## Cancer Incidence by Deprivation England, 1995-2004

## Contents

## Introduction

Page 3 Introduction

## Site specific tables

Page 6 C00-C97 excl. C44: All malignant neoplasms excl. non-melanoma skin cancer
Page 7 C00-C14 \& C30-C32: Head and neck
Page $8 \quad$ C15: Oesophagus
Page 9 C16: Stomach
Page 10 C18-C20: Colorectum
Page 11 C22: Liver
Page 12 C25: Pancreas
Page 13 C33-C34: Trachea, bronchus and lung
Page 14 C40-C41: Bone and articular cartilage
Page 15 C43: Malignant melanoma of skin
Page 16 C45: Mesothelioma
Page 17 C50: Breast
Page 18 C53: Cervix uteri
Page 19 C54: Corpus Uteri
Page 20 C56: Ovary
Page 21 C61: Prostate
Page 22 C62: Testis
Page 23 C64-C66 \& C68: Kidney and other and unspecified urinary organs
Page 24 C67: Bladder
Page 25 C70-C72: Brain, and other parts of central nervous system
Page 26 C81: Hodgkin disease
Page 27 C82-C85 \& C96: Non-Hodgkin lymphoma
Page 28 C88-C90: Myeloma
Page 29 C91-C95: Leukaemia

Page 30 NCIN core objectives, notes and methodology
Page 31 Glossary

## Introduction

One of the key goals of the Cancer Reform Strategy ${ }^{1}$ is to reduce inequalities in the incidence of cancer in England. The Strategy sets out a number of actions, within a new National Cancer Equality Initiative, designed to achieve this objective. Inequalities in cancer incidence in relation to socio-economic deprivation are one of the major concerns as it is known that risk factors for cancer, especially smoking, are strongly influenced by socio-economic determinants. This report aims to provide a set of summary statistics describing the relationship between the incidence of the most common types of cancer in relation to socio-economic deprivation within England. Previous such analyses have been carried out by the Office for National Statistics, for England and Wales, based on incidence rates in 1992-93² and in 1990-2002 ${ }^{3}$ although the latter report was restricted to breast, prostate and lung cancers, and also by the North West Cancer Intelligence Service and other members of the United Kingdom Association of Cancer Registries examining incidence by deprivation for 1998-2003 for breast, lung and cervical cancers and malignant melanoma. ${ }^{4}$

This report provides analyses for patients diagnosed in two five-year time periods 1995-99 and 200004 for 23 of the more common cancer sites or groups, and for an overall grouping of all malignancies combined (excluding non-melanoma skin cancer). Analyses are presented showing the relationship between the incidence of each cancer or cancer group and the relative socio-economic deprivation for males, females and both sexes combined.

Information is presented for 17 specific sites of solid cancer together with groupings of "head and neck" cancers (comprising lip, oral cavity, pharynx and larynx) and "brain and other central nervous system" cancers. In addition, there are results for Hodgkin disease, non-Hodgkin lymphoma, myeloma and all leukaemias. Results cover cancers diagnosed at all ages.

A geographical based measure of socio-economic deprivation, the Income Domain of the Index of Multiple Deprivation (IMD) $2007^{5}$, has been used to classify cancer patients and populations. This provides a deprivation score based on Lower Super Output Areas assigned to the postcode of residence. While this is not a perfect index for all individuals, it has the advantage of being estimated using a standard methodology and it is readily available for the entire population (as long as the postcode is known). IMD scores are ordered with the lowest quintile having the least deprivation and divided into five quintiles of socio-economic deprivation. For further details, please see the methodology section.

In the 2000-04 time period, the all malignancies site group and 11 of the 23 site groups showed a statistically significant association between cancer incidence and socio-economic deprivation with rates being higher in relatively more deprived sections of the population. For two of these site groups, the association was only present in one sex (colorectal cancer in males and mesothelioma in females).

Five of the sites (head and neck, stomach, liver, lung and cervical cancers) had particularly strong associations with social deprivation and, for these groups, rates in the most deprived quintile of the population were close to or more than double those in the most affluent quintile: head and neck cancers had a ratio of 2.1 to 1 comparing the incidence rates in the most deprived with the most affluent (males and females combined). This ratio was 1.8 to 1 for both stomach and liver cancers, 2.5 to 1 for lung cancer and 1.9 to 1 for women with cervical cancer. Other sites that showed a statistically significant association with socio-economic deprivation were oesophageal cancer (1.4 to 1), male colorectal cancer ( 1.1 to 1 ), pancreatic cancer ( 1.2 to 1 ), female mesothelioma ( 1.2 to 1 ), kidney cancer (1.2 to 1 ) and bladder cancer ( 1.2 to 1 ).

In the 2000-04 time period, seven of the sites showed a statistically significant inverse association between cancer incidence and social deprivation with rates being higher in relatively affluent sections of the population. Malignant melanoma was the site with the strongest inverse association with socioeconomic deprivation and these cancers had a ratio of 0.5 to 1 comparing the incidence rates in the most deprived with the most affluent (males and females combined). Female breast cancer and prostate cancer also showed an inverse association both with ratios of 0.8 to 1 . Other sites that showed a statistically significant inverse association were testicular cancer ( 0.8 to 1 ), male brain cancer ( 0.8 to 1 ), male non-Hodgkin lymphoma ( 0.9 to 1 ) and male myeloma ( 0.9 to 1 ).

Across all sites combined, the ratio between the most deprived and the least deprived was 1.2 to 1 . This obviously represents a balance between those sites showing a positive association and those showing an inverse association. In terms of numbers the site groups contributing most to the overall positive association are (in order of contribution) lung, head and neck, stomach, oesophageal and bladder cancers. For these site groups, if all socio-economic deprivation quintiles had the rates of the most affluent, there would be around 11,250, 1,800, 1,800, 1,000 and 900 fewer cancers diagnosed respectively each year.

Smoking plays an aetiological role in all of these cancers, especially lung cancer, and it is the association between smoking and socio-economic deprivation that could be said, therefore, to be driving the overall relationship. Other sites of cancer with a strong association with socio-economic deprivation (liver and cervical cancers) are relatively less common and, thus, do not contribute greatly to the all malignancies pattern.

It is, however, of interest that the most important risk factors for these two cancers (and stomach cancer) are infectious agents (Hepatitis B and C viruses for liver cancer, human papilloma virus for cervical cancers and Helicobacter pylori for stomach cancer) that are also likely to be associated with socio-economic deprivation. Excess alcohol consumption is an important risk factor for head and neck, oesophageal and liver cancers and also associated with socio-economic deprivation.

It is notable that for nearly all the site groups showing strong associations with socio-economic deprivation and for all malignancies combined, the association was statistically more significant among men than women. This would suggest that risk factors such as smoking and alcohol consumption may make a greater contribution to the incidence of these cancers in males.

