



**Alberta Health
Services**

The 2017 Report on Cancer Statistics in Alberta

Appendix

Surveillance & Reporting

CancerControl AB

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Table of Contents

Appendix 1: Glossary of Terms	4
Appendix 2: Cancer Definitions	6
Appendix 3: Data Notes	7
Data Sources	7
Data Quality	7
Methods and Limitations	8
2011 Canadian Standard Population	12
References	13
Contact Information	15

Appendix 1: Glossary of Terms

Age-specific rate:

The number of new cancer cases or cancer deaths per 100,000 people per year within a given age group.

Age-standardized (incidence/mortality) rate:

A weighted average of age-specific rates using weights based on a standard population age distribution. It reflects the overall rate that would be expected if the population of interest had an age structure identical to the standard population and is used to compare cancer rates among populations or identify trends over time.

Benign tumour:

A tumour that is non-cancerous and does not spread to other parts of the body.

Carcinoma:

A tumour that begins in the skin or in tissues that line or cover body organs.

Childhood cancer:

Cancers diagnosed or cancer deaths in children aged 0-14 years old.

Confidence interval:

An indication of the precision of an estimate. A wide confidence interval indicates less precision and vice-versa.

Count:

The number of cases (primaries) or deaths in a given time period.

Incidence count:

The number of new cancer cases during a period of time; often the number of new invasive cases diagnosed in a year. One patient may have multiple primary cancers.

Initial Treatment:

The initial treatment is the treatment given as a result of the patient's initial consult with an

oncologist or medical specialist for a particular cancer at the time of diagnosis.

Invasive cancer:

Cancer with a potential to spread beyond its point of origin. Sometimes referred to as malignant cancer.

Life table:

A life table presents the estimates of the likelihood of dying before the next birthday, for each year of age. From this starting point, a number of statistics can be derived and thus also included in the table: a) the probability of surviving any particular year of age; b) remaining life expectancy for people at different ages; and c) the proportion of the original birth cohort still alive. They are usually constructed separately for males and females because of their substantially different mortality rates.

Lymphatic system:

A system of vessels that carry lymph between lymph nodes located throughout the body.

Malignant tumour:

A tumour that invades and destroys surrounding tissues that may spread elsewhere in the body, and is likely to recur after removal; a cancerous tumour.

Median Age:

The age at which half of the population is older and half is younger¹.

Metastasis:

The spread of the original tumour to other parts of the body.

Mortality count:

The number of deaths due to cancer during a period of time.

Observed Survival:

The proportion of people with a particular cancer who are alive after a given length of time calculated from the cohort of cancer cases².

Primary Site of Cancer:

The tissue or organ in which the cancer originates³.

Probability of developing/dying of cancer:

The risk of an individual in a given age range developing/dying of cancer in a given time period, and is conditional on the person being cancer-free prior to the beginning of that age range.

Prognosis:

The likely outcome or course of a disease; the chance of recovery or recurrence.

Projection:

An estimate of cancer incidence or mortality in the future⁴.

Rate:

The number of cases or deaths occurring in a specified time period in a population at risk.

Relative survival:

The survival of cancer patients relative to that of the general population⁵. It is the ratio of observed survival in a group of cancer patients relative to the expected survival of a similar group of people in the general public, matched by age and sex.

Stage of cancer:

The degree of cancer progression and the size of tumor at the time of diagnosis. If the cancer has spread, the stage describes how far it has spread from the original site to other parts of the body.¹

Statistical Significance:

Describes a mathematical measure of difference between groups. The difference is said to be statistically significant if it is greater than what might be expected to happen by chance alone 95% of the time. Although statistically significant usually refers to 95% confidence, sometimes other confidence levels such as 99% or 90% are specified.¹

Surveillance:

Surveillance includes the collection of data, and the review, analysis and dissemination of findings on cancer incidence (new cases), prevalence, morbidity, survival and mortality. Surveillance also serves to collect information on the knowledge, attitudes and behaviours of the public with respect to practices that prevent cancer, facilitate screening, extend survival and improve quality of life.

