cover of this report.

Quality Assurance

The NCR and reporting facilities invest significant time and effort to ensure that the information they gather is both accurate and complete, and these efforts have met with consistent success. At least 27 times, since 1995, the NCR has met all criteria necessary to earn the gold standard certificate of data quality awarded by NAACCR, which is the accrediting body for all U.S. and Canadian central cancer registries. These criteria include:

1) Completeness of case ascertainment–-The registry must find at least 95% of the total number of cases that are estimated to have occurred.

2) Completeness of information–-The proportion of registry cases missing information on age at diagnosis, Sex, and county of residence must be no more than 2%, and the proportion missing information on race must be no more than 3%.

3) Data accuracy–-Error rates based on edit checks of selected data items must be no greater than 1%.

4) Timeliness–-All data for a single calendar year must be submitted to NAACCR for review no more than 23 months after the year has ended.

Gold standard certification also requires that all cases pass strict edits the proportion of registry cases found solely through a review of death certificates must be no more than 3% and the proportion of duplicate cases in the registry must be no more than one per 1,000.

Since the NCR has achieved the highest quality standards, its data are included in several national cancer incidence databases. These databases compile information from cancer registries throughout the United States and Canada that meet the same data quality standards as the NCR. These databases include:

1) *Cancer in North America* (http://www.naaccr.org)

2) *United States Cancer Statistics* (https://nccd.cdc.gov)

3) *Cancer Facts & Statistics* (http://www.cancer.org/research/cancerfactsstatistics)

4) *Cancer Control PLANET* (http://cancercontrolplanet.cancer.gov/)

Definitions

Several technical terms are used in presenting the information in this report. The following definitions are provided here to assist the reader.

Incidence rate

Incidence rate is the number of new cases of a disease that occur within a specific population during a given time period, divided by the size of the population. For example, if 10 residents of a county with 20,000 residents are diagnosed with colorectal cancer during a single year, then the incidence rate of colorectal cancer for that county for that year is .0005. Since cancer incidence rates are usually expressed per 100,000 population, this figure is then multiplied by 100,000 to yield a rate of 50 per 100,000 per year.

Mortality rate

Mortality rate is the number of deaths that occur within a specific population during a given time period, divided by the size of the population. Like incidence rates, mortality rates are usually expressed as the number of deaths per 100,000 population per year.

Age-adjusted rate

Age-adjustment is a simple mathematical procedure that makes it possible to compare rates between populations that have different age distributions, and to compare rates within a single population over time. All incidence and mortality rates in this report are age-adjusted using the U.S. population in 2000 as the standard. Statewide and national rates are age-adjusted using 18 age groups (0-4, 5-9, 10-14, 15-19, 20-24, 25-29, 30-34, 35-39, 40-44, 45-49, 50-54, 55-59, 60-64, 65-69, 70-74, 75-79, 80-84, 85+ years), while county and regional rates are age-adjusted using 10 age groups (<0-4, 5-14, 15-24, 25-34, 35-44, 45-54, 55-64, 65-74, 75-84, 85+ years).

Stage of Disease at Diagnosis

In situ

Tumors diagnosed as in situ consist of invasive cells that are growing in place. In situ tumors are confined to the cell group of origin and have not penetrated the supporting structure of the organ on which they arose.

Invasive

Tumors diagnosed as invasive have spread beyond the cell group of the organ where they began and may have spread further. The organ where malignancy began is also known as the primary site. Invasive tumors are subdivided into three categories:

Localized--A localized invasive tumor has not spread beyond the organ where it started.

Regional--A regional invasive tumor has spread beyond the organ where it began, by direct extension to immediately adjacent organs or tissues and/or by spread to regional lymph nodes.

Distant--A distant invasive tumor has spread beyond the primary site to distant parts of the body.

5-Year Relative Survival Rate

The 5-year relative survival rate refers to the ratio of the proportion of people who are alive for 5 years after their cancer diagnosis to the proportion of people in the general population alive over the same time interval. It's an estimate of the percentage of patients who would be expected to survive the effects of their cancer excluding the risk of dying from other causes.

Data Analysis

All the rates presented in this report were calculated using Vintage 2022 single-race population estimates developed by the U.S. Census Bureau and the National Center for Health Statistics. Incidence and mortality rates for multiple years (2018-2022) (see Tables 1, 2, 5, 6, 9-20) were calculated using population estimates for the years 2018-2022 combined, while rates for 2013-2022 (see Tables 3 and 7) were calculated using population estimates for the years 2013-2022 combined. Rates that are based on more than one year of data should be interpreted as an average annual rate.

All data presented in this report are current through December 31, 2024. However, because some cases diagnosed during or even before 2022 may not yet have been reported to the registry, the incidence data presented in this report should be considered subject to change. **In addition, the incidence data reported in previous editions of this report should be considered no longer complete.**

Internet users should also be aware that the cancer statistics for Nebraska that are published in this report and those that are posted on non-DHHS websites (see page 5) may differ. Some discrepancies may be the result of differences in the dates at which the data were compiled. As noted above, Nebraska incidence data published in this report include all cases reported to the registry through December 31, 2024; Nebraska data available on the CDC/NPCR website include cases that were reported through November 30, 2024.

Except for bladder cancer, in situ female breast cancer, and benign brain tumors, all site-specific incidence rates in this report were calculated with invasive cases only, to maintain comparability with statistics from the NPCR and other cancer registries throughout the United States. For bladder cancer, incidence rates were calculated with invasive and in situ cases combined. All incidence and mortality rates in this report were calculated per 100,000 population and were age-adjusted according to the age distribution of the population of the United States in 2000. Statewide rates were also calculated for males and females separately, and for both sexes combined. The number of cases for any county with fewer than three cases is not shown to reduce the possibility of identifying a specific person.

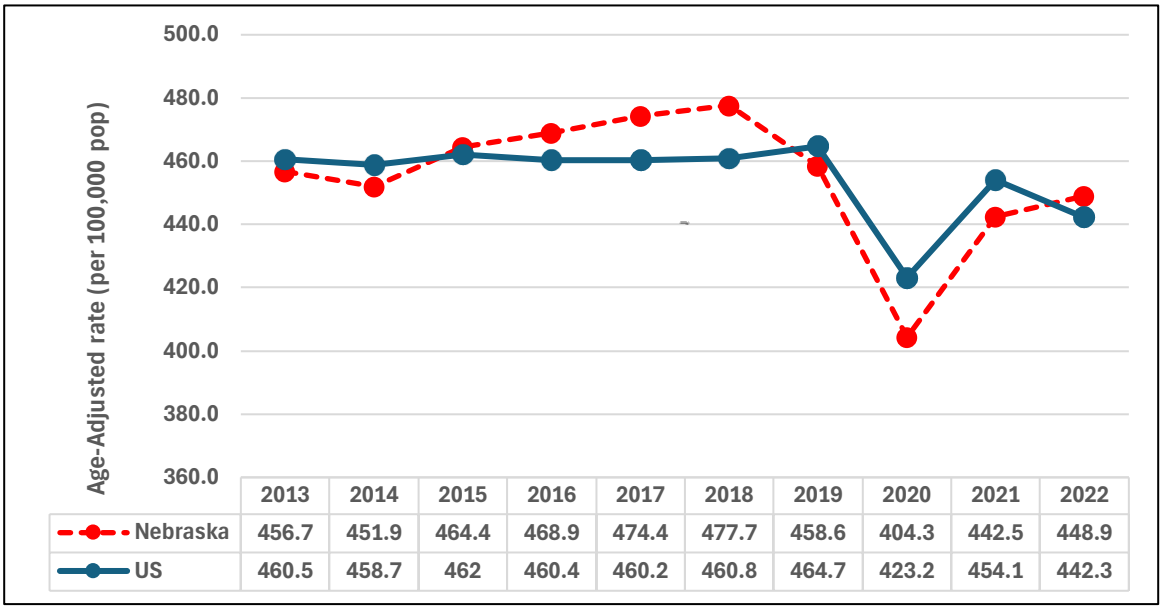
To evaluate the statistical significance of the differences between rates, confidence intervals for rates were calculated using the formula $CI = r \pm (RC \times SE)$, where CI = confidence interval, r = rate, RC = 1.96 (for 95% confidence intervals) or 2.58 (for 99% confidence intervals), and SE = standard error. The standard error for a rate was determined by dividing the rate by the square root of the number of events (cancer diagnoses or deaths). A statistically significant difference exists and is indicated in those instances where the confidence intervals of a pair of rates being compared to each other do not overlap.

CANCER INCIDENCE IN NEBRASKA

The Nebraska Cancer Registry recorded 10,220 diagnoses of cancer among Nebraska residents in 2022, a decrease from 10,300 diagnoses recorded in 2021. The 2022 number translates into an incidence rate of 429.1 cases per 100,000 population. By primary site, cancers of the prostate, female breast, lung, colon and rectum occurred most frequently, accounting for about half (47.8%) of all diagnoses.

Table 1 presents the number and rate of cancers diagnosed among Nebraska residents during 2022 and 2018-2022, for all sites combined and for cancers of specific sites. The most current estimates of U.S. cancer incidence, which cover years 2017-2021 are also included. Comparison of the most recent state and national incidence rates for the past five years shows significant differences ($p<.01$) for cancers of the stomach, liver, myeloma, lung, and ovary (Nebraska rates are lower than the U.S.) and for cancers of the colon and rectum, female breast, melanoma of skin, prostate, kidney and renal pelvis, testis, and thyroid gland (Nebraska rates are higher than the U.S.). Table 2 presents the number of cancers diagnosed in Nebraska during 2018-2022 by age at diagnosis. Table 3 presents Nebraska incidence data by race and ethnicity for the years 2013-2022.

Figure 1. Age-Adjusted Cancer Incidence Rates in Nebraska vs US, 2013 - 2022



	2013	2014	2015	2016	2017	2018	2019	2020	2021	2022
Nebraska	456.7	451.9	464.4	468.9	474.4	477.7	458.6	404.3	442.5	448.9
US	460.5	458.7	462	460.4	460.2	460.8	464.7	423.2	454.1	442.3

Nebraska's cancer incidence rate gradually increased from 2013 to 2018, reaching its highest point in 2018.
Both Nebraska and the U.S. saw a sharp decline in 2020, due to pandemic-related disruptions. Rates rebounded slightly in 2021, with Nebraska continuing to rise in 2022.

TABLE 1: Cancer Incidence
Number of Cases and Rates, by Selected Primary Site and Sex
(2022 and 2018-2022) & U.S. (2017-2021)

Site	NEBRASKA 2022						NEBRASKA 2018-2022						U.S. 2017-2021		
	Male		Female		Total		Male		Female		Total		Male	Female	Total
	No.	Rate	No.	Rate	No.	Rate	No.	Rate	No.	Rate	No.	Rate	Rate	Rate	Rate
All Sites	5233	452.9	4985	416.5	10220	429.1	26,981	482.4	25,073	427.3	52,064	448.9	481.1	421.1	444.4
Oral Cavity & Pharynx	206	17.7	90	7.6	296	12.5	1,063	18.7	439	7.3	1,502	12.8	18	6.6	12
Esophagus	79	7.1	23	1.9	102	4.3	462	8.1	125	2	587	4.9	7.7	1.8	4.5
Stomach	65	5.8	47	4	112	4.8	377	6.9	207	3.4	585	5.1	8.3	4.7	6.3
Small Intestine	34	3.2	32	2.9	66	3	132	2.5	146	2.4	278	2.4	3	2.3	2.6
Colon & Rectum	468	43	382	30.8	850	36.6	2,319	43.6	2,029	33.6	4,350	38.4	41.3	32.1	36.4
Liver & Intrahepatic Bile Ducts	98	7.9	58	4.6	156	6.1	484	8.1	252	4.2	736	6	12.8	4.9	8.6
Pancreas	170	14.8	133	10.5	303	12.4	854	15.1	724	11.3	1578	13.1	15.3	11.9	13.5
Larynx	52	4.4	14	1.1	66	2.6	236	4.1	63	1	299	2.5	4.9	1.1	2.9
Lung & Bronchus	623	51.9	644	47.4	1,267	49.4	3,213	56.3	3,060	47	6,273	51	59.4	48.4	53.3
Soft Tissue	43	3.8	31	2.6	74	3.2	191	3.8	153	2.8	344	3.2	3.9	2.8	3.3
Melanoma of the Skin	405	36.4	308	28.9	713	31.8	1,757	32.6	1,395	26.2	3,152	28.7	28.7	18.3	22.7
Breast (invasive cases)	10	0.9	1,453	124.9	1,463	64.1	84	1.6	7,387	128.9	7,462	67.1	1.3	129.8	68.5
Uterine Cervix	---	---	54	5.4	---	---	---	---	307	6.5	---	---	---	7.5	---
Uterine Corpus & Unspecified	---	---	348	27.9	---	---	---	---	1,686	27.9	---	---	---	27.8	

TABLE 1 (continued): Cancer Incidence

Site	NEBRASKA 2022						NEBRASKA 2018-2022						U.S. 2017-2021		
	Male		Female		Total		Male		Female		Total		Male	Female	Total
	No.	Rate	No.	Rate	No.	Rate	No.	Rate	No.	Rate	No.	Rate	Rate	Rate	Rate
Ovary	---	---	105	9.2	---	---	---	---	491	8.6	---	---	---	10.1	---
Prostate	1305	104.2	---	---	---	---	7,133	118.4	---	---	---	---	113.2	---	---
Testis	57	6.1	---	---	---	---	305	6.6	---	---	---	---	5.7	---	---
Urinary Bladder	307	27.4	94	6.7	401	16	1,712	31.4	461	6.9	2,173	17.8	32.5	8.1	18.8
Kidney & Renal Pelvis	314	27.3	162	13.4	478	20.1	1,396	25.3	824	14	2,222	19.4	23.3	12	17.3
Brain & Central Nervous System (invasive cases only)	83	7.5	65	5.8	148	6.5	407	7.8	335	6.2	742	6.9	7.4	5.3	6.3
Thyroid Gland	91	8.8	227	23.2	318	15.8	427	8.2	1,145	23.6	1,573	15.8	6.9	19	12.9
Hodgkin Lymphoma	29	2.9	24	2.4	53	2.7	141	2.9	97	2	238	2.4	2.8	2.3	2.5
Non-Hodgkin Lymphoma	219	19.5	192	15.6	411	17.3	1,162	21.6	931	15.3	2,095	18.2	22.5	15.4	18.5
Myeloma	71	6.4	50	3.9	121	5.1	411	7.5	289	4.6	701	5.9	8.6	5.9	7.1
Leukemia	162	14.8	103	8.3	265	11.3	946	17.8	581	9.9	1,527	13.5	17.8	11	14.1
Brain & Central Nervous System	88	7.8	215	18.5	303	13.3.	420	8.1	854	15	1,274	11.7	10	17.8	14.1
Breast (in situ cases only)	---	---	332	29.3	---	---	---	---	1,602	28.9	---	---	---	29.3	15.2

Total rates are per 100,000 population and are age-adjusted to the 2000 U.S. population.

Sex-specific rates are per 100,000 male or female population and are age-adjusted to the 2000 U.S. population.

TABLE 2: Cancer Incidence
Number of Cases and Percentage Distribution, by Selected Primary Site and Age at Diagnosis
Nebraska (2018-2022)

	0-17 Yrs.		18-44 Yrs.		45-64 Yrs.		65+ Yrs.		TOTAL	
	Number	%	Number	%	Number	%	Number	%	Number	%
All Sites	426	0.8	4,043	7.8	17,278	33.2	30,317	58.2	52,064	100.0
Oral Cavity & Pharynx	7	0.5	86	5.7	706	47.0	703	46.8	1,502	100.0
Esophagus	0	0.0	10	1.7	193	32.9	384	65.4	587	100.0
Stomach	2	0.3	36	6.2	197	33.7	350	59.8	585	100.0
Small Intestine	0	0.0	25	9.0	99	35.6	154	55.4	278	100.0
Colon & Rectum (Colorectal)	17	0.4	310	7.1	1,441	33.1	2,582	59.4	4,350	100.0
Liver & Intrahepatic Bile Ducts	8	1.1	24	3.3	271	36.8	433	58.8	736	100.0
Pancreas	1	0.1	40	2.5	462	29.3	1,075	68.1	1,578	100.0
Larynx	0	0.0	10	3.3	105	35.1	184	61.5	299	100.0
Lung & Bronchus	0	0.0	49	0.8	1,654	26.4	4,569	72.8	6,273	100.0
Soft Tissue	26	7.6	61	17.7	96	27.9	161	46.8	344	100.0
Melanoma of the Skin	9	0.3	504	16.0	1,118	35.5	1,521	48.3	3,152	100.0
Female Breast (invasive cases only)	0	0.0	707	9.6	3,027	41.0	3,644	49.4	7,378	100.0
Uterine Cervix	0	0.0	121	39.4	126	41.0	60	19.5	307	100.0
Uterine Corpus & Unspecified	0	0.0	116	6.9	743	44.1	827	49.1	1,686	100.0
Ovary	5	1.0	61	12.1	194	38.4	245	48.5	505	100.0
Prostate	0	0.0	15	0.2	2,492	34.9	4,626	64.9	7,133	100.0
Testis	9	3.0	235	77.0	53	17.4	8	2.6	305	100.0
Urinary Bladder	0	0.0	28	1.3	458	21.1	1,687	77.6	2,173	100.0
Kidney & Renal Pelvis	15	0.7	196	8.8	830	37.4	1,181	53.2	2,222	100.0
Brain & Central Nervous System (invasive cases only)	85	11.5	133	17.9	216	29.1	308	41.5	742	100.0
Thyroid Gland	25	1.6	580	36.9	619	39.4	349	22.2	1,573	100.0
Hodgkin Lymphoma	13	5.5	124	52.1	45	18.9	56	23.5	238	100.0
Non-Hodgkin Lymphoma	20	1.0	164	7.8	598	28.5	1,313	62.7	2,095	100.0
Myeloma	0	0.0	21	3.0	201	28.7	479	68.3	701	100.0
Leukemia	100	6.5	144	9.4	392	25.7	891	58.3	1,527	100.0
Brain & Central Nervous System (benign & uncertain cases only)	36	2.8	196	15.4	434	34.1	608	47.7	1,274	100.0
Female Breast (in situ cases only)	0	0.0	152	9.5	761	47.5	689	43.0	1,602	100.0

NOTE: Due to rounding, percentages may not sum to 100.0.