The greatest numerical contributions in the inverse direction are made by prostate cancer, female breast cancer and malignant melanoma. For these site groups, if all socio-economic deprivation quintiles had the rates of the most affluent there would be around $3,100,2,500$ and 2,000 more cancers diagnosed respectively each year. Prostate cancer is one of the few site groups showing a statistically significant change in the trends with socio-economic deprivation between the two time periods, with the inverse association being much more pronounced in 2000-04 than in 1995-99. It is very likely that the use of prostate specific antigen testing as a means of diagnosing prostate cancer has become relatively much more common among the more affluent sections of the population and this has influenced the association and its change over time. The pattern for breast cancer is likely to be determined by the relationships between socio-economic deprivation and the established risk factors for the disease, especially reproductive history, and also uptake into the mammography screening programme. For malignant melanoma, it would seem that the inverse association between socio-economic deprivation and the major risk factor, excess exposure to sunlight, is the most likely explanation.

Apart from the significant change over time in relation to prostate cancer noted above, the only other site group showing a statistically significant difference between the trends for 1995-99 and 2000-04 was kidney cancer. There was a significant increase in the strength of the association among females; and a change from there being no association in the earlier time period to having a significant trend in the later time period for males.

Overall it is estimated that if the entire population had the incidence rates of the least deprived quintile, there would be approximately 14,300 fewer cancers each year ( $6.2 \%$ of the total). Of these 8,700 ( $7.5 \%$ of the total) would be in men and $5,600(4.9 \%)$ in women. This net burden of excess cases represents, to some extent, a target for the scope of disease reduction that could be achieved by control of the exposure to socio-economically determined risk factors. Additional control of risk factors which are associated with relative affluence, such as excessive sun exposure could bring about a further reduction.

Thanks are due to Jonathan Shelton for undertaking the statistical analyses and for constructing and formatting this report; and to many staff in the English cancer registries and the Office for National Statistics for providing and quality assuring the underlying data.

The advice and input from Paul Silcocks (Trent Cancer Registry) and Catherine Thomson (Cancer Research UK) is particularly appreciated.

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1. Department of Health (2007) Cancer Reform Strategy (ref 283524). DH Publications: London.
2. Quinn M J et al (2001) Cancer Trends in England and Wales 1950-1999, ONS Series SMPS no. 66, TSO: London.
3. Rowan S (2007) Trends in cancer incidence by deprivation, England and Wales, 1990-2002. Health Statistics Quarterly 36:24-35.
4. Shack L et al (2008) Variation in incidence of breast, lung and cervical cancer and malignant melanoma of skin by socioeconomic group in England. BMC Cancer 2008 Sep 26;8:271.
5. http://www.communities.gov.uk/communities/neighbourhoodrenewal/deprivation/deprivation07/

C00-C97 excl. C44: All malignant neoplasms (excl. non-melanoma skin cancer)

$\square$ Males
$\square$ Females








Notes





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## C00-C14 \& C30-C32: Head and neck



Females







| Cohort | Est. Deprivation Gap (Difference in ASR) | 95\% Conidence Interval | $\begin{aligned} & \text { Modelled } \\ & \text { \%Change } \end{aligned}$ | $\begin{gathered} \text { P-value } \\ \text { for Trend } \end{gathered}$ | Cohort | Est. Deprivation Gap (Difterence in A ASR) | 95\% Conidence Interval | $\begin{gathered} \text { Modelled } \\ \text { \% Change } \end{gathered}$ | $\begin{gathered} \text { P-value } \\ \text { for Trend } \end{gathered}$ | Cohort |  | $95 \%$ Conididence <br> Interval | Modelled \%Change | P-value for Trend |
| :---: | :---: | :---: | :---: | :---: | :---: | :---: | :---: | :---: | :---: | :---: | :---: | :---: | :---: | :---: |
|  | 13.9 | 6.7 - 21.1 |  | 0.009 | 1995-1999 | 3.1 | 1.6 |  |  | 1995-1999 | 8.2 | 4.0 - 12.3 |  | 0.008 |
| 2000-2004 | 15.8 | $6.5-25.1$ | 173\% | 0.01 | 2000-2004 | 3.5 | 1.9-5.0 | 79\% | 0.006 | 2000-2004 | 9.3 | 4.0-14.5 | 139 | 0.01 |

Notes
 - The increase in ASR in relation to deprivation quintile was greater for males compared to females and the difference was statistically significant (p-value <0.001)

- In $2000-2004$, there would have been around 1,800 fewer cases of head and neck cancer each year it the ASR of each of the deprivation quintiles had been the same as the ASR for the corresponding least deprived quintile

C15: Oesophagus


| Cohort | Est. Deprivation Gap (Difference in ASR) | 95\% Conididence | Modelled | P-value | Cohort | Est. Deprivation Gap (Difference in ASR) (Difference in ASR) | 95\% Confidence Interval | $\begin{aligned} & \text { Modelled } \\ & \text { \% Change } \end{aligned}$ | P-value | Cohort | Est. Deprivation Gap (Difterence in ASR) Difierence in Asp | 95\% Confidence | Modelled | $\begin{aligned} & \text { P-value } \\ & \text { for Trend } \end{aligned}$ |
| :---: | :---: | :---: | :---: | :---: | :---: | :---: | :---: | :---: | :---: | :---: | :---: | :---: | :---: | :---: |
| 1995-1999 | 4.6 | 3.0 - 6.2 | 44\% | 0.003 | 1995-1999 | 1.8 | 1.2 - 2.4 | 38\% | 0.002 | 1995-1999 | 3.0 | 2.5 - 3.5 | 41\% | $<0.001$ |
| 2000-2004 | 5.1 | 4.4-5.9 | 45\% | $<0.001$ | 2000-2004 | 1.9 | 1.4 - 2.4 | 42\% | 0.001 | 2000-2004 | 3.4 | 3.0-3.8 | 44\% | $<0.001$ |

Notes
-The increase in ASR in relation to deprivation quintile was statistically significant in both 1995 - 1999 ( $p$-value 0.003 for males; 0.002 for females) and 2000 -2004 (p-value $<0.001$ for males; 0.001 for females)
There was no statistically significant difference between the trends tor the time periods $1995-1999$ and $2000-2004$ in the relation of ASR to deprivation quintile for either sex ( $p$-value 0.33 for males: 0.59 to
-There was no statistically significant difference between the trends tor the time periods $1995-1999$ and $2000-2004$ in the relation of ASR to deprivation quintile for either sex (p-value 0.33 for males; 0.59 for females) - The increase in ASR in relation to deprivation quintile was greater for males compared to females and the difference was statistically significant (p-value e0.001)

- In $2000-2004$, there would have been around 1,000 fewer cases of oesophageal cancer each year it the ASR of each of the deprivation quintilies had been the same as the ASR for the corresponding least deprived quintile