Survival - Cohort method:

The cohort method provides survival estimates of cases having complete follow-up for the number of years of survival of interest.⁵

Survival - Period analysis:

The period method provides up-to-date population-based survival estimates of recently diagnosed cases considering the survival experience of the most recent cases that completed follow-up for the number of years of interest, allowing for the estimation of survival of the most recent period.⁶

Three-year moving average:

Three-year moving averages are calculated based on aggregating three years of data. They are used to smooth out year-to-year fluctuations in age-standardized rates so that the underlying trend may be more easily observed.

Tumour:

An abnormal mass of tissue that is not inflammatory, arises without obvious cause from cells of pre-existent tissue, and possesses no physiologic function.

Appendix 2: Cancer Definitions

Cancer	ICD-O-3 Site/Histology Type* (Incidence)	ICD-10 (Mortality)
Oral	C00–C14	C00–C14
Esophagus	C15	C15
Stomach	C16	C16
Colorectal	C18–C20, C26.0	C18–C20, C26.0
Liver	C22.0	C22.0, C22.2–C22.7
Pancreas	C25	C25
Larynx	C32	C32
Lung	C34	C34
Melanoma	C44 (Type 8720–8790)	C43
Breast	C50	C50
Cervix	C53	C53
Body of Uterus	C54–C55	C54–C55
Ovary	C56.9	C56
Prostate	C61.9	C61
Testis	C62	C62
Bladder (including <i>in situ</i>)	C67	C67
Kidney	C64.9, C65.9	C64–C65
Brain	C70–C72	C70–C72
Thyroid	C73.9	C73
Hodgkin Lymphoma*	Type 9650–9667	C81
Non-Hodgkin Lymphoma*	Type 9590–9597, 9670–9719, 9724–9729, 9735, 9737–9738 Type 9811–9818, 9823, 9827, 9837, all sites except C42.0,.1,.4	C82–C85, C96.3
Multiple Myeloma*	Type 9731, 9732, 9734	C90.0, C90.2
Leukemia*	Type 9733, 9742, 9800–9801, 9805–9809, 9820, 9826, 9831–9836, 9840, 9860–9861, 9863, 9865–9867, 9869–9876, 9891, 9895–9898, 9910–9911, 9920, 9930–9931, 9940, 9945–9946, 9948, 9963–9964 Type 9811–9818, 9823, 9827 and 9837 sites C42.0,.1,.4	C91–C95, C90.1
All Other Cancers	All sites C00–C80 and C97 not listed above (excluding non-melanoma skin cancer)	All sites C00–C80 and C97 not listed above
All Cancers	All invasive sites	All invasive sites

* Histology types 9590–9992 (leukemia, lymphoma and multiple myeloma), 9050–9055 (mesothelioma) and 9140 (Kaposi Sarcoma) are excluded from other specific organ sites.

Only invasive cancers were included in the incidence analysis except bladder.

Basal and squamous skin cancers were excluded from incidence analysis, but included in the mortality analysis.

ICD-O-3 refers to the *International Classification of Diseases for Oncology, 3rd Edition*.⁷

ICD-10 refers to the *International Statistical Classification of Diseases and Related Health Problems, 10th Edition*.⁸

Appendix 3: Data Notes

Data Sources

- Cancer incidence and mortality data were obtained from the Alberta Cancer Registry (ACR), while population data were obtained from Alberta Health (AH).
- Canadian incidence and mortality rates and projections data were obtained from the Canadian Cancer Society (CCS) through the Chronic Disease Surveillance and Monitoring Division, Public Health Agency of Canada and through their annual Canadian Cancer Statistics 2016 publication.⁹
- Other data sources that contributed to this report are causes of death data from Health Status Assessment with data obtained from Alberta Vital Statistics, Service Alberta; and Canadian life table from Statistics Canada.

Detailed data sources by type of analysis can be found in the *Methods and Limitations* section below.

Data Quality

Most of the data presented within this report are derived from the Alberta Cancer Registry (ACR). The ACR is responsible for recording and maintaining data on all new primary cancers, as well as all cancer deaths occurring within the province of Alberta, as mandated by the Regional Health Authorities (RHA) Act of Alberta.¹⁰

The quality of data collected by any registry is evaluated based on three factors: comparability, completeness and validity.