TABLE 3: Cancer Incidence
Number of Cases and Rates, Top Ten Primary Sites, by Race and Ethnicity
Nebraska (2013-2022)

	White			African American			Native American			Asian/Pacific Islander			Hispanic		
	Site	Number	Rate	Site	Number	Rate	Site	Number	Rate	Site	Number	Rate	Site	Number	Rate
Rank	All Sites	92,609	465.1	All Sites	3,611	501.7	All Sites	560	464.6	All Sites	939	288.7	All Sites	3,018	277.8
1	Female Breast	13,179	132.8	Prostate	700	206	Colon & Rectum	75	63.2	Female Breast	144	70.5	Female Breast	424	76.3
2	Prostate	12,087	116.6	Lung & Bronchus	470	68.9	Lung & Bronchus	74	66	Lung & Bronchus	108	40	Prostate	319	72.1
3	Lung & Bronchus	11,628	54.8	Female Breast	470	125.4	Female Breast	64	91.7	Colon & Rectum	80	26.6	Colon & Rectum	291	27.6
4	Colon & Rectum	8,102	40.9	Colon & Rectum	302	42.8	Prostate	46	84.9	Liver & Intrahepatic Bile Ducts	72	23	Thyroid	192	12.1
5	Skin Melanoma	5,571	30.5	Kidney & Renal Pelvis	211	28.4	Kidney & Renal Pelvis	46	33.7	Prostate	67	55.7	Lung & Bronchus	189	23.7
6	Urinary Bladder	4,189	19.7	Pancreas	133	20.3	Liver & Intrahepatic Bile Ducts	41	30.3	Thyroid	62	14.1	Kidney & Renal Pelvis	173	17.1
7	Non-Hodgkin Lymphoma	3,913	19.6	Non-Hodgkin Lymphoma	119	15.5	Leukemia	20	15	Non-Hodgkin Lymphoma	48	15.5	Leukemia	149	10.7
8	Kidney & Renal Pelvis	3,631	18.5	Myeloma	107	16	Non-Hodgkin Lymphoma	17	14.4	Leukemia	38	11.1	Non-Hodgkin Lymphoma	142	14.2
9	Uterine Corpus & Unspecified	2,988	28.5	Liver & Intrahepatic Bile Ducts	102	13.5	Uterine Corpus & Unspecified	15	20.9	Oral Cavity & Pharynx	37	10.4	Uterine Corpus & Unspecified	105	16.1
10	Leukemia	2,780	14.3	Uterine Corpus & Unspecified	91	23.4	Thyroid	14	9.2	Pancreas	34	12.1	Liver & Intrahepatic Bile Ducts	98	10.1

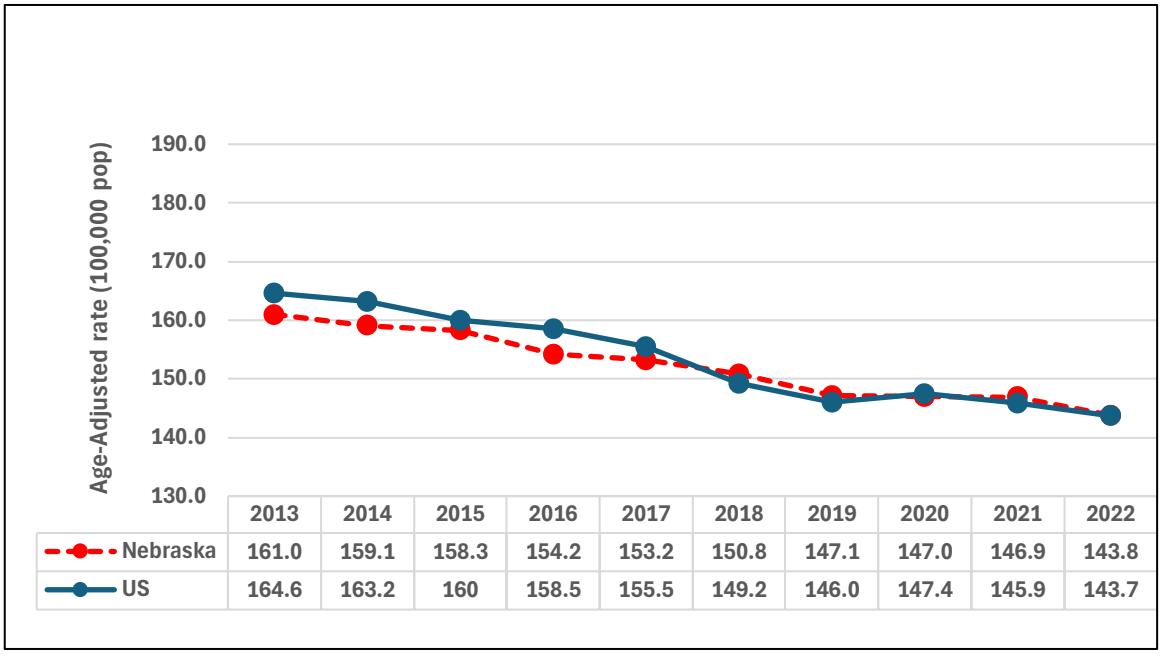
Rates are per 100,000 population, excluding Sex-specific sites (prostate, female breast, uterine corpus), which are per 100,000 male or female population. All rates are age-adjusted to the 2000 U.S. population.

CANCER MORTALITY IN NEBRASKA

In 2022, 3,392 Nebraska residents died from cancer, a number that translates into a rate of 137.4 cancer deaths per 100,000 population. These figures represent a slight decrease from the state's 2021 figures of 3,493 (cancer deaths) and 147.0 (cancer mortality rate). Cancer was the second leading cause of mortality among Nebraska residents in 2022 after heart disease. By primary site, cancers of the lung, colon and rectum, female breast, and pancreas accounted for just under half (45.8%) of Nebraska's cancer deaths in 2022.

Table 5 presents the number and rate of cancer deaths that occurred among Nebraska residents during 2022 and 2018-2022, for all sites combined and for specific sites. The most recent U.S. cancer mortality rates, which cover the years 2017 through 2021, are also included. Comparison of the most recent five-year state and national mortality rates indicates that liver cancer mortality rates in Nebraska were significantly lower than those in the United States ($p < 0.01$). Table 6 presents the number of Nebraska cancer deaths during 2018-2022 by age at death. Table 7 presents Nebraska cancer mortality data by race and ethnicity for the years 2013-2022.

Figure 2. Age-Adjusted Cancer Mortality Rates in Nebraska vs US, 2013 - 2022



	2013	2014	2015	2016	2017	2018	2019	2020	2021	2022
Nebraska	161.0	159.1	158.3	154.2	153.2	150.8	147.1	147.0	146.9	143.8
US	164.6	163.2	160	158.5	155.5	149.2	146.0	147.4	145.9	143.7

Nebraska's Mortality rate steadily decreased from 2013 to 2022, consistent with national trends in the US. In 2022, Nebraska and the U.S. had nearly identical cancer mortality rate. This downward trend reflects overall improvements in cancer detection, treatment, and prevention.

TABLE 4: Cancer Mortality

Number of Deaths and Rates by Selected Primary Site and Sex, Nebraska (2022 and 2018-2022) & U.S(2017-2021)

Site	NEBRASKA 2022						NEBRASKA 2018-2022						U.S. 2017-2021		
	Male		Female		Total		Male		Female		Total		Male	Female	Total
	No.	Rate	No.	Rate	No.	Rate	No.	Rate	No.	Rate	No.	Rate	Rate	Rate	Rate
All Sites	1,814	162.9	1577	118.3	3,392	137.4	9,087	169.1	8,122	125	17,209	143.8	176.5	128.3	148.4
Oral Cavity & Pharynx	40	3.6	15	1	55	2.2	232	4.3	93	1.3	325	2.7	4	1.4	2.6
Esophagus	75	6.4	21	1.5	96	3.8	417	7.5	115	1.7	532	4.4	6.6	1.4	3.8
Stomach	21	1.8	28	2.3	49	2.1	151	2.9	96	1.5	247	2.2	3.7	2.1	2.8
Colon & Rectum (Colorectal)	181	16.6	153	11.6	334	13.9	919	17.4	775	11.6	1,694	14.3	15.6	10.9	13.1
Liver & Intrahepatic Bile Ducts	83	6.8	51	4.1	134	5.3	365	6.3	201	3.2	566	4.6	9.6	4.2	6.6
Pancreas	170	14.9	113	8.6	283	11.5	754	13.6	648	10	1,402	11.7	12.9	9.8	11.2
Larynx	17	1.5	4	0.3	21	0.8	74	1.3	23	0.4	97	0.8	1.6	0.3	0.9
Lung & Bronchus	392	33.4	359	26.3	751	29.5	2,012	36.1	1,762	26.8	3,774	30.9	40.6	28.6	33.8
Melanoma of the Skin	40	3.6	16	1.1	56	2.3	184	3.5	101	1.5	285	2.4	3	1.3	2.1
Breast	3	0.2	184	13.9	187	7.7	15	0.3	1,190	18.9	1,205	10.3	0.3	19.6	10.8
Uterine Cervix	_	_	16	1.5	_	_	_	_	99	1.8	_	_	_	2.2	_

TABLE 4 (continued): Cancer Mortality

Site	NEBRASKA 2022						NEBRASKA 2018-2022						U.S. 2017-2021		
	Male		Female		Total		Male		Female		Total		Male	Female	Total
	No.	Rate	No.	Rate	No.	Rate	No.	Rate	No.	Rate	No.	Rate	Rate	Rate	Rate
Uterine Corpus & Unspecified	---	---	75	5.9	---	---	---	---	338	5.4	---	---	---	5.2	---
Ovary	---	---	70	5.9	---	---	---	---	338	5.4	---	---	---	6.2	---
Prostate	189	18.3	---	---	---	---	965	18.9	---	---	---	---	19.2	---	---
Kidney & Renal Pelvis	56	5.1	31	2.2	87	3.5	293	5.4	160	2.4	453	3.8	5.1	2.2	3.5
Urinary Bladder	84	7.9	21	1.4	105	4.2	350	6.8	131	1.9	481	3.9	7.2	2	4.2
Brain & Other Nervous System	60	5.4	47	3.8	107	4.6	313	5.8	261	4.3	574	5	5.4	3.6	4.4
Thyroid	6	0.6	6	0.5	12	0.6	34	0.6	38	0.6	72	0.6	0.5	0.5	0.5
Hodgkin Lymphoma	2	0.1	2	0.1	4	0.1	21	0.4	13	0.2	34	0.3	0.3	0.2	0.3
Non-Hodgkin Lymphoma	58	5.3	58	4.1	116	4.7	342	6.5	239	3.5	581	4.8	6.7	3.8	5.1
Leukemia	87	7.8	55	4.1	142	5.8	415	7.9	288	4.4	703	5.9	8	4.5	6
Myeloma	42	3.9	27	1.9	69	2.8	177	3.4	163	2.4	340	2.8	3.9	2.4	3.1

Total rates are per 100,000 population and are age-adjusted to the 2000 U.S. population.
Sex-specific rates are per 100,000 male or female population and are age-adjusted to the 2000 U.S. population.

TABLE 5: Cancer Mortality
Number of Deaths and Percentage Distribution, by Selected Primary Site and Age at Death
Nebraska (2018-2022)

	0-17 Yrs.		18-44 Yrs.		45-64 Yrs.		65+ Yrs.		TOTAL	
	Number	%	Number	%	Number	%	Number	%	Number	%
All Sites	52	0.3	418	2.4	3,836	22.3	12,903	75.0	17,209	100.0
Oral Cavity & Pharynx	0	0.0	7	2.2	116	35.7	202	62.2	325	100.0
Esophagus	1	0.2	5	0.9	161	30.3	365	68.6	532	100.0
Stomach	0	0.0	14	5.7	78	31.6	155	62.8	247	100.0
Colon & Rectum (Colorectal)	0	0.0	56	3.3	392	23.1	1,246	73.6	1,694	100.0
Liver & Intrahepatic Bile Ducts	1	0.2	17	3.0	174	30.7	374	66.1	566	100.0
Pancreas	0	0.0	15	1.1	330	23.5	1,057	75.4	1,402	100.0
Lung & Bronchus	0	0.0	22	0.6	850	22.5	2,902	76.9	3,774	100.0
Melanoma of the Skin	0	0.0	9	3.2	76	26.7	200	70.2	285	100.0
Female Breast	0	0.0	54	4.5	336	28.2	800	67.2	1,190	100.0
Uterine Cervix	0	0.0	19	19.2	46	46.5	34	34.3	99	100.0
Uterine Corpus & Unspecified	0	0.0	9	2.7	80	23.7	248	73.6	337	100.0
Ovary	0	0.0	13	3.8	93	27.5	232	68.6	338	100.0
Prostate	0	0.0	0	0.0	89	9.2	876	90.8	965	100.0
Kidney & Renal Pelvis	1	0.2	11	2.4	109	24.1	332	73.3	453	100.0
Urinary Bladder	0	0.0	4	0.8	45	9.4	432	89.8	481	100.0
Brain & Central Nervous System	24	4.2	45	7.8	182	31.7	323	56.3	574	100.0
Thyroid	0	0.0	2	2.8	17	23.6	53	73.6	72	100.0
Hodgkin Lymphoma	0	0.0	4	11.8	8	23.5	22	64.7	34	100.0
Non-Hodgkin Lymphoma	0	0.0	17	2.9	89	15.3	475	81.8	581	100.0
Leukemia	9	1.3	24	3.4	83	11.8	587	83.5	703	100.0
Myeloma	0	0.0	2	0.6	52	15.3	286	84.1	340	100.0

NOTE: Due to rounding, percentages may not sum to 100.0.

TABLE 6: Cancer Mortality
Number of Deaths and Rates, Top Ten Primary Sites, by Race and Ethnicity
Nebraska (2013-2022)

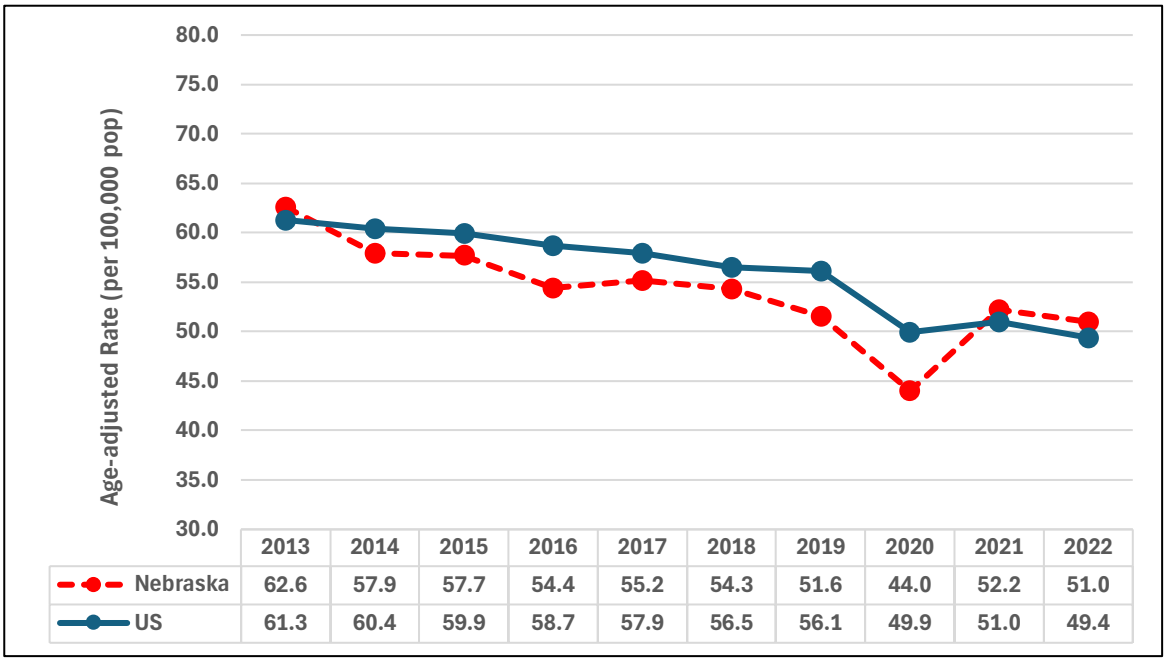
	White			African American			Native American			Asian/Pacific Islander			Hispanic		
	Site	Number	Rate	Site	Number	Rate	Site	Number	Rate	Site	Number	Rate	Site	Number	Rate
Rank	All Sites	31,796	151.1	All Sites	1212	190.4	All Sites	163	152.5	All Sites	250	87.2	All Sites	727	86.5
1	Lung & Bronchus	7,573	35.7	Lung & Bronchus	295	45.4	Lung & Bronchus	39	37.9	Lung & Bronchus	44	15.8	Lung & Bronchus	116	15.2
2	Colon & Rectum	3040	14.6	Colon & Rectum	121	19.4	Colon & Rectum	21	17.2	Liver & Intrahepatic Bile Ducts	42	13.6	Colon & Rectum	73	8.7
3	Pancreas	2,396	11.4	Pancreas	117	18.7	Liver & Intrahepatic Bile Ducts	14	11.1	Pancreas	20	7.9	Liver & Intrahepatic Bile Ducts	56	6.2
4	Female Breast	2227	19.9	Prostate	90	39.8	Pancreas	9	7.2	Colon & Rectum	17	6.3	Pancreas	55	6.3
5	Prostate	1674	18.5	Female Breast	90	26.1	Female Breast	8	15.1	Stomach	12	4.5	Female Breast	46	8.8
6	Leukemia	1347	6.3	Liver & Intrahepatic Bile Ducts	63	8.3	Ovary	7	14.0	Oral Cavity & Pharynx	12	3.2	Stomach	34	3.6
7	Non-Hodgkin Lymphoma	1125	5.3	Myeloma	39	6.7	Kidney & Renal Pelvis	7	4.8	Female Breast	11	6.5	Brain $ CNS	32	3.1
8	Brain $ CNS	1029	5.2	Stomach	34	5.5	Corpus & Unspecified	6	8.0	Leukemia	9	3.5	Non-Hodgkin Lymphoma	31	4.4
9	Esophagus	974	4.6	Leukemia	33	5.4	Prostate	5	13.7	Ovary	7	3.7	Leukemia	30	2.8
10	Liver & Intrahepatic Bile Ducts	882	4.2	Kidney & Renal Pelvis	32	5.2	Leukemia	4	4.5	Prostate	7	7.2	Prostate	29	10.5

Rates are per 100,000 population, excluding Sex-specific sites (prostate, female breast, ovary), which are per 100,000 male or female population. All rates are age-adjusted to the 2000 U.S. population. Abbreviation: CNS, central nervous system

Lung and Bronchus

Although lung cancer was only the second most frequently diagnosed cancer among Nebraska residents in 2022, it was the year's leading cause of cancer mortality, accounting for 22.1% of the state's cancer deaths. During the five-year period from 2018 to 2022, 6,273 lung cancer cases were diagnosed, and more than 3,774 deaths were recorded. Although lung cancer is more likely to strike men than women, the lung cancer death rate for Nebraska men has fallen by over 40% since 1990, while remaining almost unchanged for Nebraska women. Due to the small number of cases that are detected at an early stage of the disease, the 5-year relative survival rate for people diagnosed with lung cancer is about 26.5%.