C16: Stomach


## $\square$ Males








Notes
-The increase in ASR in relation to deprivation quintile was statistically significant in both $1995-1999$ (p-value 0.001 for males; 0.003 for femaless) and $2000-2004$ (p-value 0.002 for males; 0.008 for females)
There was no statistically significant difference between the trends for the time periods $1995-99$ and $2000-04$ in the relation of ASR to deprivation quintile for either sex (p-value 0.25 for males; 0.35 for females
There was no statistically significant difiference between the trends for the time periods $1995-99$ and $2000-04$ in the relation of ASR to deprivation quintile for either sex ( $p$-value 0.25 for males; 0.35 for females)


|  | Males |  |  |  |  |  |  | Females |  |  |  |  |  |  | Persons |  |  |  |  |  |  |
| :---: | :---: | :---: | :---: | :---: | :---: | :---: | :---: | :---: | :---: | :---: | :---: | :---: | :---: | :---: | :---: | :---: | :---: | :---: | :---: | :---: | :---: |
| Deprivation Quintile | Number of cases | Crude | ASR | 95\% Confidence Interval |  | $\begin{aligned} & \text { ASR } \\ & \text { Ratio } \end{aligned}$ | $\begin{aligned} & \text { Excess } \\ & \text { Cases } \end{aligned}$ | Number of cases | Crude | ASR | 95\% Confidence Interval |  | $\begin{gathered} \text { ASR } \\ \text { Ratio } \end{gathered}$ | Excess | Number of cases | $\begin{gathered} \text { Crude } \\ \text { Rate } \end{gathered}$ | ASR | 95\% Conifidence | $\begin{aligned} & \text { idence } \\ & \text { al } \end{aligned}$ | $\begin{array}{r} \text { ASR } \\ \text { Ratio } \end{array}$ | Excess Cases |
| 1995-1999 |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Least deprived | 13,886 | 59.5 | 52.0 | 51.2 | 52.9 | 1.0 | 0 | 11,911 | 49.0 | 33.7 | 33.1 - | 34.3 | 1.0 |  | 25,797 | 54.2 | 41.8 | 41.3 | 42.4 | 1.0 |  |
| 2 | 15,336 | 65.3 | 54.0 | 53.2 | 54.9 | 1.0 | 560 | 13,954 | 56.5 | 35.9 | 35.3 . | 36.5 | 1.1 | No | 29,290 | 60.8 | 43.9 | 43.4 | 44.4 | 1.0 | No |
| 3 | 15,812 | 67.1 | 55.5 | 54.7 | 56.4 | 1.1 | 993 | 14,714 | 59.1 | 36.7 | 36.1 . | 37.3 | 1.1 | Significant | 30,526 | 63.0 | 44.8 | 44.3 | 45.3 | 1.1 | Sig |
| 4 | 14,970 | 62.8 | 55.8 | 54.9 | 56.7 | 1.1 | 1,012 | 14,092 | 55.8 | 36.5 |  | 37.1 | 1.1 | Difference | 29,062 | 59.2 | 45.0 |  | 45.5 |  | Difference |
| Most deprived | 13,894 | 57.1 | 56.3 | 55.3 | 57.2 | 1.1 | 1,046 | 12,002 | 46.8 | 34.4 | 33.8 - | 35.1 | 1.0 |  | 25,896 | 51.8 | 44.0 | 43.5 | 44.5 | 1.1 |  |
| Overall | 73,898 | 62.3 | 54.7 | 54.3 | 55.1 |  |  | 66,673 | 53.4 | 35.5 | 35.3 - | 35.8 |  |  | 140,571 | 57.8 | 44.0 | 43.7 | 4.2 |  |  |
| 2000-2004 |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Least deprived | 15,265 | 62.3 | 51.3 | 50.5 | 52.1 | 1.0 | 0 | 12,137 | 48.5 | 32.8 | 32.2 - | 33.3 | 1.0 |  | 27,402 | 55.3 | 41.2 | 40.7 | 41.6 | 1.0 |  |
| 2 | 16,444 | 67.6 | 52.1 | 51.3 | 52.9 | 1.0 | 256 | 14,101 | 55.8 | 34.3 | 33.8 - | 34.9 | 1.0 | No | 30,545 | 61.6 | 42.3 | 41.8 | 42.8 | 1.0 |  |
| 3 | 16,385 | 67.5 | 53.3 | 52.5 | 54.1 | 1.0 | 623 | 14,436 | 56.9 | 34.6 | 34.0 - | 35.2 | 1.1 | Significant | 30,821 | 62.0 | 42.9 | 42.4 | 43.4 | 1.0 |  |
|  | 15,522 | 63.7 | 55.3 | 54.5 | 56.2 | 1.1 | 1,135 | 13,431 | 52.6 | 34.1 | 33.5 - |  | 1.0 | Difference | 28,953 | 58.0 | 43.4 | 42.9 |  | 1.1 |  |
| Most deprived | 13,826 | 56.3 | 56.8 | 55.8 | 57.7 | 1.1 | 1,340 | 11,150 | 43.5 | 33.4 | 32.8 - |  | 1.0 |  | 24,976 | 49.8 | 43.8 | 43.3 | 44.3 | 1.1 |  |
| Overall | 77,442 | 63.5 | 53.6 | 53.2 | 54.0 |  |  | 65,235 | 51.4 | 33.9 | 33.6 - | 34.2 |  |  | 142,697 | 57.3 | 42.7 | 42.5 | 42.9 |  |  |

$\square$ Males



Males







Notes
-The increase in ASR in relation to deprivation quintile was statistically significant for males in both $1995-1999$ (p-value 0.02 ) and 2000 -2004 (p-value 0.001 ) whilst for females there was no statistically significant change for either cohort
There was no statistically significant difference between the trends for the time periods $1995-1999$ and 2000 -2004 in the relation of $A$ SR to deprivation quintilif for males ( $p$-value 0.08 )
In 2000 -2004, there would have been around 700 fewer cases of colorectal cancer in males each year it the ASR of each of the deprivation quintiles had been the same as the ASR for the corresponding least deprived quintile
)

## C22: Liver



| Cohort | Est. Deprivation Gap (Difference in ASR) | $\begin{aligned} & 95 \% \text { Conidence } \\ & \text { Interval } \end{aligned}$ | $\begin{aligned} & \text { Modelled } \\ & \text { \%Change } \end{aligned}$ | $P$-value for Trend | Cohort | Est. Deprivation Gap (Difference in ASR) | 95\% Confidence Interval | $\begin{aligned} & \text { Modelled } \\ & \% \text { change } \end{aligned}$ | $\begin{aligned} & \text { P-value } \\ & \text { for Trend } \end{aligned}$ | cohort | Est. Deprivation Gap (Difference in ASR) | $95 \%$ Conididence Interval | $\begin{aligned} & \text { Modelled } \\ & \text { \%Change } \end{aligned}$ | $\begin{gathered} \text { P-value } \\ \text { for Trend } \end{gathered}$ |
| :---: | :---: | :---: | :---: | :---: | :---: | :---: | :---: | :---: | :---: | :---: | :---: | :---: | :---: | :---: |
| 1995-1999 | 2.8 | 0.8-4.8 | 101\% | 0.02 | 1995-1999 | 1.2 | 0.7 - 1.8 | 89\% | 0.005 | 1995-1999 | 2.0 | $0.8-3.1$ | 97\% | 0.013 |
| 2000-2004 | 3.6 | 0.6 - 6.6 | 109\% | 0.03 | 2000-2004 | 1.5 | $0.6-2.4$ | 92\% | 0.01 | 2000-2004 | 2.5 | $0.5-4.4$ | 104\% | 0.026 |

Notes

- The increase in ASR in relation to deprivation quintile was statistically significant in both $1995-1999$ ( $p$-value 0.02 for males; 0.005 for females) and $2000-2004$ (p-value 0.03 for males; 0.01 for females)
There was no statistically significant difference between the trends for the time periods $1995-1999$ and $2000-2004$ in the relation of $A S R$ to deprivation quintile for either sex ( $p$-value 0.51 for males; 0 .