Firstly, comparability is accomplished by applying standard practices regarding classification and coding of new cases and by using consistent definitions, such as the coding of multiple primaries. To allow for comparability, the ACR employs the International Classification of Diseases for Oncology (ICD-O-2 for 1987-2000 data and ICD-O-3 for 2001 onwards) to classify all cancers by site and morphology. For this report, ICD-O-2 cases were converted to ICD-O-3, therefore applying the same site definitions across the period 1994-2014. Cancer deaths are coded using the International Classification of Diseases and Related Health Problems (ICD-9 for 1987-2000 data and ICD-10 for 2001 onwards). The Surveillance, Epidemiology and End Results (SEER) coding rules are used for the definition of multiple primaries.¹¹ Collaborative staging rules were used to stage the cancers.¹²

Cancer death numbers in this report are based on coder cause of death information in the Alberta Cancer Registry; this may slightly vary from the Alberta Vitals Statistics official cause of death (when more information is available to the Alberta Cancer Registry).

Childhood cancer is classified using the International Classification of Childhood Cancers (ICCC), 3rd Edition.¹³ ICCC classification is based on tumour morphology and cancer site with more emphasis on morphology.

Secondly, completeness refers to the extent to which all the newly diagnosed cancers among Albertan residents are accurately captured by the ACR. The ACR is notified of new cancers by doctors and laboratories throughout the province, who are mandated to report such information. Cancer-related deaths are recorded and validated by the ACR using registry and Alberta Vital Statistics information. Over the years, the ACR has achieved a completeness of over 95%.¹⁴

Lastly, validity depends on the availability of validated rules and the level of expertise in the abstracting, coding and recording of data within a registry, according to these rules. The ACR has numerous data edits to ensure all information is input as accurately as possible. For example, date of diagnosis of cancer

must be after the date of birth. There are additional data quality reviews performed on ACR data by the Canadian Cancer Registry and the North American Association of Central Cancer Registries (NAACCR). For many years, the Alberta Cancer Registry has been certified by NAACCR and has achieved a Gold Standard for completeness of the data, timely reporting and other measures that judge data quality.

Confidentiality and security of personal and health information are protected by the Alberta Health Information Act (HIA), Regional Health Authorities Act (RHA), and Freedom of Information and Protection of Privacy Act (FOIP). The Alberta Cancer Registry maintains the trust of the public, government and data providers by ensuring rigorous security and privacy practices/procedures are enforced relative to all collection, access, use and disclosure processes specific to the Cancer Registry database. Formal policies in accordance with HIA, RHA and FOIP legislations are available on the AHS website, from AHS Privacy at privacy@ahs.ca or on request from the Alberta Cancer Registry.

By recording information on cancer cases and cancer-related deaths over the past few decades, the Alberta Cancer Registry has been able to compare cancer statistics in Alberta with other provinces and countries. The Registry also provides information to health care stakeholders throughout the province so that they can plan effective prevention, treatment and research programs.

Methods and Limitations

In this dashboard, the term “cancer” refers to invasive cancers unless otherwise specified. It is important to note that the dashboard contains both actual and estimated data; distinctions are made where applicable. The numbers published in this report should be considered provisional, as a few cases and deaths may be registered in subsequent years. The data in this report reflect the state of the Alberta Cancer Registry as of July 4, 2016.

Incidence rates and counts presented in this dashboard exclude basal and squamous skin cancers. Although approximately 30% of the malignant cancers diagnosed among Albertans each year are basal and squamous skin cancers, these tumours are generally not life-threatening and are inconsistently reported and coded across registries; therefore basal and squamous skin cancers are rarely included in cancer registry reports. Actual data in this report cover the period from 1994 to 2014, while short-term projections cover the period from 2014 to 2019.