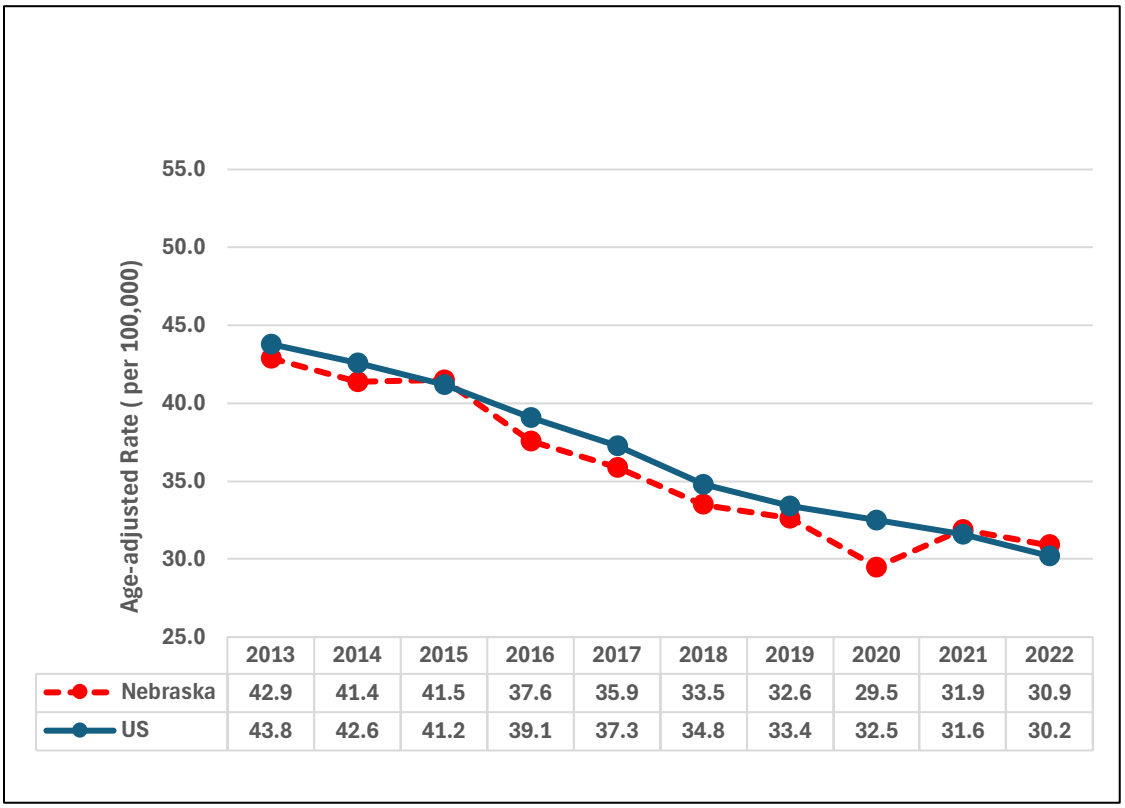
Figure 3. Age-Adjusted Incidence Rates for Lung and Bronchus Cancer in Nebraska vs US, 2013 - 2022



	2013	2014	2015	2016	2017	2018	2019	2020	2021	2022
Nebraska	62.6	57.9	57.7	54.4	55.2	54.3	51.6	44.0	52.2	51.0
US	61.3	60.4	59.9	58.7	57.9	56.5	56.1	49.9	51.0	49.4

Nebraska showed a steady decline from 2013 to 2019, followed by a sharp drop in 2020 and an increasing trend thereafter. The US exhibited a similar pattern, with a gradual decline from 2013 to 2019 and a substantial decrease in 2020. In 2022, Nebraska's cancer incidence rate is slightly higher than the US rate, making it the second consecutive year in which this happened.

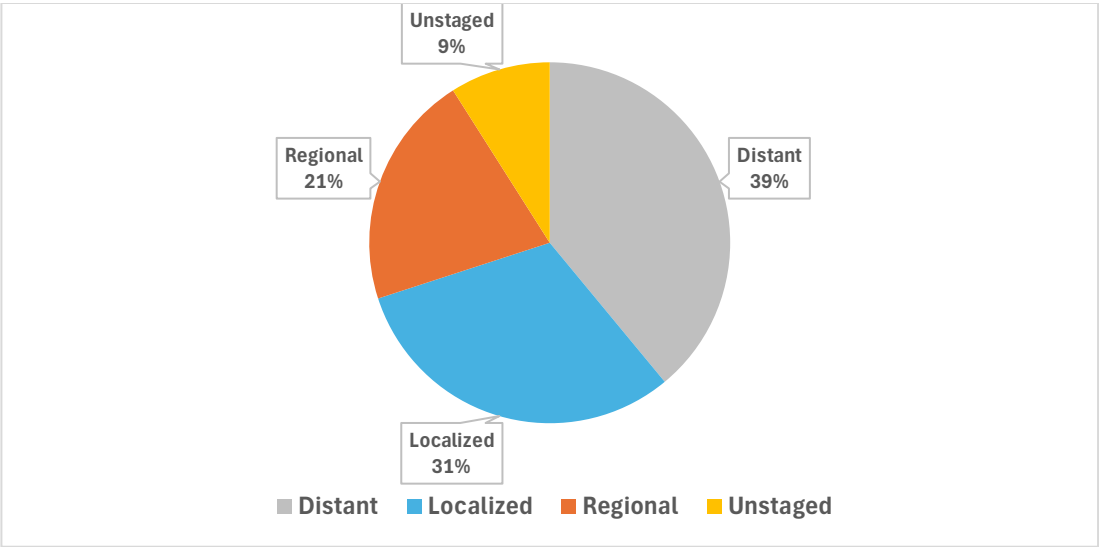
Figure 4. Age-Adjusted Mortality Rates for Lung and Bronchus Cancer in Nebraska vs US, 2013 - 2022



	2013	2014	2015	2016	2017	2018	2019	2020	2021	2022
Nebraska	42.9	41.4	41.5	37.6	35.9	33.5	32.6	29.5	31.9	30.9
US	43.8	42.6	41.2	39.1	37.3	34.8	33.4	32.5	31.6	30.2

From 2013 to 2022, Nebraska experienced an overall decline in age-adjusted lung and bronchus cancer mortality rates, consistent with the U.S. trends. Nebraska's rate showed a slight decrease in 2022 compared to 2021.
The Nebraska rates were generally slightly lower than the U.S. rates except 2021 and 2022.

Figure 5. Percentage of Lung and Bronchus Cancer Cases by Stage of Disease at Diagnosis in Nebraska, 2018-2022

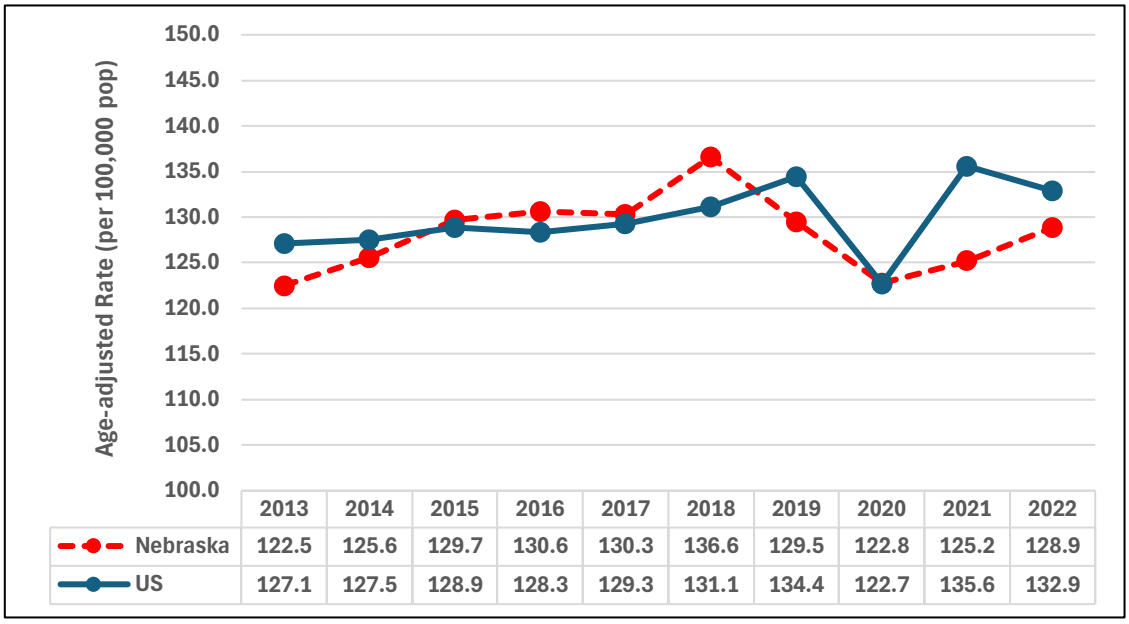


This pie chart displays the largest portion (39%) of cases were diagnosed at distant stage, indicating late detection. Localized-stage cases accounted for 31%, while 21% were diagnosed at the regional stage. Unstaged cases made up 9%, where the extent of disease wasn't determined.

Breast (Female only)

Breast cancer is the most common type of cancer among women and the second most frequent cause of female cancer deaths in U.S. Between 2018 and 2022, 7,387 Nebraska women were diagnosed with invasive breast cancer and 1,190 women died from breast cancer. Since 1990, the rate of breast cancer deaths in Nebraska and the U.S. has declined significantly. Recent declines in the rate of breast cancer diagnoses have been attributed to the decreasing use of postmenopausal hormone replacement therapy, early detection through screening, and increased awareness. The 5-year relative survival rate for women diagnosed with female breast cancer is about 91% (Centers for Disease Control and Prevention, 2025).

Figure 6. Age-Adjusted Incidence Rates for Female Breast Cancer in Nebraska vs US, 2013 - 2022

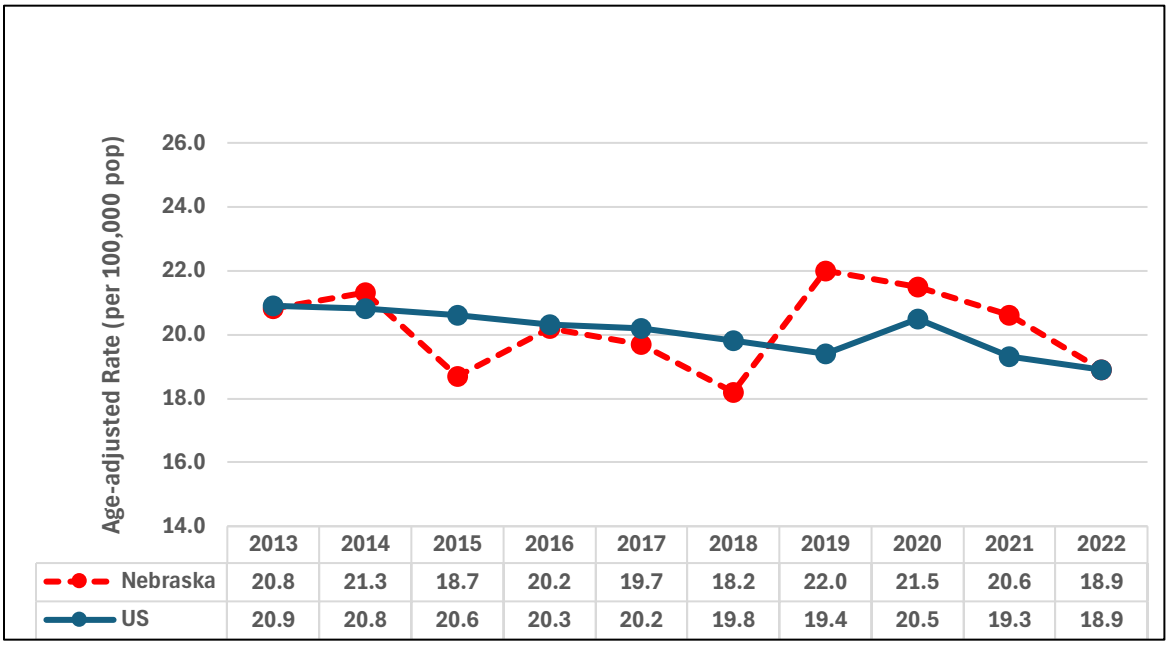


	2013	2014	2015	2016	2017	2018	2019	2020	2021	2022
Nebraska	122.5	125.6	129.7	130.6	130.3	136.6	129.5	122.8	125.2	128.9
US	127.1	127.5	128.9	128.3	129.3	131.1	134.4	122.7	135.6	132.9

In 2022, Nebraska's rate was higher than in 2021 but remained slightly lower than the US rate.

Female breast cancer incidence rates in Nebraska increased from 2013 to 2018, declined thereafter to a low point in 2020, and then rose again through 2022, close to reflect the US trend.