There was no statistically significant difference between the trends for the time periods $1995-1999$ and $2000-2004$ in the ereation of ASR to deprivation quintile for either sex (p-value 0.51 for males; 0.45 for females - The increase in ASR in relation to deprivation quintile was greater for males compared to females and the difference was statistically significant ( $p$-value 0.04 )

- $2000-2004$, , there would have been around 430 fewer cases of liver cancer each year it the $A S R$ of each of the deppivation quintilies had been the same as the ASR for the corresponding least deprived quintile

C25: Pancreas




| Cohort | Est. Deprivation Gap (Difference in ASR) (Difference in ASR) | 95\% Confidence Interval | $\begin{aligned} & \text { Modelled } \\ & \text { \%Change } \end{aligned}$ | P-value for Trend | Cot | Est. Deprivation Gap (Difference in ASR) Difference in ASR) | 95\% Confidence Interval | Modelled | P-value for Trend | Cohort | Est. Deprivation Gap (Difference in ASR) | 95\% Confidence Interval | Modelled \%Change | P-value for Trend |
| :---: | :---: | :---: | :---: | :---: | :---: | :---: | :---: | :---: | :---: | :---: | :---: | :---: | :---: | :---: |
| 1995-1999 | 2.2 | 1.4 - 3.1 | 24\% | 0.004 | 1995-1999 | 1.5 | 1.2-1.8 | 21\% | 0.001 | 1995-1999 | 1.8 | 1.3-2.4 | 23\% | 0.00 |
| 2000-2004 | 2.5 | 2.1 - 2.8 | 27\% | $<0.001$ | 2000-2004 | 1.4 | $0.3-2.4$ | 19\% | 0.02 | 2000-2004 | 1.8 | 1.2-2.5 | 23\% | 0.003 |

Notes
-The increase in ASR in relation to depivation quintile was statistically significant in both $1995-1999$ (p-value 0.004 for males; 0.001 for females) and $2000-2004$ (p-value 0.001 for males; 0.02 for females) - The increase in ASR in relation to deprivation quintile was greater for males compared to females and the difference was statistically significant ( $p$-value 0.002 )

- In $2000-2004$, there would have been around 600 fewer cases of pancreatic cancer each year it the ASR of each of the deprivation quintilies had been the same the ASR for the corresponding least deprived quintile

C33-C34: Trachea, bronchus and lung

|  | Males |  |  |  |  |  | Females |  |  |  |  |  |  | Persons |  |  |  |  |  |  |
| :---: | :---: | :---: | :---: | :---: | :---: | :---: | :---: | :---: | :---: | :---: | :---: | :---: | :---: | :---: | :---: | :---: | :---: | :---: | :---: | :---: |
| Deprivation Quintile | $\begin{array}{r} \text { Number of } \\ \text { cases } \end{array}$ | $\begin{gathered} \text { Crude } \\ \text { Rate } \end{gathered}$ | ASR | 95\% Confidence Interval | $\begin{gathered} \text { ASR } \\ \text { Ratio } \end{gathered}$ | $\begin{aligned} & \text { Excess } \\ & \text { Cases } \end{aligned}$ | $\begin{array}{r} \text { Number of } \\ \text { cases } \end{array}$ | $\begin{gathered} \text { Crude } \\ \text { Rate } \end{gathered}$ | ASR | 95\% Conifidence |  | $\begin{gathered} \text { ASR } \\ \text { Ratio } \end{gathered}$ | Excess $\begin{gathered} \text { Excess } \\ \text { Cases } \end{gathered}$ | Number of cases | Crude Rate | ASR | 95\% Confidence |  | $\begin{gathered} \text { ASR } \\ \text { Ratio } \end{gathered}$ | $\begin{gathered} \text { Excess } \\ \text { Cases } \end{gathered}$ |
| 1995-1999 |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Least deprived | 12,794 | 54.9 | 47.1 | $46.3-47.9$ | 1.0 | 0 | 7,175 | 29.5 | 20.8 | 20.4 - | 21.3 | 1.0 | 0 | 19,969 | 41.9 | 32.0 | 31.5 - | 32.4 | 1.0 | 0 |
|  | 17,053 | 72.6 | 58.7 | 57.8 - 59.5 | 1.2 | 3,355 | 9,397 | 38.1 | 25.3 | 24.8 - | 25.9 | 1.2 | 1,670 | 26,450 | 54.9 | 39.6 | 39.1 - | 40.0 | 1.2 | 5,025 |
| 3 | 20,225 | 85.8 | 70.1 | 69.1 - 71.0 | 1.5 | 6,623 | 11,578 | 46.5 | 31.0 | 30.4 - | 31.5 | 1.5 | 3,785 | 31,803 | 65.6 | 47.5 | 47.0 - | 48.0 | 1.5 | 10,409 |
| 4 | 23,793 | 99.8 | 87.7 | 86.6 - 88.8 | 1.9 | 11,005 | 14,122 | 55.9 | 40.1 | 39.5 - | 40.8 | 1.9 | 6,785 | 37,915 | 77.2 | 60.1 | 59.5 - | 60.7 | 1.9 | 17,790 |
| Most deprived | 27,443 | 112.7 | 110.9 | 109.6-112.2 | 2.4 | 15,786 | 16,733 | 65.2 | 53.1 | 52.3 - | 53.9 | 2.5 | 10,165 | 44,176 | 88.3 | 77.8 | 77.1 - | 78.6 | 2.4 | 25,951 |
| Overall | 101,308 | 85.4 | 74.1 | 73.6 - 74.5 |  |  | 59,005 | 47.3 | 33.8 | 33.5 - | 34.0 |  |  | 160,313 | 65.9 | 50.9 | 50.7 - | 51.2 |  |  |
| 2000-2004 |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Least deprived | 12,544 | 51.2 | 41.3 | 40.6-42.1 | 1.0 | 0 | 7,691 | 30.7 | 20.9 | 20.5 - | 21.4 | 1.0 | 0 | 20,235 | 40.9 | 29.8 | 29.4 - | 30.3 | 1.0 | 0 |
| 2 | 15,920 | 65.4 | 49.6 | 48.8- 50.4 | 1.2 | 2,647 | 10,290 | 40.8 | 26.0 | 25.5 - |  | 1.2 | 2,003 | 26,210 | 52.9 | 36.3 | 35.8 - | 36.7 | 1.2 | 4,650 |
| 3 | 18,525 | 76.3 | 59.7 | 58.8 - 60.5 | 1.4 | 5,693 | 12,140 | 47.8 | 31.1 | 30.5 | 31.7 | 1.5 | 3,972 | 30,665 | 61.7 | 43.3 | 42.9 | 43.8 | 1.5 | 9,666 |
| 4 | 21,525 | 88.3 | 76.3 | 75.3 - 77.3 | 1.8 | 9,866 | 14,719 | 57.6 | 40.7 | 40.0 - | 41.3 | 1.9 | 7,143 | 36,244 | 72.6 | 55.8 | 55.3 . | 56.4 | 1.9 | 17,008 |
| Most deprived | 24,351 | 99.2 | 100.6 | 99.4-101.9 | 2.4 | 14,345 | 17,024 | 66.4 | 55.9 | 55.0 - | 56.7 | 2.7 | 10.647 | 41,375 | 82.5 | 75.2 | 74.5 - | 75.9 | 2.5 | 24,993 |
| Overall | 92,865 | 76.1 | 63.7 | 63.3 - 64.1 |  |  | 61,864 | 48.8 | 34.0 | 33.8 - | 34.3 |  |  | 154,729 | 62.2 | 46.9 | 46.6 | 47.1 |  |  |