Analysis	Data Sources	Notes
Demography	Alberta Cancer Registry, Analytics, Alberta Health Services;	<p>The population estimates are available from the Alberta Health Services Patient/Care Based Funding Population database, and are derived from the Provincial Registry data using the Alberta Health Population Projections.</p> <p>The changes due to an aging population, population growth and change in cancer rate were calculated in Canproj R-package⁴ using the projected age-specific rates and population sizes.</p>
Probability of Developing/ Dying from Cancer	Alberta Cancer Registry, Alberta Health Services; Alberta Health	<p>Probability of developing or dying of cancer was estimated using DevCan software version 6.7.3 published by the National Cancer Institute in the USA.¹⁵ DevCan uses incidence and mortality counts to calculate incidence and mortality rates using population estimates from census data for these areas and then converts these rates to the probabilities of developing or dying from cancer for a hypothetical population relatable to Alberta.^{16,17}</p> <p>The probability of developing or dying from cancer for an individual in a given age range is conditional on the person being cancer-free prior to the beginning of that age range.</p> <p>Specific probabilities that are less than 1 in 10,000 are not reported.</p>
New Cases and Deaths	Alberta Cancer Registry, Alberta Health Services	The new cases and deaths bar charts include cancer sites whose count of new cases or deaths greater than 15 cases. Those with a count of less than 15 are suppressed.
Incidence and Mortality	Alberta Cancer Registry, Analytics, Alberta Health Services; Statistics Canada	Age Standardized Rate (per 100,000) is a weighted average of age-specific rates, where the weights are the proportion of persons in the corresponding age groups of the 2011 Canadian Standard Population representing a 21-year period from 1994-2014. Age Standardized Rates are presented as three year moving averages, which are calculated by averaging the age-specific rates over three years before applying standard population weights. Statistical significance of the trends was determined by using Joinpoint ¹⁸ . Joinpoint models are based on actual yearly age standardized rates; hence there may be slight differences in the rates presented in the text (from Joinpoint model) and the graphs (where ASIRs and ASMRs are shown as three-year moving averages). Age-specific rates are crude rates for each five-year age group.
Projections	Alberta Cancer Registry, Alberta Health Services; Public Health Agency of Canada; Statistics Canada	<p>Alberta six-year projections (2014-2019) are provided for incidence and mortality rates and counts using the Canproj⁴ R-package, version 1, which contains 9 projection models. In general, the choice of projection model was based on the age, period, and/or cohort analysis for each cancer type by sex, and automatically performed in Canproj software. Based on validation analysis, however, the age-specific period trends model was selected for prostate cancer incidence projection.</p> <p>Canada incidence rates are single-year rates provided by the Canadian Cancer Society⁹ and are estimated by the Public Health Agency of Canada using the Nordpred method, which is an age, period and cohort projection model.²⁰ Both Canada incidence rates and mortality rates are projected for the years 2014 to 2016.</p>