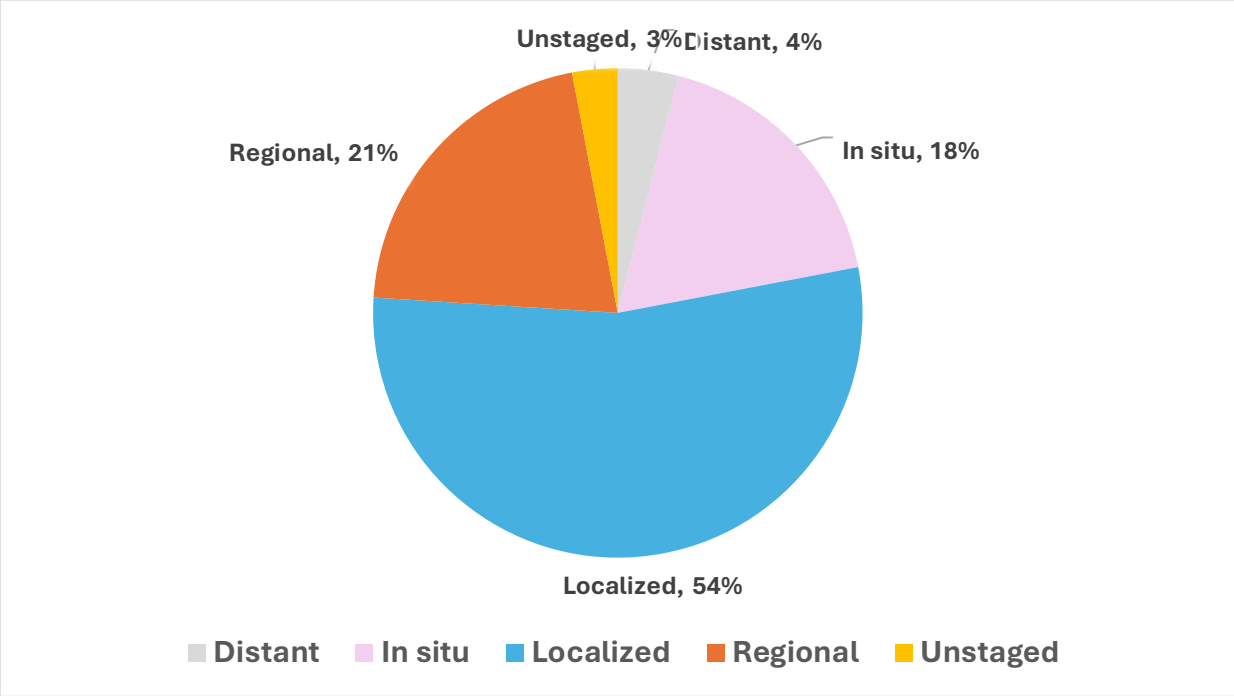
Figure 7. Age-Adjusted Mortality Rates for Female Breast Cancer in Nebraska vs US, 2013 - 2022



	2013	2014	2015	2016	2017	2018	2019	2020	2021	2022
Nebraska	20.8	21.3	18.7	20.2	19.7	18.2	22.0	21.5	20.6	18.9
US	20.9	20.8	20.6	20.3	20.2	19.8	19.4	20.5	19.3	18.9

Nebraska's female breast cancer death rates fluctuated significantly from 2013 to 2022, falling until 2018 before hitting a sharp peak in 2019. In contrast, US rates maintained a steady and consistent decline. While Nebraska remained above the national average from 2019 through 2021, its rate matched the U.S. figure by 2022

Figure 8. Percentage of Female Breast Cancer Cases by Stage of Disease at Diagnosis in Nebraska, 2018- 2022



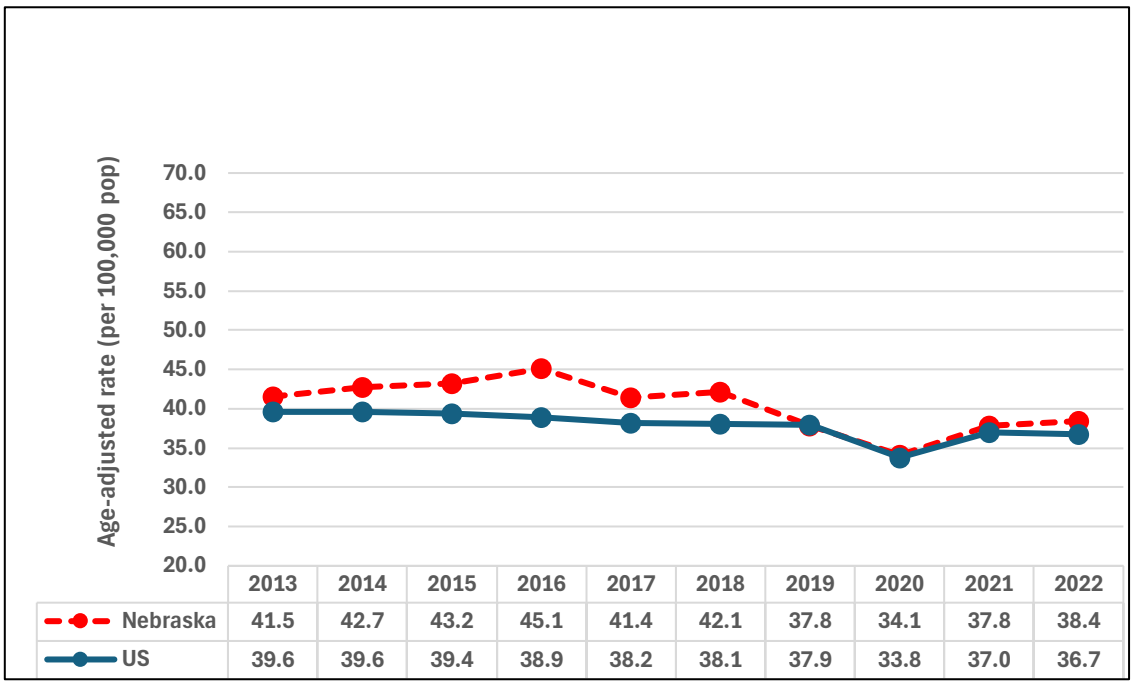
This pie chart shows the majority of cases (54%) were diagnosed at the localized stage, indicating early detection. Regional and in situ stages accounted for 21% and 18%, respectively. Only 4% of cases were diagnosed at the distant stage, and 3% remained unstaged. These figures suggest effective screening and early diagnosis efforts in Nebraska.

Colon and Rectum (Colorectal)

In 2022, colorectal cancer was the fourth most frequently diagnosed cancer among Nebraska residents, accounting for 850 new cases. It was also the second leading cause of cancer mortality in the state, accounting for 334 deaths.

The risk of developing colorectal cancer increases with age. More than half (59%) of all colorectal cancer cases that occurred in Nebraska during 2018-2022 were 65 or older at diagnosis. The 5-year relative survival rate for people diagnosed with colorectal cancer is about 64.4%.

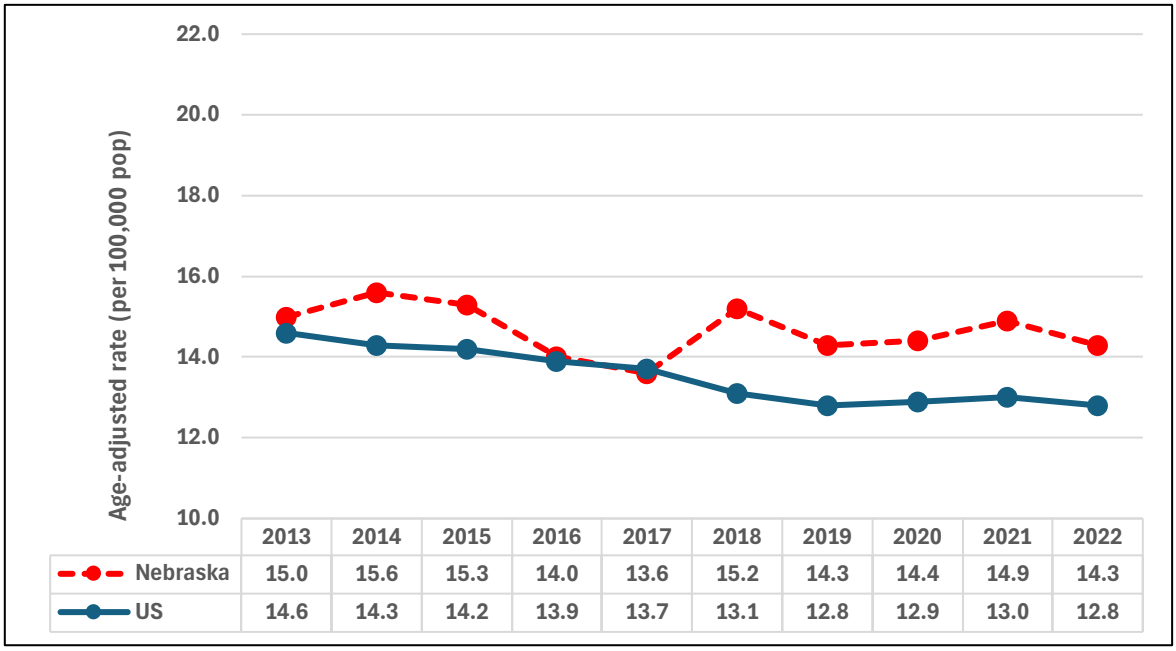
Figure 9. Age-Adjusted Incidence Rates for Colorectal Cancer in Nebraska vs US, 2013 - 2022



	2013	2014	2015	2016	2017	2018	2019	2020	2021	2022
Nebraska	41.5	42.7	43.2	45.1	41.4	42.1	37.8	34.1	37.8	38.4
US	39.6	39.6	39.4	38.9	38.2	38.1	37.9	33.8	37.0	36.7

Nebraska experienced a modest increase in colorectal cancer incidence from 2013 to 2016, followed by a steady decline through 2022. This pattern mirrors the overall US trend; however, generally Nebraska's incidence rate continued to exceed the U.S. rate through 2022.

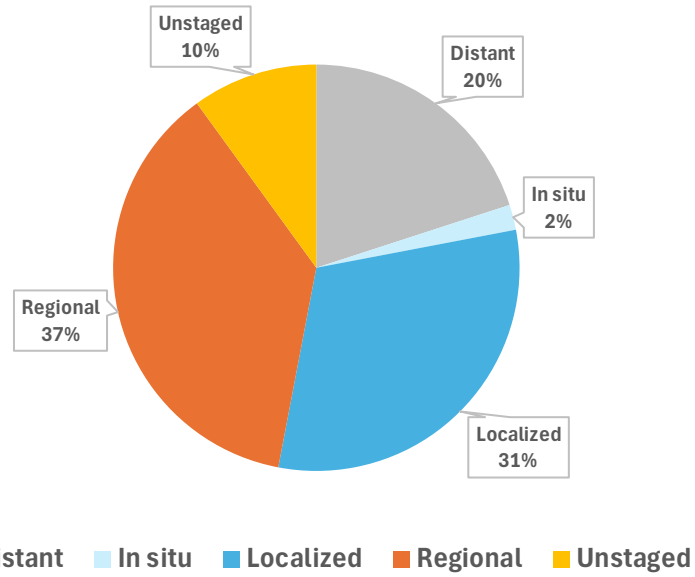
Figure 10. Age-Adjusted Mortality Rates for Colorectal Cancer in Nebraska vs US, 2013 - 2022



	2013	2014	2015	2016	2017	2018	2019	2020	2021	2022
Nebraska	15.0	15.6	15.3	14.0	13.6	15.2	14.3	14.4	14.9	14.3
US	14.6	14.3	14.2	13.9	13.7	13.1	12.8	12.9	13.0	12.8

Nebraska's colorectal cancer mortality rates exhibited modest fluctuations. The mortality rate in 2022 is slightly lower than the rates in previous 4 years, while the U.S. demonstrated a clearer downward trend. Which is not observer in Nebraska However, Nebraska's mortality rate remained higher than the US rate, including in 2022.

Figure 11. Percentage of Colorectal Cancer Cases by Stage of Disease at Diagnosis in Nebraska, 2018-2022



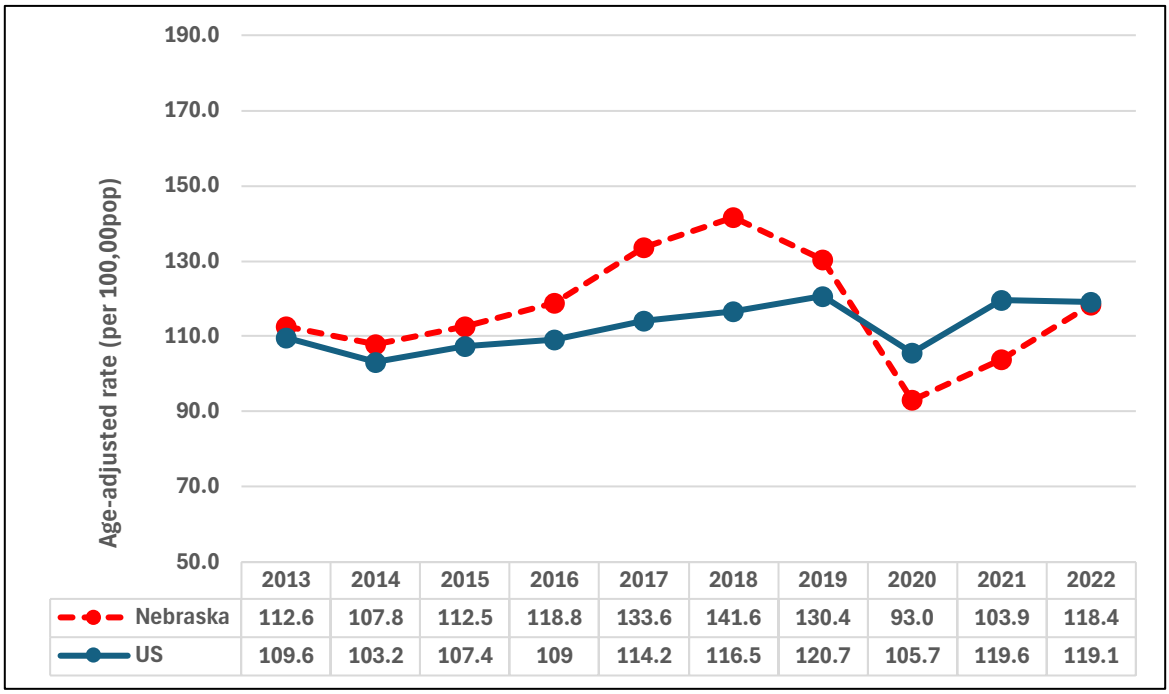
This pie chart shows the largest percentage of cases (37%) were diagnosed at the regional stage. Localized cases made up 31%, while distant stage cases accounted for 20%. Only 2% of cases were diagnosed in situ, and 10% were unstaged. The data highlights the need for early detection to reduce advanced-stage diagnoses.

Prostate

In 2022, prostate cancer was the most diagnosed cancer among men in Nebraska, with 1,305 reported cases. During the past five years (2018-2022), it has also been the second leading cause of cancer deaths among Nebraska men, accounting for 965 deaths. Since the mid-1990s, prostate cancer death rates have declined substantially, both in Nebraska and throughout the United States.

Little is known about what causes prostate cancer. Risk increases with age (about 65% of Nebraska men diagnosed with prostate cancer during 2018-2022 were 65 or older) and is significantly greater among African Americans. Men with a close relative (father, brother, or son) who has had prostate cancer, especially at a young age, are also at increased risk. The 5-year relative survival rate for people diagnosed with prostate cancer is 96.9%.

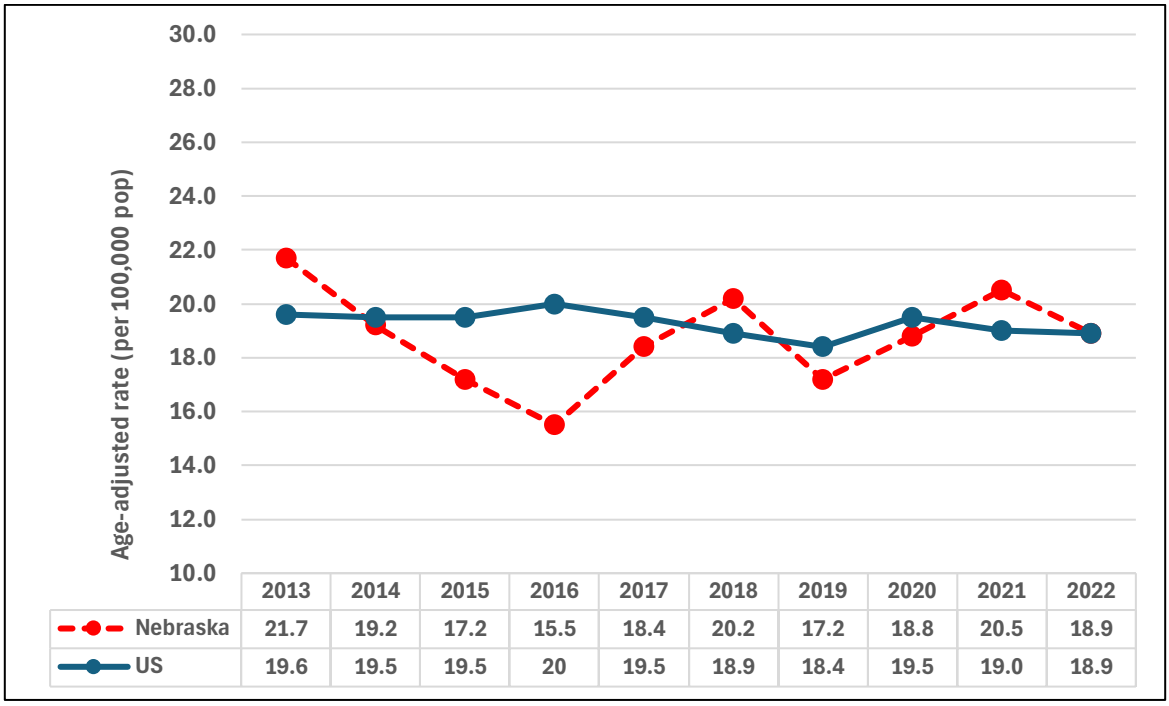
Figure 12. Age-Adjusted Incidence Rates for Prostate Cancer in Nebraska vs US, 2013 - 2022



	2013	2014	2015	2016	2017	2018	2019	2020	2021	2022
Nebraska	112.6	107.8	112.5	118.8	133.6	141.6	130.4	93.0	103.9	118.4
US	109.6	103.2	107.4	109	114.2	116.5	120.7	105.7	119.6	119.1

The Nebraska incident rate is higher in 2022 than in 2021, as continued rising since 2020. Nebraska's rates were typically higher than the U.S. rates, peaking in 2018 but it is reversed since 2020.