$\square$ Males


2000-2004




| Cohort | Est. Deprivation Gap Difference in ASR) | 95\% Confidence Interval | $\begin{gathered} \text { Modelled } \\ \text { \%Change } \end{gathered}$ | P-value for Trend | Cohort | Est. Deprivation Gap (Difference in ASR) (Difference in ASR | 95\% Confidence nterval | $\begin{aligned} & \text { Modelled } \\ & \text { \%Change } \end{aligned}$ | P-value for Trend | Cohort | Est. Deprivation Gap (Difference in ASR) (Difference in ASR) | 95\% Confidence Interval | $\begin{aligned} & \text { Modelled } \\ & \text { \% Change } \end{aligned}$ | $\begin{aligned} & \text { P-value } \\ & \text { for Trend } \end{aligned}$ |
| :---: | :---: | :---: | :---: | :---: | :---: | :---: | :---: | :---: | :---: | :---: | :---: | :---: | :---: | :---: |
| 1995-1999 | 65.5 | 0-85.1 | 155\% | 0.002 | 1995-1999 | 33.8 | 20.7 - 46.9 | 196\% | 0.004 | 1995-1999 | 7.4 | 63.7 | 171\% | . 003 |
| 2000-2004 | 62.4 | $37.5-87.4$ | 182\% | 0.004 | 2000-2004 | 36.8 | $20.3-53.3$ | 222\% | 0.006 | 2000-2004 | 47.7 | 27.2-68.3 | 196\% | 0.005 |

Notes
The increase in ASR in relation to deprivation quintile was statistically significant in both $1995-1999$ (p-value 0.002 for males; 0.004 for females) and $2000-2004$ ( $p$-value 0.004 for males; $; 0.006$ for females)
There was no statastically significant difference between the trends for the time periods $1995-1999$ and $2000-2004$ in the relation of $A S R$ to deprivation quintile for either sex $(p$ value 0.76 for males; 0.65 for females)


C40-C41: Bone and articular cartilage


Notes
-The was no statistically significant change in the ASR in relation to depivation quintile for either sex in both $1995-1999$ (p-value 0.89 for males; 0.53 for females) and $2000-2004$ (p-value 0.13 for males; 0.92 for females)

C43: Malignant melanoma of skin



Notes
-The decrease in ASR in relation to deprivation quintile was statistically significant in both $1995-1999$ ( $p$-value 0.005 for males; 0.003 for females) and 2000 -2004 ( $p$-value 0.002 for males; 0.004 for females
-There was no statistically significant difference between the trends for the time periods $1995-1999$ and $2000-2004$ in the relation of $A$ SR to deprivation quintile for either sex ( $p$-value 0.06 for males; 0.09 tor females)

- There was no statistically significant difference in the decrease in ASR in relation to deprivation quintile between the sexes (p-value 0.58 )
- In 2000 -2004,
there would have been around 2,000 more cases of malignant melanoma skin cancer each year it the ASR of each of the deprivation quintilies had been the same as the ASR for the corresponding least deprived quintilie


C45: Mesothelioma


Notes
-The increase in ASR in relation to deppivation quintile was statistically signiticant tor males in 1995-1999 (p-value 0.006 ) but not in $2000-2004$ (p-value 0.42 )
The increase in ASR in relation to deprivation quintile was not statistically significant for females in $19-999$ (p-value 0.07 ) but was statistically significant in $2000-2004$ (p-value 0.04 )

- Although there were significant increases for males and females in ASR in relation to deprivation quintile, these increases were relatively small
inteligence network


## C50: Breast



Notes
-The decrease in ASR in relation to deprivation quintile was statistically significant in both $1995-1999$ ( $p$-value 0.01 ) and 2000 -2004 ( $p$-value 0.008 )
There was no statistically significant difference between the trends for the time periods $1995-1999$ and $2000-2004$ in the relation 1 AS
08)

In 2000-2004, there would have been around 2.500 more cases of breast cancer each year it the ASR of each of the deprivation quintilies had been the same as the ASR for the corresponding least deprived quintile

C53: Cervix uteri


Notes

There was no statistically signiticant difference between the trends for the time periods $1995-1999$ and $2000-2004$ in the relation of ASR to deprivation quintile ( $p$-value 0.20 )
In $2000-2004$, there would have been around 650 fewer cases of cervical cancer each yeari it the ASR of each of the deprivation quintiles had been the same as the ASR for the corresponding least deprived quintile

## C54: Corpus Uteri



Notes
-There was no statistically significant change in ASR in relation to deprivation quintile in both $1995-1999$ ( $p$-value 0.98 ) and $2000-2004$ (p-value 0.70 )


## C56: Ovary



Notes
-There was no statistically significant change in ASR in relation to deprivation quintile in both $1995-1999$ ( $p$-value 0.23 ) and $2000-2004$ (p-value 0.52 )

intelligence network

C61: Prostate


Notes

- The decrease in ASR in relation to deprivation quintile was statistically significant in both $1995-1999$ (p-value 0.03 ) and $2000-2004$ (p-value 0.001 )
There was a statistically significant difference between the trends tor the time periods $1995-1999$ and $2000-2004$ in the relation of ASR to de
(h) $2000-2004$, there would have heen