		Caution should be exercised when comparing Alberta and Canada rates.
Geographic Variation in Incidence and Mortality	Alberta Cancer Registry, Analytics, Alberta Health Services; Statistics Canada	Age-standardized rates (ASRs), standardized to the 2011 Canadian Standard Population, for 2010 - 2014 are calculated for each zone and the rest of Alberta (excluding the zone of interest). The residence in the zones is determined from the postal code of residence at diagnosis/death. Evidence of a difference between zonal rates, the rest of Alberta rates and the provincial rate were interpreted based on comparisons between the confidence intervals of the rates in the zones, the rests of Alberta and the province. ²¹
Stage	Alberta Cancer Registry, Analytics, Alberta Health Services; Statistics Canada	The Alberta Cancer Registry started to collect the information on stage at diagnosis in 2004 using the collaborative staging system which is based on the AJCC (American Joint Committee on Cancer) Cancer Staging Manual. ¹⁹ The ASIRs by stage and the age-standardized RSRs by stage are calculated using stage generated by the AJCC 6 th Edition.
Relative Survival	Alberta Cancer Registry, Alberta Health Services; Statistics Canada	Relative survival ratios (RSRs) are standardized by the age structure in the standard cancer population (i.e. all persons who were diagnosed with that cancer in Canada between 1994 and 2014) to permit RSRs to be compared over time, independent of differences in age distribution of cancer cases. RSRs for cohorts 1994-1996, 2000-2002 and 2006-2008 are estimated by the cohort method ⁷ where complete follow-up data (i.e. at least five years of follow-up to estimate five-year ratio) after diagnosis are available. For recently diagnosed cases (cohort 2012-2014), whose complete follow-up data are not available, the up-to-date estimates are computed using the period method ⁶ . Comparison between cohort and period RSRs should be interpreted with caution because of the two different methods used to derive the respective ratios.
Treatment	Alberta Cancer Registry, Alberta Health Services	The Alberta Cancer Registry collects initially planned treatment to the primary site only for all cases diagnosed in Alberta. If part of the planned treatment is giving additional treatment at a later time, this is also recorded. The initial treatment given is the result of the patient's consult with an oncologist or medical specialist at the time of diagnosis. The treatment information that is presented in this report is only for the initial treatment.
Childhood Cancers	Alberta Cancer Registry, Analytics, Alberta Health Services; Statistics Canada	Childhood cancers are defined as invasive cancers diagnosed and cancer deaths that affect children up to and including the age of 14, and are classified according to the International Classification of Childhood Cancer, 3rd Edition. ¹³ As with adults, the classification of childhood cancer is based on both tumor morphology and cancer site. However, greater emphasis is placed on morphology rather than site, as compared to adults where greater emphasis is placed on site. Age-standardized rates (ASRs) are calculated using the 2011 Canadian Standard Population for ages 0 - 14 years and are expressed as rates per 1,000,000.

		Observed survival proportions for childhood cancer for all the cohorts (1995-1999, 2000-2004 and 2005-2009) are estimated by cohort method, where complete follow-up data are available.
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2011 Canadian Standard Population

The age-standardized cancer incidence and mortality rates in the 2017 Report on Cancer Statistics in Alberta are approximately 30% higher in comparison to the previous reports due to a change in the reference population used. In this report, the reference population for calculating age-standardized cancer incidence and mortality rates was changed to the 2011 Canadian Standard Population from the 1991 Canadian Standard Population used in previous years' cancer statistics reports, as has been done by Statistics Canada and other national reporting organizations. The increase in rates does not reflect an increase in the burden of Alberta cancers; the number of cancer cases has not been affected by the change in standard population. Because cancer is more likely to be diagnosed in older people, and the proportion of older people is greater in the 2011 Canadian Standard Population than it was in the 1991 Canadian Standard Population, rates will appear higher. A technical explanation for the increase in age-standardized rates caused by the change of reference population is available in "The 2014 Cancer System Performance Report" (see pages 136 – 137, and Figures 8.ii and 8.iii) by the Canadian Partnership against Cancer (CPAC) at

http://www.cancerview.ca/idc/groups/public/documents/webcontent/sp_report_2014.pdf

or <http://www.systemperformance.ca/reports/>.

Age Group	Population (per 100,000)	Weights (%)
0-4	5529.7	5.5
5-9	5271.7	5.3
10-14	5585.3	5.6
15-19	6519.4	6.5
20-24	6855.5	6.9
25-29	6900.6	6.9
30-34	6778.6	6.8
35-39	6618.8	6.6
40-44	6947.4	6.9
45-49	7919.9	7.9
50-54	7836.5	7.8
55-59	6851.8	6.9
60-64	5970.5	6.0
65-69	4463.6	4.5
70-74	3359.7	3.4
75-79	2676.9	2.7
80-84	2041.6	2.0
85+	1872.5	1.9
Total	100,000	100