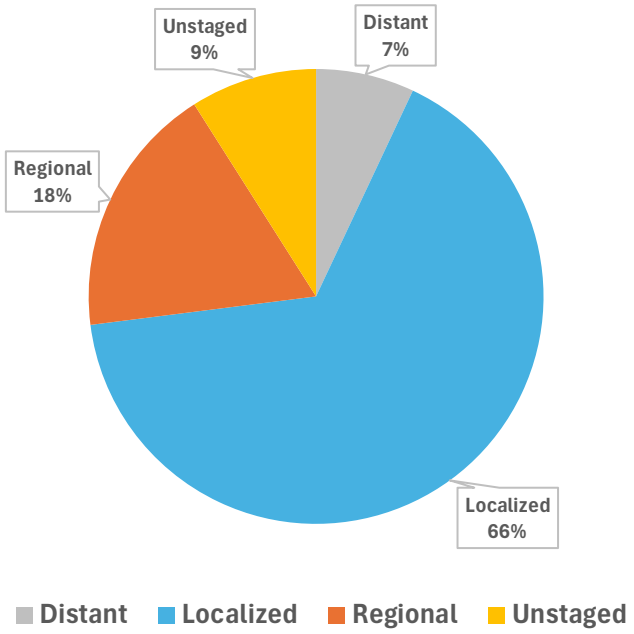
Figure 13. Age -Adjusted Mortality Rates for Prostate Cancer in Nebraska vs US, 2013 - 2022



	2013	2014	2015	2016	2017	2018	2019	2020	2021	2022
Nebraska	21.7	19.2	17.2	15.5	18.4	20.2	17.2	18.8	20.5	18.9
US	19.6	19.5	19.5	20	19.5	18.9	18.4	19.5	19.0	18.9

Nebraska's prostate cancer mortality rate was lower in 2022 than in 2021, and fluctuated more than U.S. rates, with a notable low of 15.5 in 2016.

Figure 14. Percentage of Prostate Cancer Cases by Stage of Disease at Diagnosis in Nebraska, 2018-2022

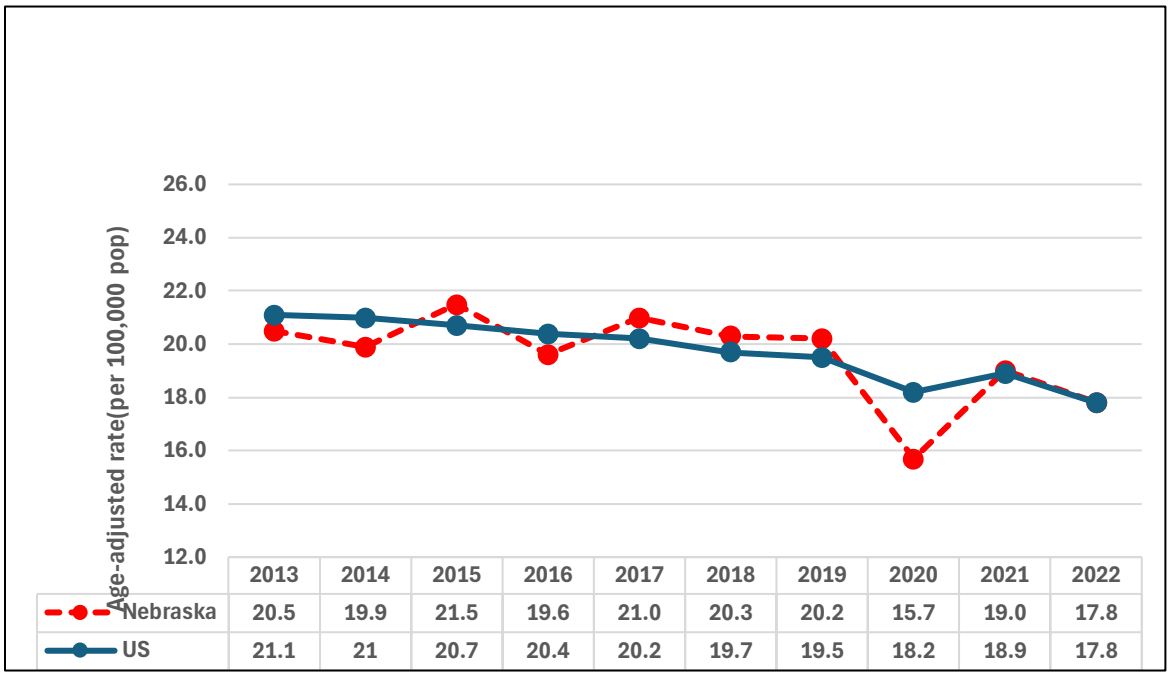


This pie chart shows two-thirds of cases (66%) were diagnosed at the localized stage, indicating early detection. Regional stage cases made up 18%, while distant stage accounted for only 7%. Unstaged cases comprised 9% of the total. The data suggests effective early diagnosis efforts for prostate cancer in Nebraska.

Urinary Bladder

Between 2018 and 2022, 2,173 Nebraska residents were diagnosed with bladder cancer. Bladder cancer occurs much more frequently among men than women (by about a 3-to-1 ratio), and it now ranks as the fifth most common site of cancer diagnoses among Nebraska men. However, deaths from bladder cancer occur far less often (481 Nebraska residents died from it during 2018-2022), which is the result of a high percentage of early-stage diagnoses and the existence of effective treatments. Survival prospects have improved considerably in recent decades, to the point where the most current national data show that the five-year relative survival rate for all bladder cancer patients is 76.8% (Centers for Disease Control and Prevention, 2025).

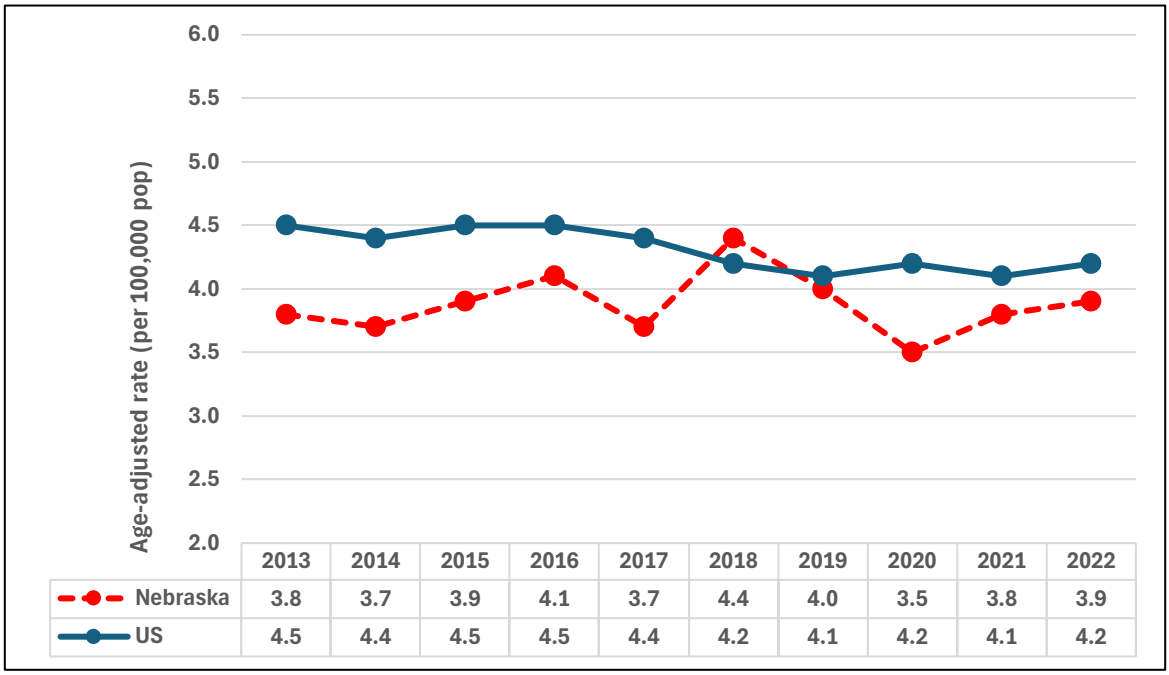
Figure 15. Age-Adjusted Incidence Rates for Urinary Cancer in Nebraska vs US, 2013-2022



	2013	2014	2015	2016	2017	2018	2019	2020	2021	2022
Nebraska	20.5	19.9	21.5	19.6	21.0	20.3	20.2	15.7	19.0	17.8
US	21.1	21	20.7	20.4	20.2	19.7	19.5	18.2	18.9	17.8

Nebraska's rate in 2022 was lower than in 2021. Although the annual rates showed some fluctuation, the overall pattern reflects a downward trend consistent with national trends in the US, including a notable decline in 2020. This decrease may be attributable to improvements in prevention, early detection, and risk factor management.

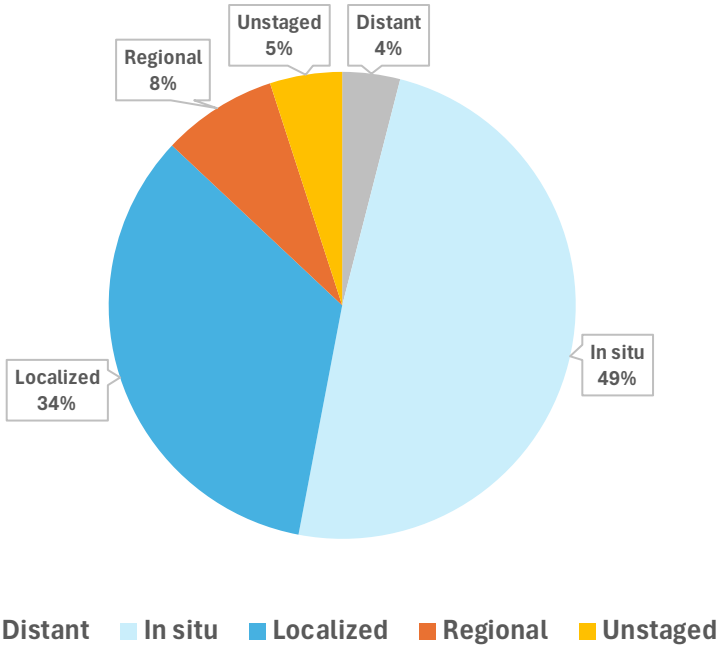
Figure 16. Age- Adjusted Mortality Rates for Urinary Cancer in Nebraska vs US, 2013 - 2022



	2013	2014	2015	2016	2017	2018	2019	2020	2021	2022
Nebraska	3.8	3.7	3.9	4.1	3.7	4.4	4.0	3.5	3.8	3.9
US	4.5	4.4	4.5	4.5	4.4	4.2	4.1	4.2	4.1	4.2

Nebraska's urinary cancer mortality rates are relatively stable from 2013 to 2022, and a noticeable increase in 2018. The US shows a gradual decrease overall, while Nebraska remains lower than the US in most years and more variable, but generally stable. In 2022, Nebraska's mortality rates are slightly lower than the US rate, and the gap is similar to previous years.

Figure 17. Percentage of Urinary Bladder Cancer Cases by Stage of Disease at Diagnosis in Nebraska, 2018 - 2022



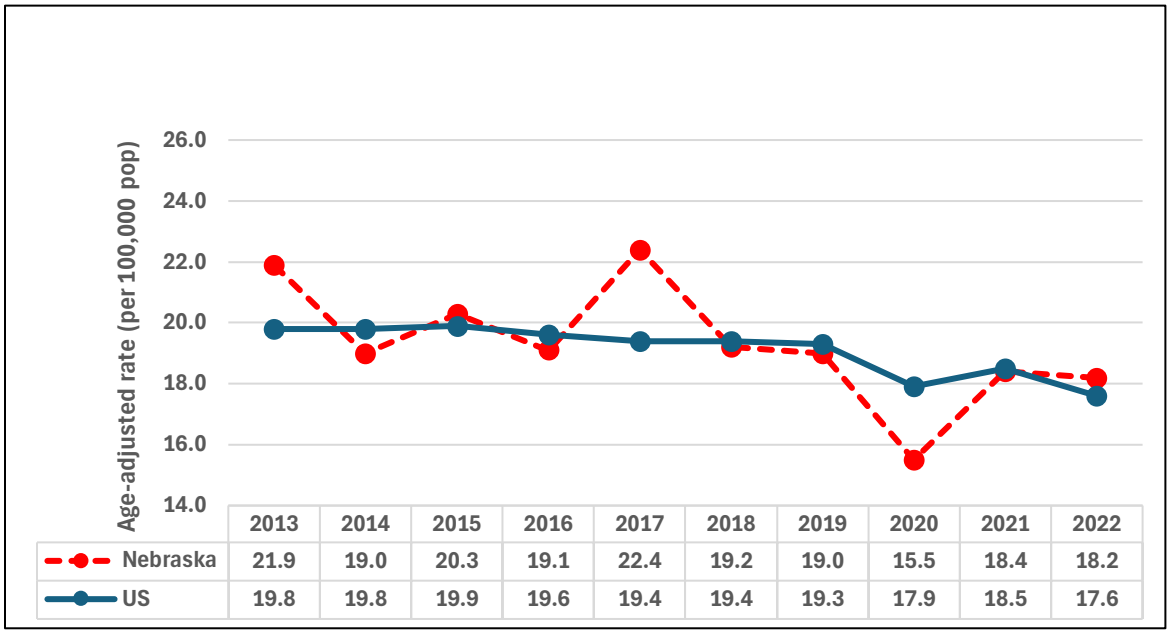
This pie chart shows nearly half of cases (49%) were diagnosed in situ, followed by 34% at the localized stage. Regional diagnoses accounted for 8%, and distant stage cases were 4%. An additional 5% of cases were unstaged. The data suggests early detection is common, with over 80% of cases identified at in situ or localized stages.

Non-Hodgkin Lymphoma

Lymphomas are cancers that affect the white blood cells of the immune system and are usually classified as either Hodgkin or non-Hodgkin lymphoma. Non-Hodgkin lymphoma is by far the more common disorder of the two, accounting for 2,095 diagnoses and 581 deaths among Nebraska residents between 2018 and 2022 (for Hodgkin lymphoma, the comparable figures are 238 diagnoses and 34 deaths).

The current trends from 2013 to 2022 have shown that both incidence as well as mortality rate of non-Hodgkin lymphoma have steadily declined at the state and national level. The five-year relative survival rate for non-Hodgkin lymphoma is 72.6%.

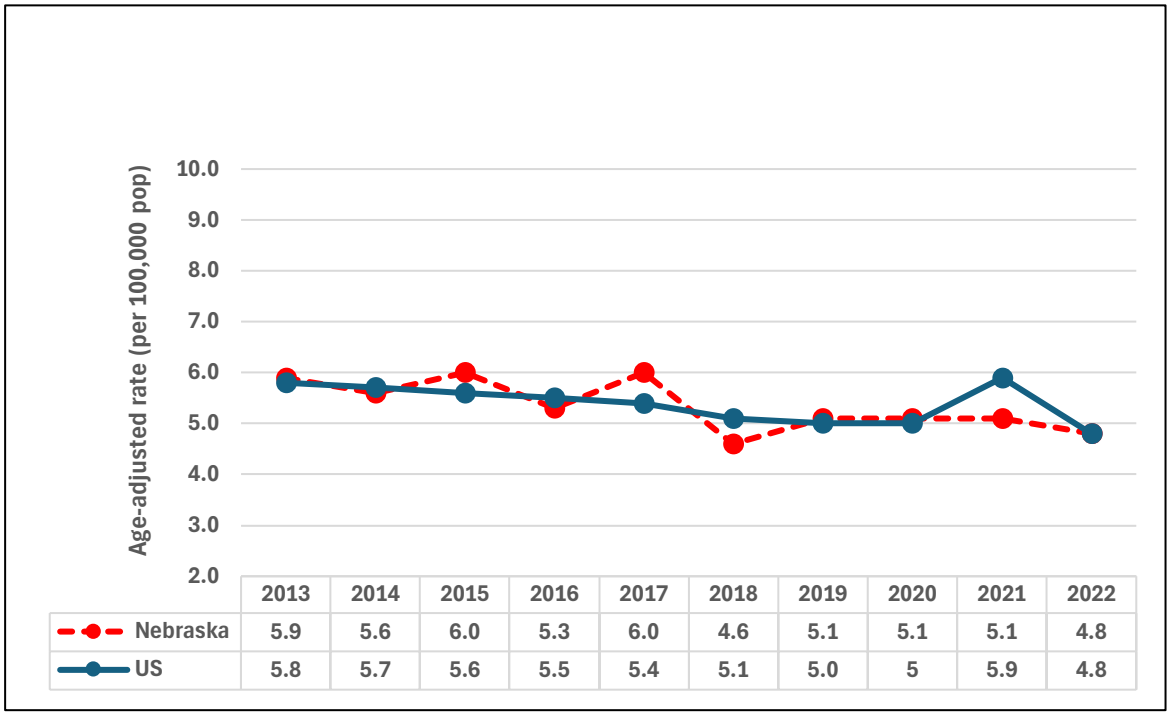
Figure 18. Age-Adjusted Incidence Rates for Non-Hodgkin Lymphoma Cancer in Nebraska vs US, 2013 - 2022



	2013	2014	2015	2016	2017	2018	2019	2020	2021	2022
Nebraska	21.9	19.0	20.3	19.1	22.4	19.2	19.0	15.5	18.4	18.2
US	19.8	19.8	19.9	19.6	19.4	19.4	19.3	17.9	18.5	17.6

Nebraska's non-Hodgkin lymphoma incidence rates show more volatility compared to the U.S. rates, with noticeable peaks in 2013 and 2017, and a significant dip in 2020.