C64-C66 \& C68: Kidney and other and unspecified urinary organs

$\square$ Males
$\square$ Females


2000-2004



| Cohort | Est. Deprivation Gap (Difference in ASR) | 95\% Confidence Interval | $\begin{aligned} & \text { Modelled } \\ & \text { \% Change } \end{aligned}$ | P-value for Trend | Cohort | Est. Deprivation Gap (Difference in ASR) | $95 \%$ Confidence Interval | $\begin{gathered} \text { Modelled } \\ \text { \% Change } \end{gathered}$ | P-value for Trend for Trend | Coho | Est. Deprivation Gap (Difterence in ASR) | 95\% Confidence | $\begin{gathered} \text { Modelled } \\ \text { \% Change } \end{gathered}$ | $\begin{aligned} & \text { P-value } \\ & \text { for Trend } \end{aligned}$ |
| :---: | :---: | :---: | :---: | :---: | :---: | :---: | :---: | :---: | :---: | :---: | :---: | :---: | :---: | :---: |
| 1995-1999 | 0.5 | -0.8-1.9 |  | 0.28 | 1995-1999 | 1.0 | 0.5 - 1.5 | 22\% | 0.01 | 1995-1999 | 0.7 | $0.0-1.5$ |  | 0.05 |
| 2000-2004 | 1.3 | $0.8-1.9$ | 13\% | 0.005 | 2000-2004 | 1.5 | 1.1-1.8 | 30\% | 0.001 | 2000-2004 | 1.3 | 1.1-1.6 | 18\% | 0.001 |

Notes
-The increase in ASR in relation to deprivation quintile was statistically significant in $1995-1.1999$ for females (p-value 0.01 ) but not males ( $p$-value 0.28 ). It was statistically significant for both sexes in 2000 -2004 (p-value 0.005 for males; 0.001 for females)
-The was a statisticall significant difference between the trens for the time periods $1995-1999$ and $2000-2004$ in the relation of $A S R$ to deprivation quintile for females (p-value 0.006 ) with the increase greater in $2000-2004$ he was a statistically significant difference between the trends for the time periods $1995-1999$ and $2000-2004$ in the relation of ASR 10 wation quintile for females (p-value 0.006 ) with the increase greater in $2000-200$


## C67: Bladder

|  | Males |  |  |  |  |  | Females |  |  |  |  |  |  | Persons |  |  |  |  |  |  |
| :---: | :---: | :---: | :---: | :---: | :---: | :---: | :---: | :---: | :---: | :---: | :---: | :---: | :---: | :---: | :---: | :---: | :---: | :---: | :---: | :---: |
| Deprivation Quintile | Number of cases | Crude | ASR | 95\% Conididence | $\begin{aligned} & \text { ASF } \\ & \text { Ratio } \end{aligned}$ | $\begin{aligned} & \text { Excess } \\ & \text { Cases } \end{aligned}$ | Number of | $\begin{gathered} \text { Crude } \\ \text { Rate } \end{gathered}$ | ASR | $\begin{gathered} 95 \% \text { Conifide } \\ \text { Interval } \end{gathered}$ |  | $\begin{gathered} \text { ASR } \\ \text { Ratio } \end{gathered}$ | Excess Cases | Number of cases | Crude | ASR | 95\% Conifidence |  | $\begin{gathered} \text { ASR } \\ \text { Ratio } \end{gathered}$ | $\begin{aligned} & \text { Excess } \\ & \text { Cases } \end{aligned}$ |
| ${ }^{\text {1995-1999 }}$ |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Least deprived | 6,962 | 29.9 | 25.7 | 25.1 - 26.3 | 1.0 |  | 2,431 | 10.0 | 6.5 | 6.3 - | 6.8 | 1.0 | 0 | 9,393 | 19.7 | 14.8 | 14.5 | 15.1 | 1.0 |  |
| , | 7,866 | 33.5 | 27.2 | $26.6-27.8$ | 1.1 | No | 3,129 | 12.7 | 7.7 | 7.4. | 8.0 | 1.2 | 487 | 10,995 | 22.8 | 16.1 | 15.8 | 16.4 | 1.1 |  |
| 3 | 8,345 | 35.4 | 28.9 | 28.3 - 29.5 | 1.1 | Significant | 3,318 | 13.3 | 8.0 | 7.7. | 8.2 | 1.2 | 609 | 11,663 | 24.1 | 16.9 | 16.6 | 17.2 | 1.1 |  |
| 4 | 8,450 | 35.4 | 31.1 | 30.4 - 31.8 | 1.2 | Difference | 3,536 | 14.0 | 9.0 | 8.7 - | 9.3 | 1.4 | 986 | 11,986 | 24.4 | 18.4 | 18.0 | 18.7 | 1.2 |  |
| Most deprived | 7,278 | 29.9 | 29.3 | 28.6 - 30.0 | 1.1 |  | 3,117 | 12.1 | 8.9 | 8.6 - | 9.2 | 1.4 | 835 | 10,395 | 20.8 | 17.5 | 17.2 | 17.9 | 1.2 |  |
| Overall | 38,901 | 32.8 | 28.4 | 28.1-28.7 |  |  | 15.531 | 12.4 | 8.0 | 7.9 - | 8.1 |  |  | 54,432 | 22.4 | 16.7 | 16.6 | 16.9 |  |  |
| 2000-2004 |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Least depived | 5,704 | 23.3 | 18.8 | $18.3-19.3$ | 1.0 | 0 | 2,079 | 8.3 | 5.2 | $5.0-$ | 5.5 | 1.0 | 0 | 7,783 | 15.7 | 11.2 | 10.9 | 11.4 | 1.0 |  |
| 2 | 6,399 | 26.3 | 19.7 | 19.2-20.2 | 1.0 | 290 | 2,407 | 9.5 | 5.4 | 5.2 - | 5.6 | 1.0 | 76 | 8,806 | 17.8 | 11.6 | 11.4 | 11.9 | 1.0 | 366 |
| 3 | 6,641 | 27.3 | 21.1 | 20.6 - 21.6 | 1.1 | 722 | 2,596 | 10.2 | 5.7 |  | 5.9 | 1.1 | 220 | 9,237 | 18.6 | 12.3 | 12.1 | 12.6 | 1.1 | 942 |
| 4 | 6,438 | 26.4 | 22.5 | 21.9 - 23.0 | 1.2 | 1,055 | 2,747 | 10.7 | 6.5 | 6.2 . | 6.7 | 1.2 | 526 | 9,185 | 18.4 | 13.3 | 13.0 | 13.6 | 1.2 |  |
| Most deprived | 5,546 | 22.6 | 22.5 | 21.9-23.1 | 1.2 | 914 | 2,481 | 9.7 | 7.0 | 6.7 - | 7.3 | 1.3 | 635 | 8.027 | 16.0 | 13.7 | 13.4 | 14.0 | 1.2 | 1,549 |
| Overall | 30,728 | 25.2 | 20.8 | 20.5 - 21.0 |  |  | 12,310 | 9.7 | 5.9 | 5.8 - | 6.0 |  |  | 43,038 | 17.3 | 12.4 | 12.2 |  |  |  |