References

1. National Cancer Institute - Surveillance Epidemiology and End Results [Internet]. USA National Institutes of Health. Glossary of Statistical Terms; 2017 Jan 23[cited 2017 Jan 23]; Available from: <http://seer.cancer.gov/cgi-bin/glossary/glossary.pl>
2. Canadian Cancer Society's Steering Committee: Canadian Cancer Statistics 2010. Toronto, Canada: Canadian Cancer Society, 2010.
3. Cancer Surveillance, Alberta Cancer Board. Annual Report on Cancer Statistics 2005. Edmonton, Canada: Alberta Cancer Registry, 2008.
4. Qiu Z. Canproj - The R package of cancer projection methods based on generalized linear models for age, period, and/or cohort, User's Manual, Version 1. Technique Report for Cancer Projections Network (C-Proj), Canadian Partnership Against Cancer (CPAC); Alberta Health Services: 2013-02-16.
5. Ederer F, Axtell LM and Cutler SJ. The relative survival rate: a statistical methodology. Natl Cancer Inst Monogr, 1961; 6: 101–121.
6. Brenner H, Gefeller O and Hakulinen T. Period analysis for 'up-to-date' cancer survival data: theory, empirical evaluation, computational realisation and applications. European Journal of Cancer, 2004; 40: 326–335.
7. Fritz A, Jack A and Parkin DM et al. editors. International Classification of Diseases for Oncology. Third Edition. Geneva, Switzerland: World Health Organization, 2000.
8. World Health Organization. International Statistical Classification of Diseases and Related Health Problems, Tenth Revision, Volume 1. Geneva, Switzerland: World Health Organization, 1992.
9. Canadian Cancer Society's Steering Committee. Canadian Cancer Statistics 2016. Toronto, Canada: Canadian Cancer Society; 2016.
10. Regional Health Authorities Act, Cancer Registry Regulation, Alberta Regulation. 71/2009.
11. Johnson CH, Peace S, Adamo P, Fritz A, Percy-Laurry A and Edwards BK. The 2007 Multiple Primary and Histology Coding Rules. National Cancer Institute, Surveillance, Epidemiology and End Results Program. Bethesda, MD, 2007.
12. Collaborative Staging Task Force of the American Joint Committee on Cancer. Collaborative Staging Manual and Coding Instructions, version 1.0. Jointly published by American Joint Committee on Cancer (Chicago, IL) and U.S. Department of Health and Human Services (Bethesda, MD), 2004. NIH Publication Number 04-5496.
13. Steliarova-Foucher E, Stiller C, Lacour B and Kaatsch P. International Classification of Childhood Cancer. Third Edition. Cancer, 2005; 103: 1457–1467.

14. North American Association of Central Cancer Registries Certification [Internet]. USA North American Association of Central Cancer Registries; c2016. Canadian Registries Certified in 2016 for 2013 Incidence Data; 2017 [cited 2017 Jan 23]; Available from: <http://www.naaccr.org/Certification/Cert2013.aspx>
15. National Cancer Institute - Surveillance Epidemiology and End Results [Internet]. USA National Institutes of Health.DevCan - Probability of Developing or Dying of Cancer; 2016 Jul 10 [cited 2017 Jan 23]; Available from: <http://surveillance.cancer.gov/devcan/>
16. Fay MP, Pfeiffer R, Cronin KA, Le C and Feuer EJ. Age-conditional probabilities of developing cancer. *Stat Med*. 2003; 22(11):1837-1848.
17. Fay MP. Estimating age conditional probability of developing disease from surveillance data. *Popul Health Metr*; 2004 ; 2(1): 6.
18. Kim H-J, Fay M and Feuer E. Permutation tests for Joinpoint regression with applications to cancer rates. *Stat Med*, 2000; 19: 335-351.
19. Greene FL, Page DL, Fleming ID, Fritz AG, Balch CM, Haller DG and Morrow M (Eds). *AJCC Cancer Staging Manual*, 6th ed. Chicago: American Joint Committee on Cancer, 2002. Available from <https://cancerstaging.org/references-tools/deskreferences/Documents/AJCC6thEdCancerStagingManualPart1.pdf>
20. Møller B, Fekjær H and Hakulinen T et al. Prediction of cancer incidence in the Nordic countries: empirical comparison of difference approaches. *Stat Med*, 2003; 22: 2751-2766.
21. Fay MP and Feuer EJ. Confidence intervals for directly standardized rates: a method based on the gamma distribution. *Stat Med*, 1997; 16: 791 – 801.

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