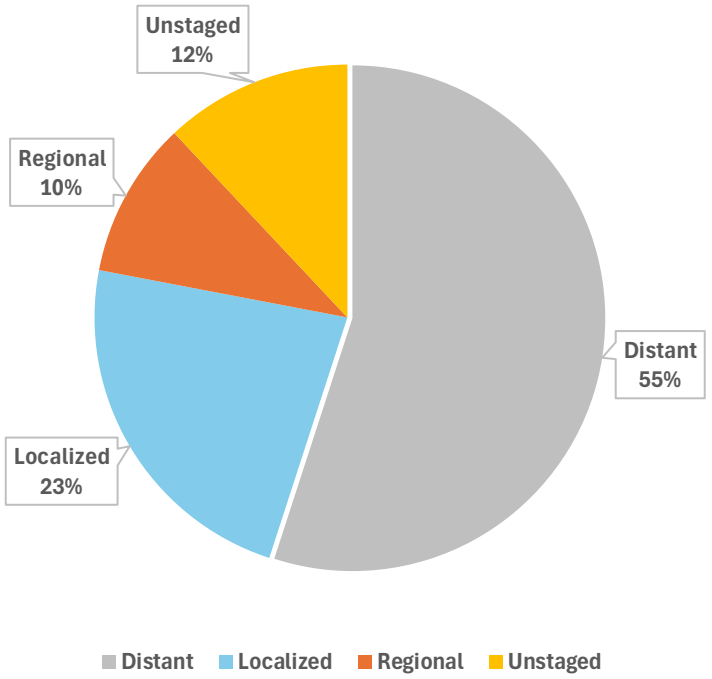
Figure 19. Age-Adjusted Mortality Rates for Non-Hodgkin Lymphoma Cancer in Nebraska vs US, 2013 - 2022



	2013	2014	2015	2016	2017	2018	2019	2020	2021	2022
Nebraska	5.9	5.6	6.0	5.3	6.0	4.6	5.1	5.1	5.1	4.8
US	5.8	5.7	5.6	5.5	5.4	5.1	5.0	5	5.9	4.8

Nebraska's mortality rates for non-Hodgkin lymphoma show a slight overall decline from 2013 to 2022, with minor fluctuations. The US also shows a gradual decrease overall, while Nebraska's rates are similar but slightly more variable, generally aligning with the US by 2022. In 2022, Nebraska's mortality rate equals the US rate exactly.

Figure 20. Percentage of Non-Hodgkin Lymphoma Cancer Cases by Stage of Disease at Diagnosis in Nebraska, 2018 - 2022



This pie chart illustrates the majority of cases (55%) were diagnosed at the distant stage, indicating advanced disease. Localized cases accounted for 23%, while regional stage diagnoses were 10%. Unstaged cases made up 12%, reflecting incomplete data at diagnosis.

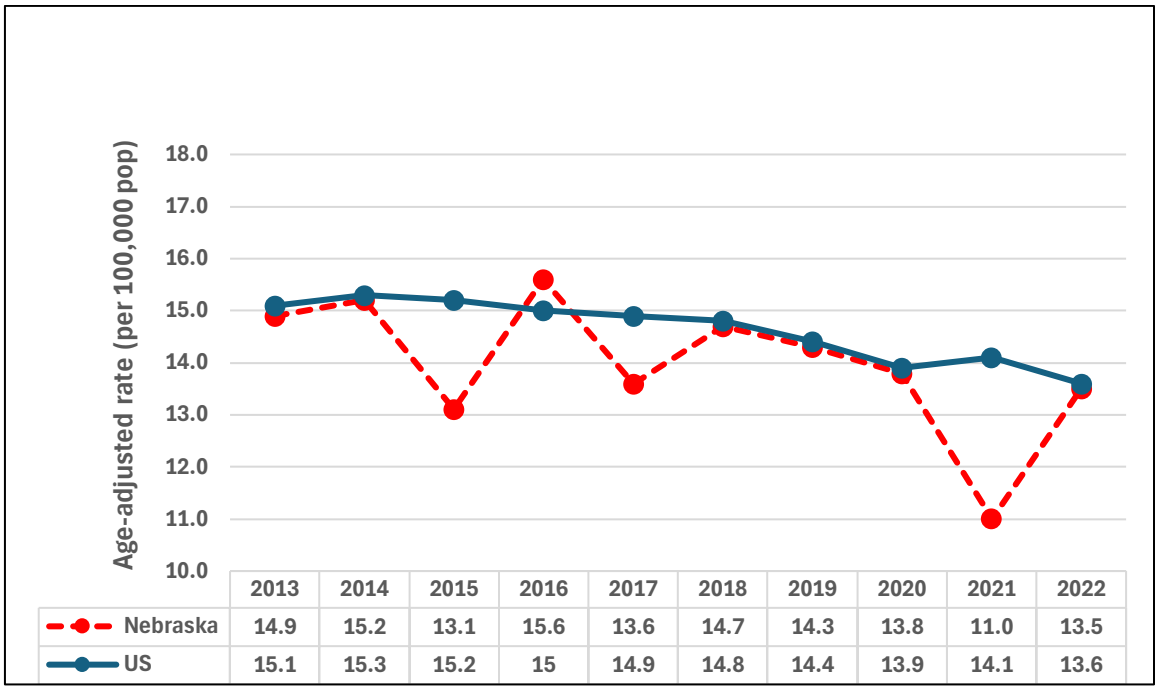
Leukemia

Table 7 shows that between 2018 and 2022, leukemia accounted for 1,527 diagnoses among Nebraska residents. Although leukemia is one of the most common cancers diagnosed among children and adolescents, over half (58.3%) of the cases in Nebraska occurred in individuals aged 65 years or older at diagnosis, a trend that was consistent across all years.

TABLE 7. Leukemia Incidence by Age Group and Year, 2018 to 2022, Nebraska

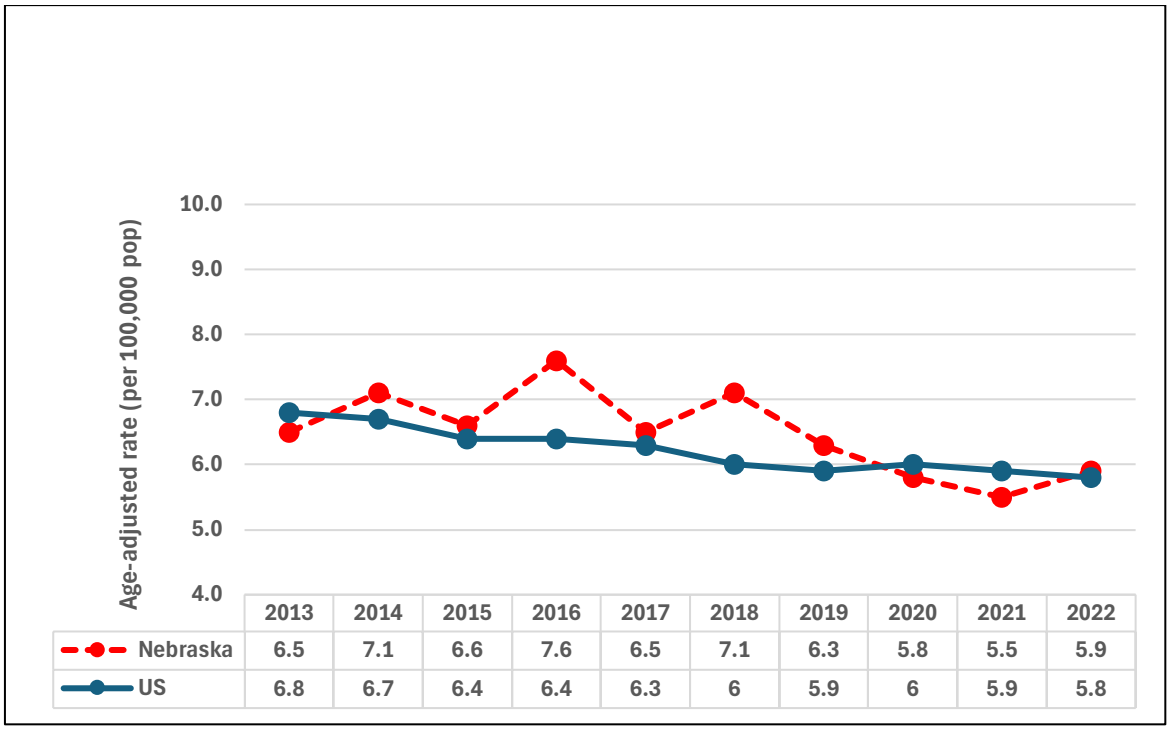
Age Groups	Year											
	2018		2019		2020		2021		2022		Total	
	N	N%	N	N%	N	N%	N	N%	N	N%	N	N%
00-64	131	38.0	140	41.0	140	42.8	125	49.2	100	37.7	636	41.7
65-69	209	62.0	201	59.0	187	57.2	129	50.8	165	62.3	891	58.3
Total	340	100.00	341	100.00	327	100.00	254	100.00	265	100.00	1527	100.00

Figure 21. Age-Adjusted Incidence Rates for Leukemia Cancer in Nebraska vs US, 2013 - 2022



Nebraska experienced greater fluctuations in leukemia incidence compared to the U.S, with notable declines in 2015 and 2021. In 2016, its incidence briefly exceeded U.S. rate. Overall, both Nebraska and the US showed a downward trend over the decade, with Nebraska's rate nearly matching the US average by 2022.

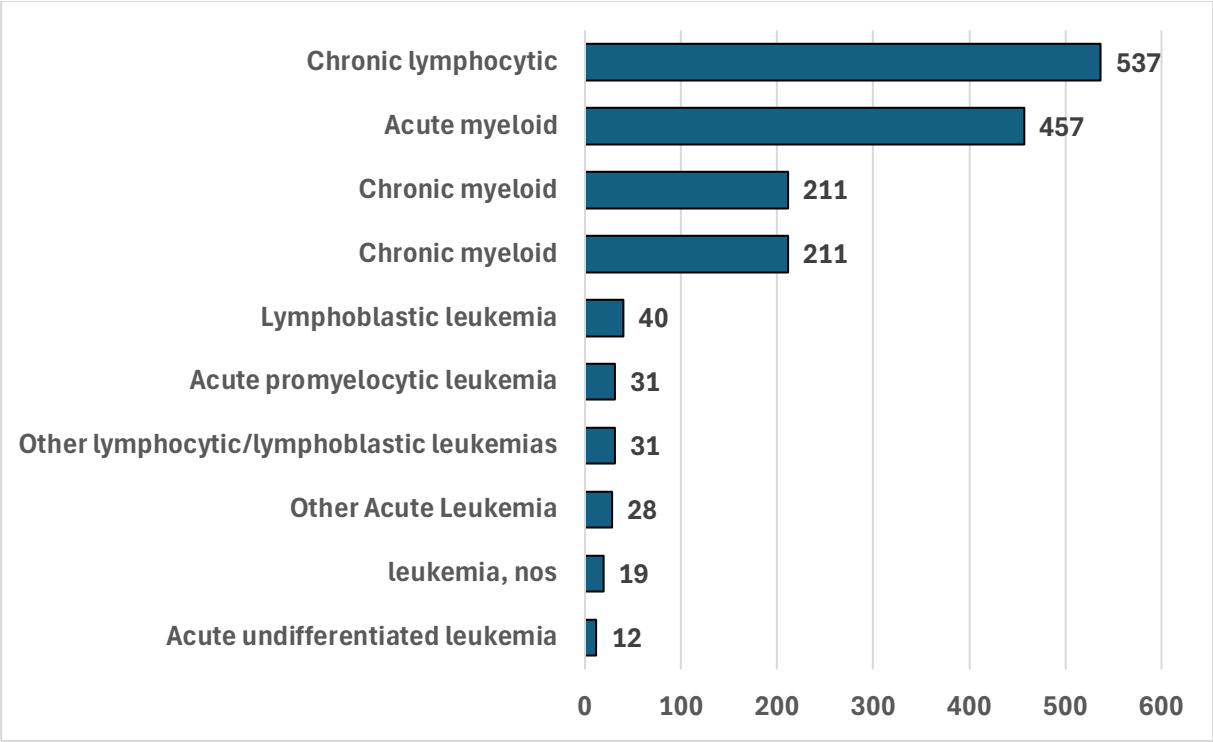
Figure 22. Age-Adjusted Mortality Rates for Leukemia Cancer in Nebraska vs US, 2013 - 2022



	2013	2014	2015	2016	2017	2018	2019	2020	2021	2022
Nebraska	6.5	7.1	6.6	7.6	6.5	7.1	6.3	5.8	5.5	5.9
US	6.8	6.7	6.4	6.4	6.3	6	5.9	6	5.9	5.8

Nebraska shows a slightly declining trend from 2013 to 2022, despite some year-to-year fluctuations. Nebraska's rates are generally similar but a bit more variable, while the U.S. shows a steadier gradual decline over the same period. In 2022, Nebraska's mortality rate is slightly higher than the US rate.

Figure 23. Number of Leukemia Cases by Histologic Type in Nebraska, 2018 - 2022

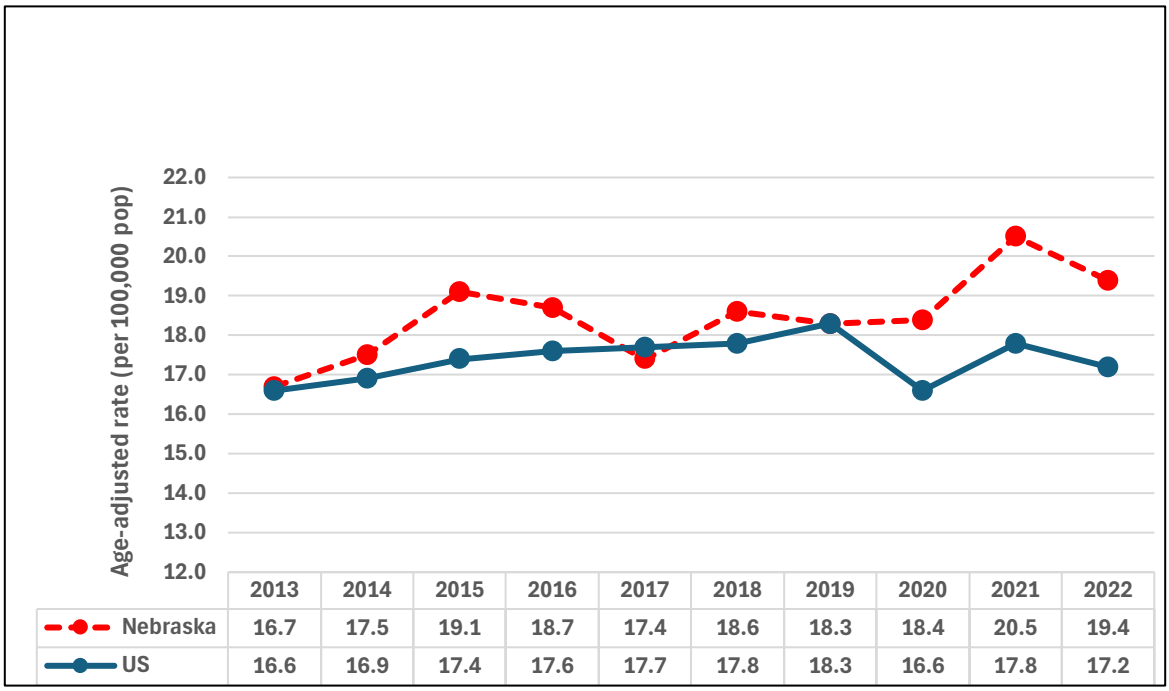


The graph shows the number of leukemia cases in Nebraska by histologic type from 2018 to 2022. Chronic lymphocytic leukemia had the highest number of cases, followed by acute myeloid leukemia. Chronic myeloid and acute lymphoblastic leukemia also had significant case numbers. Other types such as lymphoblastic, promyelocytic, and undifferentiated leukemia had fewer cases. Overall, the distribution highlights the prevalence of specific leukemia types in Nebraska during this period.

Kidney and Renal Pelvis

Cancers of the kidney and renal pelvis accounted for 2,222 diagnoses in Nebraska between 2018 and 2022 and accounted for 453 deaths in Nebraska during the same years. State and national trends since 1990 show a significant increase in the rate of diagnosis of these cancers, but little change in the mortality rate. The chances of survival for people with kidney cancer are relatively high, with the most current national statistics showing that the five-year relative survival rate for cancers of the kidney and renal pelvis is now over 77.8%.

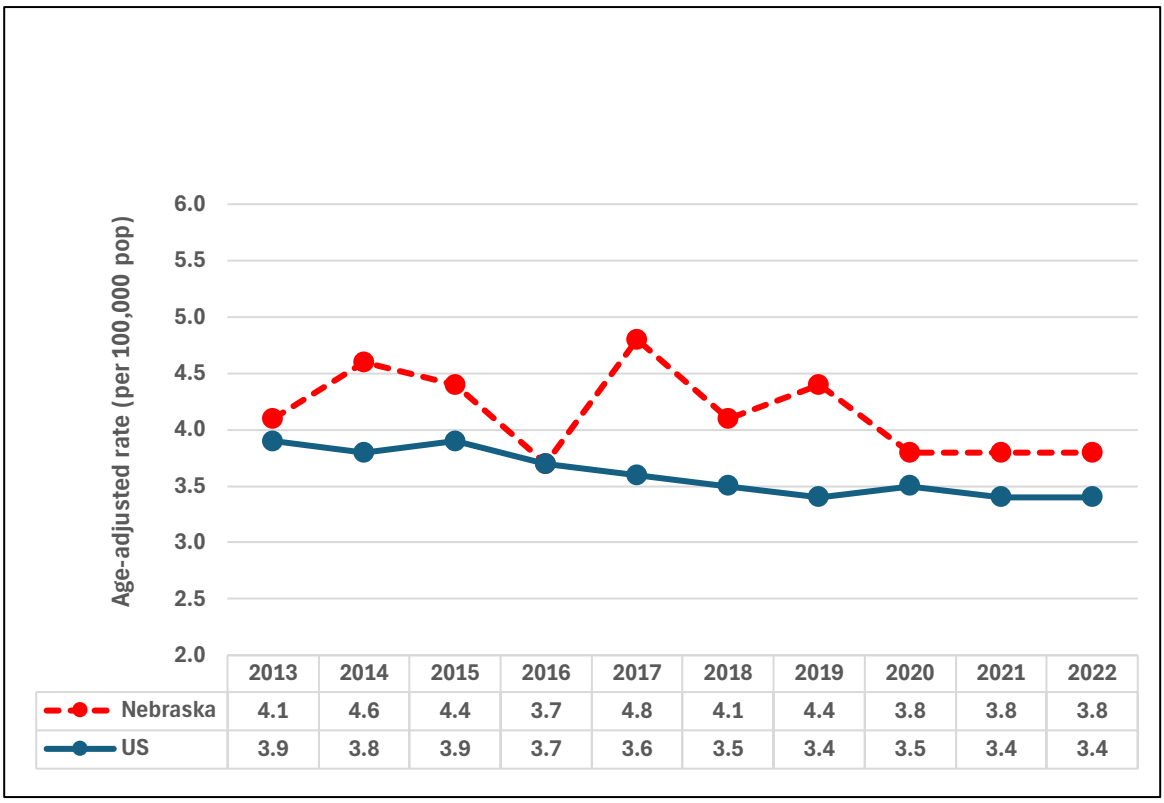
Figure 24. Age – Adjusted Incidence Rates for Kidney and Renal Pelvis Cancer in Nebraska vs US, 2013 - 2022



	2013	2014	2015	2016	2017	2018	2019	2020	2021	2022
Nebraska	16.7	17.5	19.1	18.7	17.4	18.6	18.3	18.4	20.5	19.4
US	16.6	16.9	17.4	17.6	17.7	17.8	18.3	16.6	17.8	17.2

Nebraska's rates for kidney and renal pelvis cancer generally increased from 2013 to 2022, with some year-to-year fluctuations. Nebraska's incidence rates were slightly higher, and more variable compared to the U.S, which showed a more gradual and stable increase over the same period. By 2022, Nebraska's rate was significantly higher than U.S. rate.