2000-2004


| Cohort | Est. Deprivation Gap (Difference in ASR) | $95 \%$ Conidence <br> Interval | $\begin{aligned} & \text { Modelled } \\ & \text { \%Change } \end{aligned}$ | $\begin{array}{r} \text { P-value } \\ \text { for Trend } \end{array}$ | Cohort | Est. Deprivation Gap (Difference in ASR) | $\begin{gathered} 95 \% \text { Conidence } \\ \text { Intevval } \end{gathered}$ | $\begin{aligned} & \text { Modelled } \\ & \text { \%Change } \end{aligned}$ | $\begin{gathered} \text { P-value } \\ \text { for Trend } \end{gathered}$ | Cohort | Est. Deprivation Gap (Difference in ASR) | $95 \%$ Conididence interval | $\begin{gathered} \text { Modelled } \\ \text { \%Change } \end{gathered}$ | $\begin{gathered} \text { P-value } \\ \text { for Trend } \end{gathered}$ |
| :---: | :---: | :---: | :---: | :---: | :---: | :---: | :---: | :---: | :---: | :---: | :---: | :---: | :---: | :---: |
| 1995-1999 | 4.3 | -1.0-9.6 |  | 0.08 | 1995-1999 | 2.4 | 0.8 - 4.0 | 35\% | 0.02 | 1995-1999 | 3.0 | 0.1 - 6.0 | 20\% | , |
| 2000-2004 | 4.0 | 2.1 - 5.8 | 21\% | 0.006 | 2000-2004 | 1.9 | $1.1-2.7$ | 38\% | 0.004 | 2000-2004 | 2.7 | $2.0-3.4$ | 24\% | 0.001 |
| Notes |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|  hence accounting for the large drop in incidence observed between the time periods 1995-1999 and 2000-2004 <br>  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| - The increase in ASR in relation to deprivation quintile was greater for males compared to females and the difiference was statistically significant ( $p$-value 0.0001 ) - l 2000-2004, there would have been around 900 fewer cases of bladder cancer each year it the ASR of each of the deprivation quintiles had been the same as the ASR for the corresponding least deprived quintile |  |  |  |  |  |  |  |  |  |  |  |  |  |  |



C70-C72: Brain, and other parts of central nervous system


Notes
-The increase in ASR in relation to deprivation quintile was statisticially significicant in $1995-1999$ for both sexes ( $p$-value 0.004 for males; 0.008 for females) but was only statisticially significant for males in $2000-2004$ ( $p$-value 0.002 for males; 0.26 for females) - There was no statistically signiticant difference between the trends tor the time periods $1995-1999$ and 2000 -2004 in the relation of ASR to deprivation quintile for males ( $p$-value 0.69$)$. 1 .


C81: Hodgkin disease


Notes

- There was no statistically significant change in ASR in relation to deprivation quintile for either sex in both $1995-1999$ (p-value 0.93 for males; 0.45 for females) and $2000-2004$ ( $p$-value 0.55 for males; 0.2 for females)

|  | Males |  |  |  |  |  |  | Females |  |  |  |  |  |  | Persons |  |  |  |  |  |  |
| :---: | :---: | :---: | :---: | :---: | :---: | :---: | :---: | :---: | :---: | :---: | :---: | :---: | :---: | :---: | :---: | :---: | :---: | :---: | :---: | :---: | :---: |
| Deprivation Quintile | Number of | $\begin{gathered} \text { Crude } \\ \text { Rate } \end{gathered}$ | ASR | 95\% Confidence |  | $\begin{aligned} & \text { ASR } \\ & \text { Ratio } \end{aligned}$ | Excess Cases | Number of cases | $\begin{gathered} \text { Crude } \\ \text { Rate } \end{gathered}$ | ASR | 95\% Confidence nterval |  | $\begin{gathered} \text { ASt } \\ \text { Ratio } \end{gathered}$ | $\begin{aligned} & \text { Excess } \\ & \text { Cases } \end{aligned}$ | $\begin{array}{r} \text { Number of } \\ \text { cases } \end{array}$ | $\begin{gathered} \text { Crude } \\ \text { Rate } \end{gathered}$ | ASR | 95\% Conidence |  | $\begin{gathered} \text { ASR } \\ \text { Ratio } \end{gathered}$ | $\begin{aligned} & \text { Excess } \\ & \text { Cases } \end{aligned}$ |
| 1995-1999 |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Least deprived | 3,998 | 17.1 | 15.5 | $15.0-$ | 16.0 | 1.0 |  | 3,308 | 13.6 | 10.6 | 10.2 - | 11.0 | 1.0 |  | 7,306 | 15.3 | 12.8 | 12.5 - | 13.1 | 1.0 |  |
| 2 | 4,315 | 18.4 | 16.0 | 15.6. | 16.5 | 1.0 | No | 3,573 | 14.5 | 10.5 | 10.2 . | 10.9 | 1.0 | No | 7,888 | 16.4 | 13.1 | 12.8. | 13.4 | 1.0 | No |
| 3 | 4,208 | 17.9 | 15.7 | 15.2 . | 16.1 | 1.0 | Significant | 3,698 | 14.8 | 10.7 | 10.3 . | 11.0 | 1.0 | Significant | 7,906 | 16.3 | 13.0 | 12.7 . | 13.2 | 1.0 | Significant |
| ${ }_{4}^{4}$ | 3,800 | 15.9 | 14.8 | 14.4 - | 15.3 | 1.0 | Difference | ${ }^{3,688}$ | 14.6 | 11.1 | 10.8 - | 11.5 | 1.1 | Difference | 7,488 | 15.2 | 12.8 | 12.5 | 13.1 | 1.0 | Difference |
| Most deprived | 3,405 | 14.0 | 14.2 | 13.8 - | 14.7 | 0.9 |  | 3,063 | 11.9 | 10.1 | 9.8 - | 10.5 | 1.0 |  | 6,468 | 12.9 | 12.0 | 11.7 - |  | 0.9 |  |
| Overall | 19,726 | 16.6 | 15.3 | 15.1 - | 15.5 |  |  | 17,330 | 13.9 | 10.6 | 10.5 - | 10.8 |  |  | 37,056 | 15.2 | 12.8 | 12.6 - | 12.9 |  |  |
| 2000-2004 |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Least depived | 4,612 | 18.8 | 16.1 | 15.6. | 16.5 | 1.0 | 0 | 3,790 | 15.1 | 11.3 | 11.0 - | 11.7 | 1.0 |  | 8,402 | 17.0 | 13.5 | 13.2 | 13.8 | 1.0 |  |
| 2 | 4,722 | 19.4 | 15.9 | 15.4 - |  | 1.0 | -60 | 4,140 | 16.4 | 11.5 | 11.2 . | 11.9 | 1.0 |  | 8,862 | 17.9 | 13.5 | 13.2 . | 13.8 | 1.0 |  |
| 3 | 4,575 | 18.8 | 15.8 | 15.4 - | 16.3 | 1.0 | -69 | 4,091 | 16.1 | 11.3 | 11.0 - | 11.6 | 1.0 | Significant | 8,666 | 17.4 | 13.4 | 13.1 . | 13.6 | 1.0 |  |
| 4 | 4,179 | 17.1 | 15.7 | 15.3 . | 16.2 | 1.0 | -91 | 3,843 | 15.0 | 11.2 | 10.9 - |  | 1.0 | Difference | 8,022 | 16.1 | 13.3 | 13.0 - | 13.6 | 1.0 |  |
| Most deprived | 3.616 | 14.7 | 15.2 | 14.7. | 15.7 | 0.9 | -202 | 3,357 | 13.1 | 11.4 | 11.0 - |  | 1.0 |  | 6,973 | 13.9 | 13.1 | 12.8 - | 13.4 | 1.0 |  |
| Overall | 21,704 | 17.8 | 15.8 | 15.6 - | 16.0 |  |  | 19,221 | 15.2 | 11.4 | 11.2 - | 11.5 |  |  | 40,925 | 16.4 | 13.4 | 13.3 - | 13.5 |  |  |