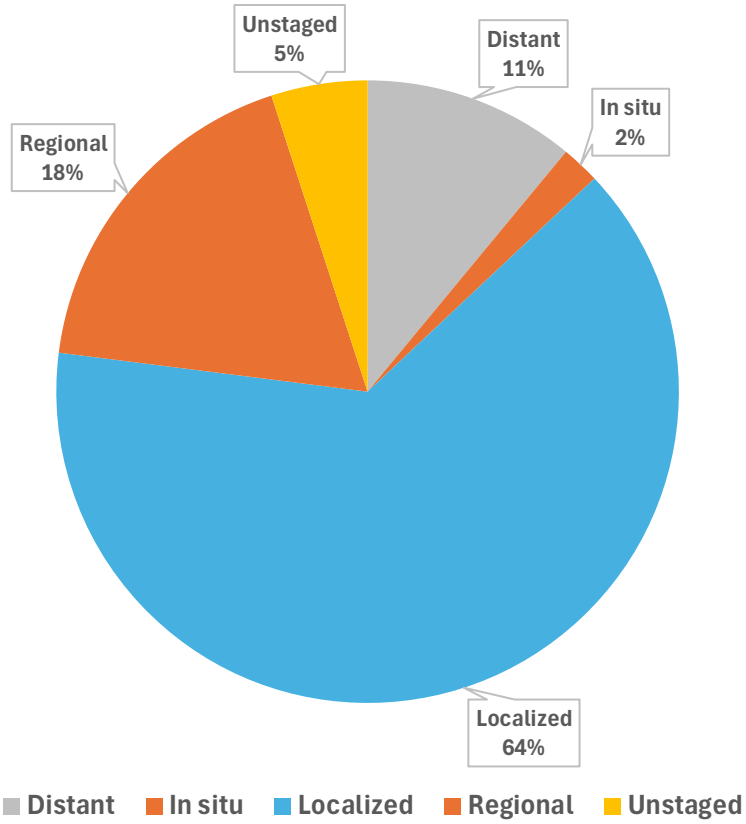
Figure 25. Age-Adjusted Mortality Rates for Kidney and Renal Pelvis Cancer in Nebraska vs US, 2013 - 2022



	2013	2014	2015	2016	2017	2018	2019	2020	2021	2022
Nebraska	4.1	4.6	4.4	3.7	4.8	4.1	4.4	3.8	3.8	3.8
US	3.9	3.8	3.9	3.7	3.6	3.5	3.4	3.5	3.4	3.4

Nebraska's mortality rates for kidney and renal pelvis cancer fluctuated more than the US between 2013 and 2022, with notable peaks around 2014 and 2017 that exceeded U.S. rate. Both Nebraska and the US showed a slight downward trend in mortality rates toward 2022. Overall, Nebraska's rates remained slightly higher but have tended to align more closely with U.S. rate.

Figure 26. Percentage of Kidney and Renal pelvis cancer Cases by Stage of Disease at Diagnosis in Nebraska, 2018 - 2022

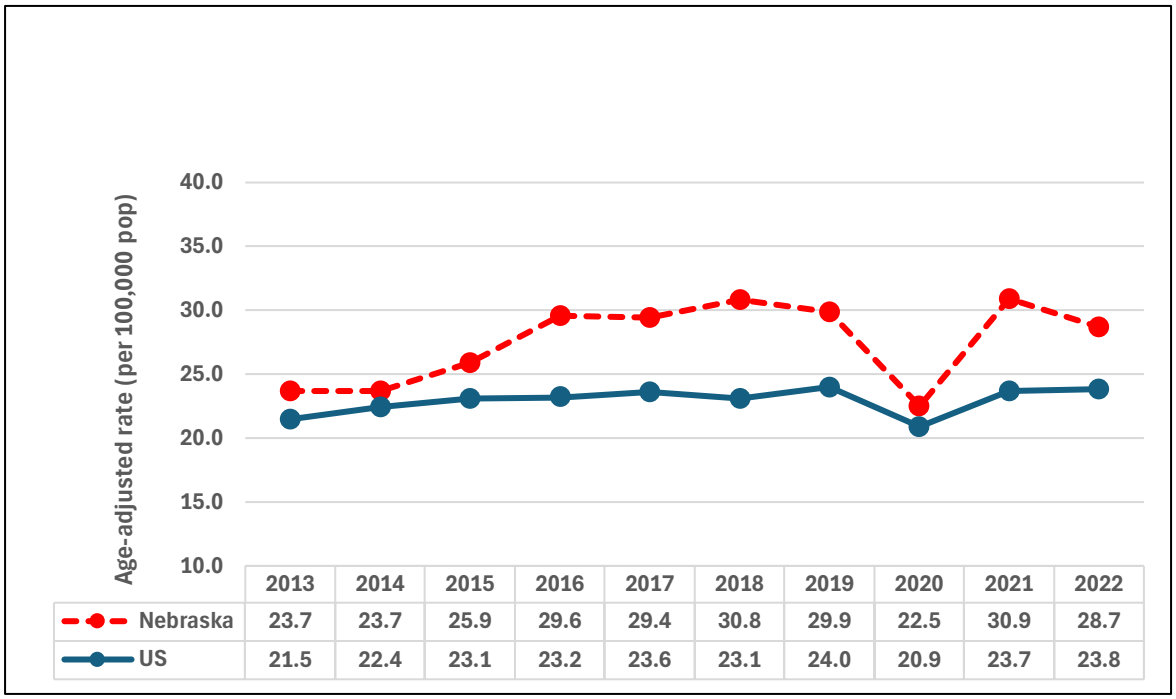


The majority of kidney and renal pelvis cancer cases in Nebraska are diagnosed at the localized stage, comprising 64% of cases. Regional stage diagnoses account for 18%, while distant stage cases represent 11%. A small percentage of cases are unstaged at 5%, and only 2% are diagnosed in situ. This indicates that most cases are detected relatively early. Early detection at localized stages may contribute to better treatment outcomes.

Melanoma of the Skin

There are several different types of skin cancer, but melanomas are the most serious. Nationally, melanomas comprise about 1% of all skin cancer diagnoses but the vast majority of skin cancer deaths. In Nebraska, melanomas of the skin accounted for 3,152 diagnoses and 285 deaths between 2018 and 2022. The incidence of melanoma continues to increase significantly in Nebraska and throughout the United States. Because most melanomas are discovered early in their development and can be surgically removed, the relative five-year survival rate is now 94.6%.

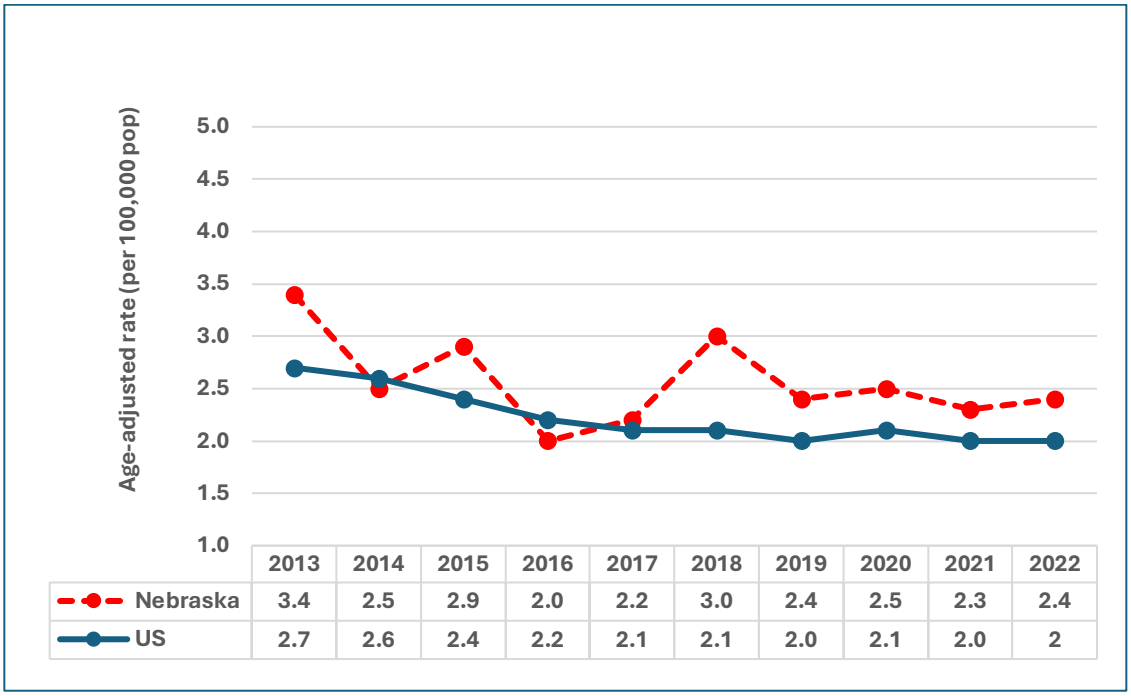
Figure 27. Age-Adjusted Incidence Rates for Melanoma of Skin Cancer in Nebraska vs US, 2013 - 2022



	2013	2014	2015	2016	2017	2018	2019	2020	2021	2022
Nebraska	23.7	23.7	25.9	29.6	29.4	30.8	29.9	22.5	30.9	28.7
US	21.5	22.4	23.1	23.2	23.6	23.1	24.0	20.9	23.7	23.8

Nebraska's incidence rates for melanoma of the skin generally increased from 2013 to 2022, though notable fluctuations occurred, including a drop around 2020. Nebraska's rates were consistently higher and more variable than the U.S. rates, which showed a more stable, modest upward trend over the same period.

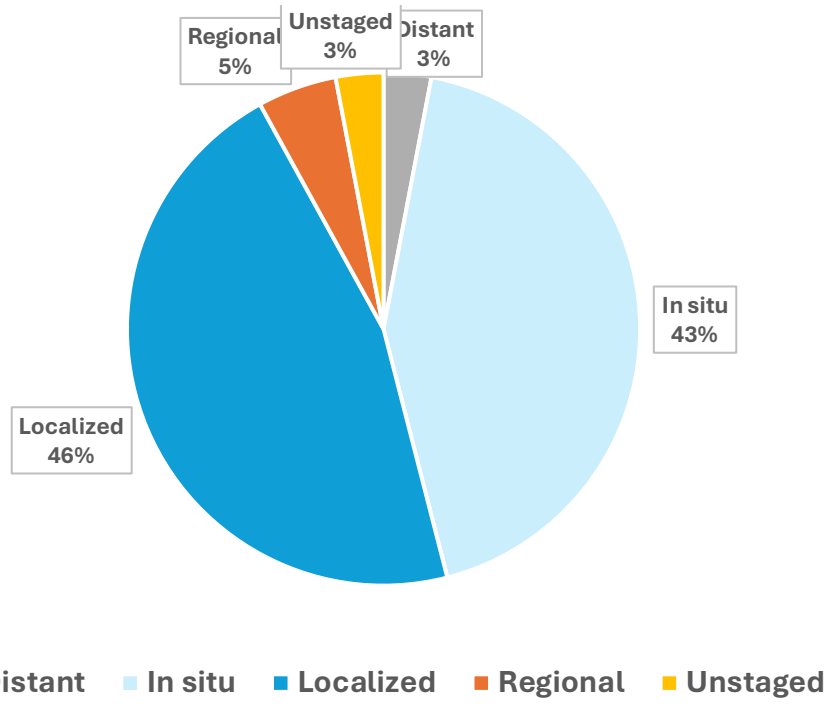
Figure 28. Age-Adjusted Mortality Rates for Melanoma of the Skin Cancer in Nebraska vs US, 2013 – 2022



	2013	2014	2015	2016	2017	2018	2019	2020	2021	2022
Nebraska	3.4	2.5	2.9	2.0	2.2	3.0	2.4	2.5	2.3	2.4
US	2.7	2.6	2.4	2.2	2.1	2.1	2.0	2.1	2.0	2

Nebraska's mortality rates for melanoma of the skin remained generally stable, with a slight decline from 2013 to 2022 and some year-to-year variability. Throughout this period, Nebraska's rates were consistently higher than U.S. rates with exception of 2014 and 2016.

Figure 29. Percentage of Melanoma of Skin Cancer Cases by Stage of Disease at Diagnosis in Nebraska, 2018 – 2022



The pie chart illustrates the stage at diagnosis for melanoma of the skin in Nebraska from 2018 to 2022. Close to half of the cases (46%) were diagnosed at the localized stage. In situ cases made up 43%, indicating early detection. Regional and distant stages accounted for only 5% and 3%, respectively. A small percentage (3%) of cases remained unstaged at diagnosis.
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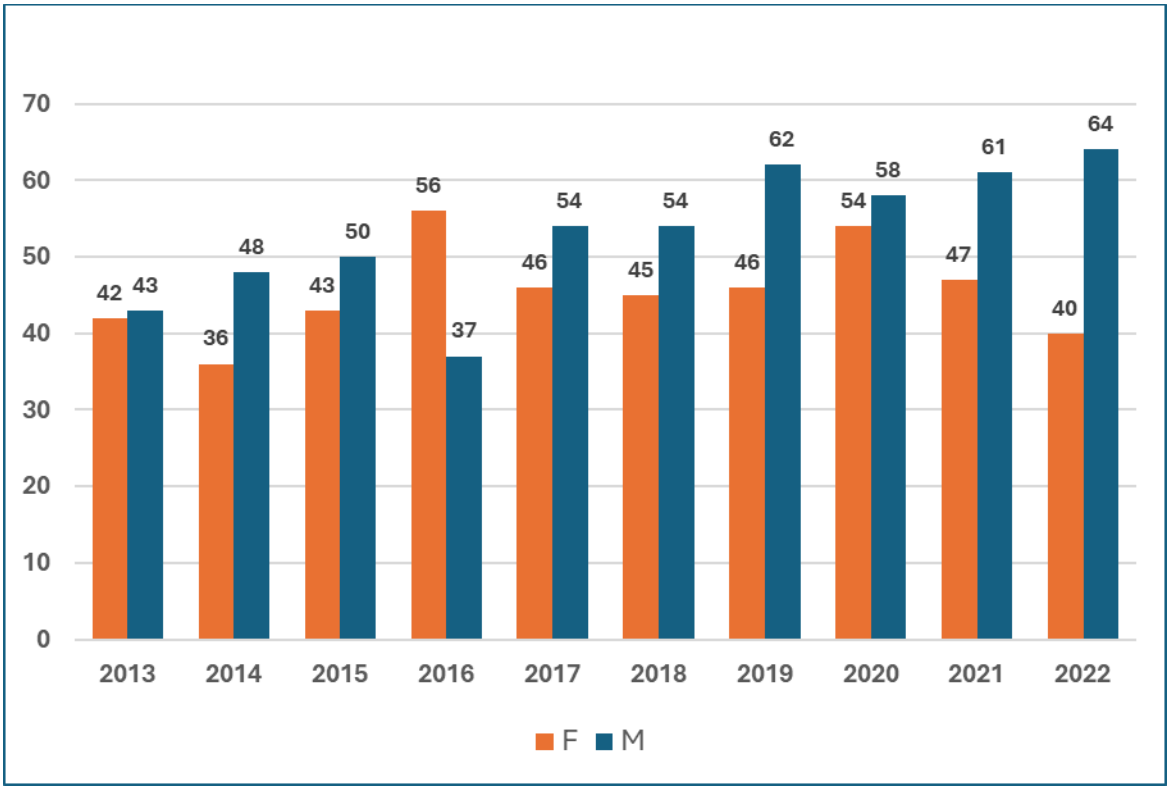
Early-onset colorectal cancer (EOCRC)

Early-onset colorectal cancer (EOCRC) defined as colorectal cancer diagnosed before age 50. EOCRC incidence has been increasing worldwide, with potential risk factors including genetic predisposition, obesity, and lifestyle choices. Symptoms can include rectal bleeding, abdominal pain, and changes in bowel habits, and early detection is crucial for better outcomes (Global Colon Cancer Association, 2025).

During the most recent past five years (2018–2022), EOCRC accounted for 533 new cases and 94 deaths among Nebraska residents, representing a 15.1% increase in incident cases and a 9.3% increase in deaths compared with the previous five-year period (2013-2017), which recorded 463 new cases and 86 deaths. The increase in incidence was primarily driven by males.

Figure 30. Early-Onset Colorectal Cancer Cases in Males and Females in Nebraska by Sex, 2013-2022



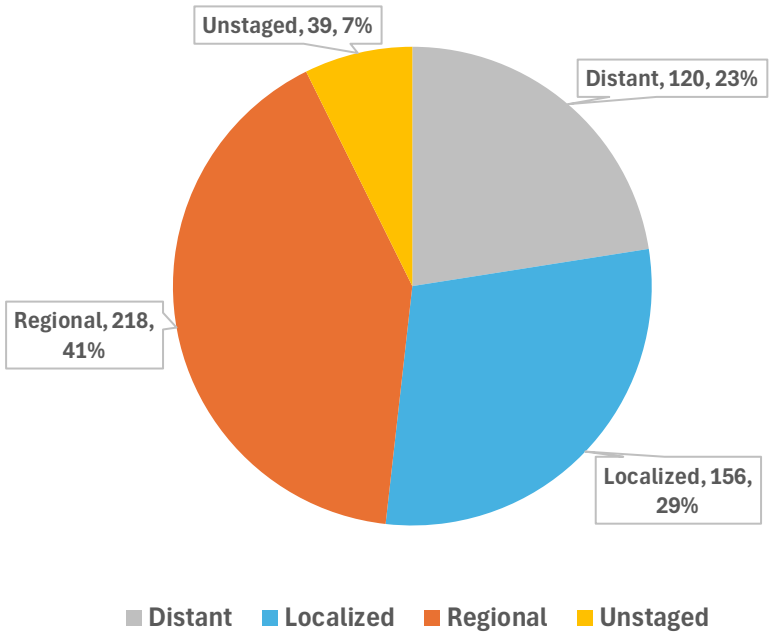
The bar chart displays EOCRC by sex in Nebraska from 2013 to 2022. In each year, more males (531) were diagnosed with EOCRC cases than females (455). Male cases ranged from 54 to 64 annually, while female cases varied between 40 and 54. The highest male incidence occurred in 2022, while female incidence peaked in 2020. This indicates a consistent sex disparity in diagnosis over the ten-year period.

TABLE 8. Percentage of increase in EOCRC Incident by Age Group and Sex from 2013 to 2017 vs 2018 to 2022, Nebraska

Age Group	Sex	EOCRC Cases (2013-2017)	EOCRC Cases (2018-2022)	% of increase
0-39	Male	74	105	41.9%
0-39	Female	95	100	5.3%
40-49	Male	158	194	22.8%
40-49	Female	128	132	3.1%

EOCRC cases increased across age groups and by sex from 2013–2017 to 2018–2022. Males accounted for the majority of the increase, with the largest rise observed among those aged 0–39 years (41.9%), followed by those aged 40–49 years (22.8%). In contrast, increases among females were modest: 5.3% for the 0–39 age group and 3.1% for the 40–49 age group.

Figure 31. Percentage of early Onset Colorectal Cancer Cases by Stage of Disease at Diagnosis in Nebraska, 2018 - 2022



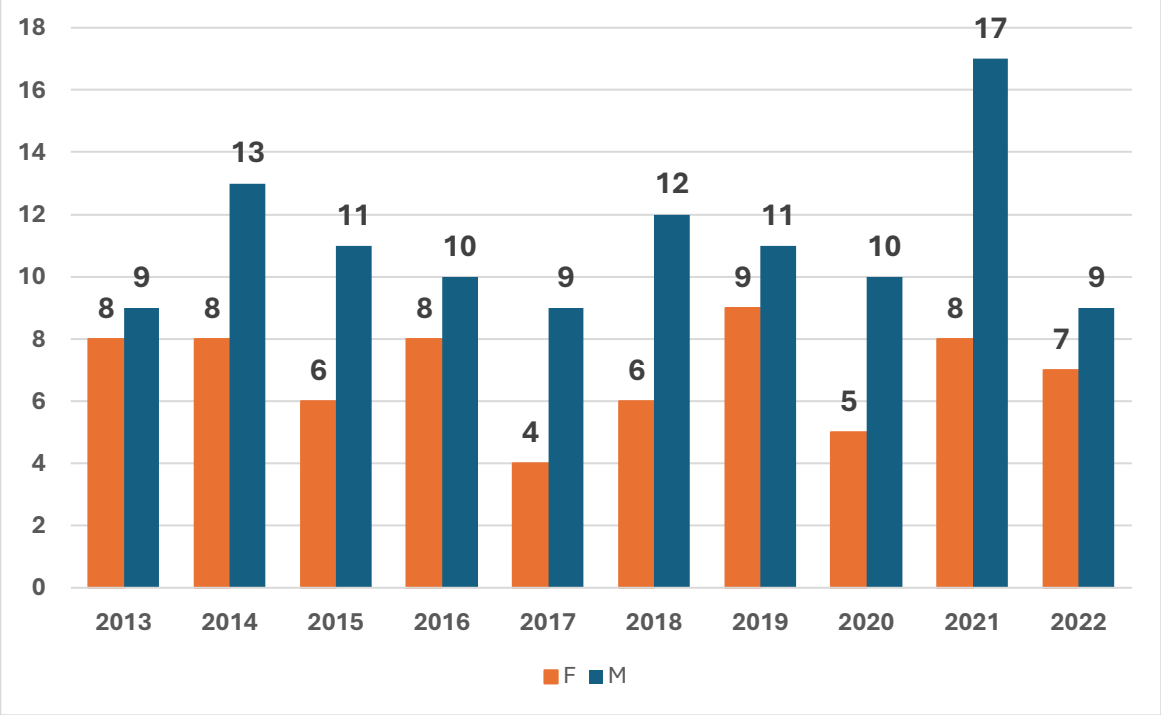
The pie chart shows the largest proportion of cases (41%) were diagnosed at the regional stage. Localized cases made up 29%, while 23% were detected at the distant stage. Unstaged cases accounted for 7%. This suggests many cases are identified at an advanced stage rather than early stage.

TABLE 9. Percentage Change of EOCRC Stage by Age Group 2013 to 2017 vs. 2018 to 2022, Nebraska

Age Group	Staging	% Stage (2013-2017)	%Stage (2018-2022)	% of increase or decrease
0-39	Unstaged	7.7%	7.2%	0.5% ↓
0-39	Localized	43.8%	31.9%	11.9% ↓
0-39	Regional	31.4%	40.6%	9.2% ↑
0-39	Distant	17.2%	20.3%	3.1% ↑
40-49	Unstaged	2.1%	7.4%	5.3% ↑
40-49	Localized	31.9%	27.6%	4.3% ↓
40-49	Regional	37.1%	41%	3.9% ↑
40-49	Distant	29%	23.9%	5.1% ↓

The distribution of EOCRC stages varied by age group over the years. Among individuals aged 0–39 years, cases at the localized stage declined by 11.9%, while cases at the regional and distant stages increased by 9.2% and 3.1%, respectively, from 2013–2017 compared with 2018–2022. In contrast, among those aged 40–49 years, cases at the localized and distant stages decreased by 4.3% and 5.1%, respectively, whereas cases at the regional stage increased by 3.9% over the same period.

Figure 32. Comparison of Early-Onset Colorectal Cancer Deaths in Males and Females in Nebraska, 2013-2022



Males consistently outnumbered females in EOCRC deaths from 2013 to 2022.

Figure 33. Early-Onset Colorectal Cancer Death Cases by Age Groups and Sex, Nebraska, 2018-2022

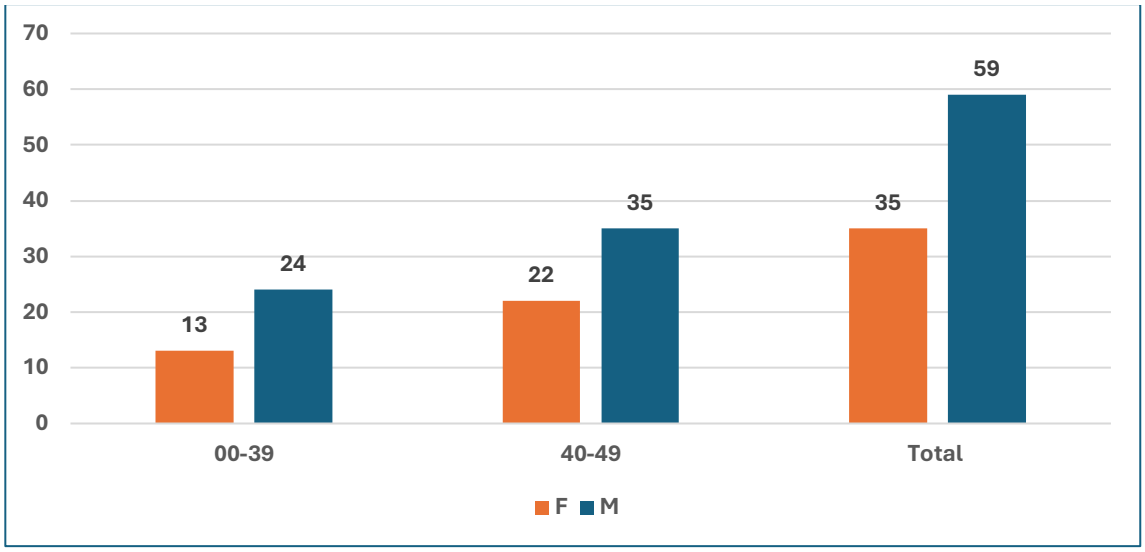
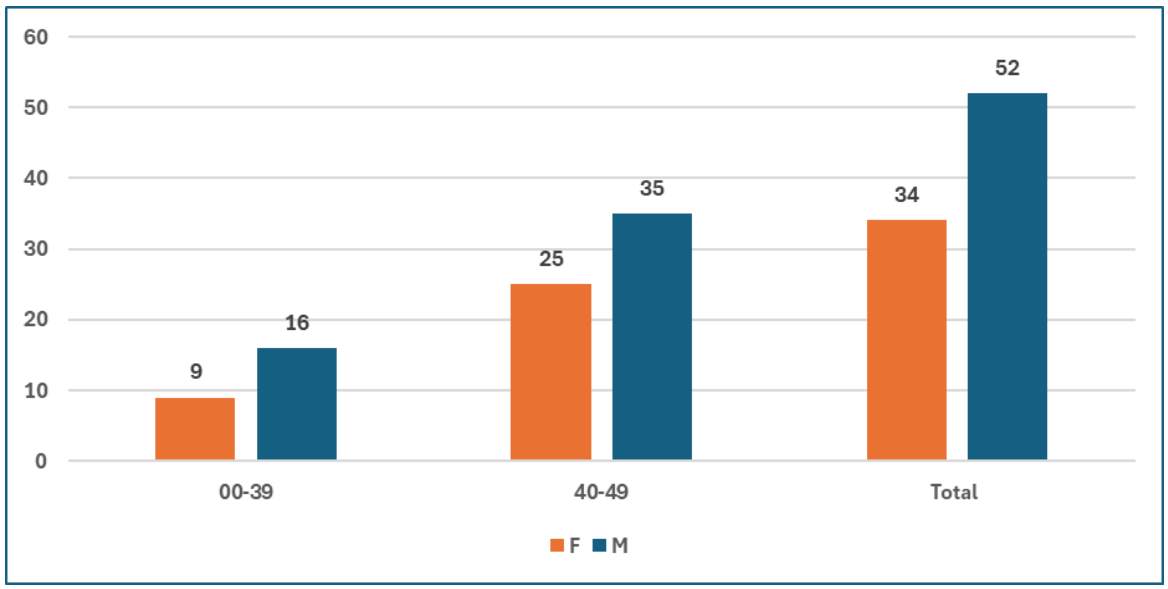


Figure 34. Early-Onset Colorectal Cancer Death Cases by Age Groups and Sex, Nebraska, 2013-2017



The Figure 33 and 34 shows that higher numbers of deaths occurred among males, particularly in the 40-49 age group, during 2018–2022 and 2013-2017.

REFERENCES

Early onset colorectal cancer: GCCA. Early onset colorectal cancer | GCCA. (2025).
https://www.globalcca.org/learn/early-onset-colorectal-cancer

U.S. Cancer Statistics Working Group. U.S. Cancer Statistics Data Visualizations Tool, based on
2020 submission data (1999-2018): U.S. Department of Health and Human Services, Centers for Disease Control and Prevention and National Cancer Institute; www.cdc.gov/cancer/dataviz, released in June 2021.

Centers for Disease Control and Prevention. (June 2025). USCS data visualizations - CDC. Centers for Disease Control and Prevention.
https://www.cdc.gov/cancer/dataviz

United States Cancer Statistics - Mortality Data: 1999-2022, WONDER Online Database. United States Department of Health and Human Services, Centers for Disease Control and Prevention.
2022. Available at: https://wonder.cdc.gov/wonder/help/cancer

REPORTING FACILITIES

Ainsworth--Brown County Hospital Albion--Boone County Health Center
Alliance--Box Butte General Hospital Alma--Harlan County Health System Atkinson--West Holt Memorial Hospital, Inc.
Auburn--Nemaha County Hospital
Aurora--Memorial Hospital
Bassett--Rock County Hospital Beatrice--Beatrice Community Hospital & Health Center, Inc.
Benkelman--Dundy County Hospital
Blair--Memorial Community Hospital Bridgeport--Morrill County Community Hospital
Broken Bow--Jennie Melham Memorial Medical Ctr. Callaway--Callaway District Hospital
Cambridge--Tri Valley Health System Central City--Litzenberg Memorial County Hospital Chadron--Chadron Community Hospital & Health Services
Columbus--Columbus Community Hospital, Inc.
Cozad--Cozad Community Hospital
Creighton--Creighton Area Health Services
Crete--Crete Area Medical Center
David City--Butler County Health Care Center
Fairbury--Jefferson Community Health Center, Inc.
Falls City--Community Medical Center, Inc.
Franklin--Franklin County Memorial Hospital
Fremont--Fremont Area Medical Center
Friend--Warren Memorial Hospital
Geneva--Fillmore County Hospital
Genoa--Genoa Community Hospital/LTC
Gordon--Gordon Memorial Hospital District
Gothenburg--Gothenburg Memorial Hospital
Grand Island--CHI Health St. Francis
Grant--Perkins County Health Services
Hastings--Mary Lanning Memorial Hospital
Hebron--Thayer County Health Services
Henderson--Henderson Health Care Services
Holdrege--Phelps Memorial Health Center

Imperial--Chase County Community Hospital
Kearney--CHI Health Good Samaritan
Kearney--CHI Health Good Samaritan Pathology
Kimball--Kimball Health Services & Hospital
Lexington--Tri-County Area Hospital District
Lincoln--Bryan-LGH Medical Center East & West
Lincoln--CHI Health Saint Elizabeth
Lincoln--Pathology Medical Services
Lincoln--Williamsburg Radiation Center
Lincoln--CHI Health Nebraska Heart Lincoln--UNMC College of Dentistry
Lynch--Niobrara Valley Hospital Corp. McCook--Community Hospital
Minden--Kearney County Health Services
Nebraska City--CHI Health St. Mary's
Neligh--Antelope Memorial Hospital
Norfolk--Faith Regional Health Services East & West North Platte--Great Plains Regional Medical Center
North Platte--Pathology Services
Oakland--Oakland Memorial Hospital
Ogallala--Ogallala Community Hospital
Omaha--CHI Health Bergan Mercy
Omaha--CHI Health Immanuel Omaha--Children's Hospital
Omaha--VA Nebraska-Western Iowa Health Care System
Omaha--Methodist Hospital Pathology Center
Omaha--Nebraska Medical Center
Omaha--Nebraska Methodist Hospital Omaha--CHI Health Creighton University Med. Ctr.
Omaha--Boys Town National Research Hospital
Omaha--CHI Health Lakeside
Omaha--CHI Health Bergan Mercy Pathology
Omaha--Bishop Clarkson Hospital Pathology
Omaha--Creighton Pathology Associates
Omaha--Physicians Lab
O'Neill--Avera St. Anthony's Hospital
Ord--Valley County Hospital
Osceola--Annie Jeffrey Memorial County Health Ctr.
Oshkosh--Garden County Health Services
Osmond--Osmond General Hospital
Papillion--CHI Health Midlands
Pawnee City--Pawnee County Memorial Hospital
Pender--Pender Community Hospital
Plainview--CHI Health Plainview
Red Cloud--Webster County Community Hospital
Schuyler--CHI Health Schuyler
Scottsbluff--Regional West Medical Center
Scottsbluff--Western Pathology Consultants
Seward--Memorial Hospital
Sidney--Memorial Health Center
St. Paul--Howard County Community Hospital
Superior--Brodstone Memorial Hospital
Syracuse--Community Memorial Hospital
Tecumseh--Johnson County Hospital
Tilden--Tilden Community Hospital
Valentine--Cherry County Hospital
Wahoo--Saunders County Health Services
Wayne--Providence Medical Center
West Point--St. Francis Memorial Hospital
Winnebago--USPHS Indian Hospital
York--York General Hospital

Other States:
Sioux City, IA--Mercy Medical Center

State cancer registries participating in the National Interstate Data Exchange Agreement, and the state cancer registries of Illinois, Kansas, Minnesota, Missouri, and South Dakota.

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