Notes

- There was no statistically significant change in ASR in relation to deprivation quintile for either sex in $1995-1999$ (-value 0.08 for males; 0.80 for females)
for females (p-value 0.73
In $2000-2004$, there would have been around 85 more cases of NHL each year it the ASR of each of the deprivation quintilies had been the same as the ASR for the corresponding least deprived quintile

C88-C90: Myeloma


Notes
-There was no statistically significant change in ASR in relation to deprivation quintile for either sex in $1995-1999$ (p-value 0.44 for males; 0.94 for females)

- The decrease in ASR in relation to deprivation quintile was statistically significant for males in 2000 -2004 (p-value 0.05 ) but not for females $($ p-value 0.7 )


C91-C95: Leukaemia


Notes
-There was no statistically significant change in ASR in relation to deprivation quintile for either sex in both $1995-1999$ (p-value 0.14 for males; 1.00 for females) and $2000-2004$ (p-value 0.84 for males; 0.17 for females)

## NCIN core objectives

## Using information to improve quality and choice for cancer patients

- Promoting efficient and effective data collection throughout the cancer journey
- Providing a common national repository for cancer datasets
- Producing expert analyses, based on robust methodologies, to monitor patterns of cancer care
- Exploiting information to drive improvements in standards of cancer care and clinical outcomes
- Enabling use of cancer information to support audit and research programmes


## Notes

There are differences in the coding of some cancers between this report and previous NCIN reports.

- Head and neck cancer has been used to describe the grouping of ICD10 codes C00-C14 \& C30-C32 replacing the previous grouping C00-C14: Lip, oral cavity and pharynx
- C54: Corpus Uteri is now used, replacing C54-C55: Uterus.
- C64-C66 \& C68: Kidney and other and unspecified urinary organs is used instead of C64: Kidney, except renal pelvis
- C70-C72: Brain and other parts of the central nervous system no longer contains C69: Eye
- C82-C85 \& C96: Non-Hodgkin lymphoma now includes C96.

New sites previously unreported in NCIN publications include:

- C22: Liver
- C45: Mesothelioma
- C88-C90 Myeloma


## Methodology

Anonymised data for all registrations of malignant neoplasms excluding non melanoma skin cancer were obtained for patients diagnosed between 1995 and 2004 from the English cancer registries and ONS. Records were excluded when there was no age and where ICD coding was incomplete or missing.

Deprivation scores are available for each lower super output area (LSOA) in England. The Income Score from the Index of Multiple Deprivation 2007 (IMD2007) ${ }^{1}$ was used here. Each LSOA was ranked by deprivation score such that each quintile contained $20 \%$ of the population. , The postcode of residence of each patient was used to assign the relevant deprivation quintile through the LSOA. Populations for both of the five year cohorts were created using the sum of the populations for each quintile for each year.

[^0]
## Glossary

## Deprivation Quintile

This publication used the Income Score from IMD2007 to assign each LSOA in England a deprivation quintile. The quintiles were re-ordered such that deprivation was presented from the least deprived (1) to the most deprived (5).

## Number of Cases

The number of new registrations of cancer diagnosed within the specified five year cohort.

## Crude Rate

The crude rate was calculated by dividing the number of cases by the population at risk for each deprivation quintile, as well as overall. In this case using the sum of cases over each five year period divided by the sum of the population over the corresponding five year period to give an average annual crude rate. This rate does not take into account the age structure of the different populations and therefore does not adjust for the confounding effect this may have.

## Age Standardised Rate (ASR)

Age standardised rates are used to eliminate the variation in the age structures of populations and as such enable comparisons between different areas or over time to be made. They are obtained by using a weighted average of age specific rates, i.e. the crude rates within each 5 -year age group. Direct age standardisation has been used here, applied to the European Standard Population. The ASRs are the figures which should be used when making comparisons between the different time periods.

## 95\% Confidence Interval (95\% C.I.)

For the age standardised rates and the modelled estimated deprivation gap, a $95 \%$ confidence interval is given. Confidence intervals are used as a measure of uncertainty in the estimated rates. The upper and lower limits of the interval show how big a contribution chance may have made to a particular statistic. The $95 \%$ confidence intervals quoted give the range in which the rate in question would fall 19 times out of 20 , were it possible to repeat the analysis.

## ASR Ratio

The ASR ratio was calculated by dividing the ASR of each deprivation quintile with the corresponding ASR of the least deprived quintile. The resulting ratio indicates the increase or decrease in ASR compared to the least deprived quintile.

## Excess Cases

For males and females, the number of excess cases for each quintile was calculated by dividing the number of cases by the ASR Ratio and subtracting this result from the number of cases. This gives a crude estimate as to how many extra or fewer cases there would have been had that quintile had the same ASR as the least deprived quintile. These figures are not shown in the situation when the corresponding regression analysis showed a non statistically significant trend across the quintiles.

For persons, the number of excess cases was calculated as the sum of the excess cases for males and females. Again these results are not shown if the test for trend across the quintiles was not significant for either males or females.

## Estimated Deprivation Gap (Difference in ASR)

Weighted ordinary least squares linear regression was used to model the trend across ASRs for the deprivation quintiles. The estimated deprivation gap and corresponding confidence intervals were then derived using the modelled ASR for the most deprived quintile minus the modelled ASR for the least deprived quintile. The weight used for the linear regression was the corresponding variance for each quintile. This weighting was used to take into account any differences between the quintiles.

## Modelled \% Change (between most and least deprived quintiles)

This is the estimated deprivation gap as a percentage of the modelled ASR for the least deprived quintile. Where the regression analysis did not produce a statistically significant trend across the quintiles, the modelled percentage change was not calculated.

## P -value for Trend

The $p$-value given in the table is the resulting $p$-value from the weighted ordinary least squares linear regression.

P -value for difference between trends (on graph)

As a way of examining whether or not the trends have changed significantly over time, a z-test was performed using the regression coefficients and their corresponding standard errors from the linear regression analyses for each time period. The $p$-value shown on the trends graph is from the $z$-test for the trends over the two time periods.

For further reading please see: L Shack, C Jordan, C Thomson et al; Variation in incidence of breast, lung and cervical cancer and malignant melanoma of skin by socioeconomic group in England. BMC Cancer 2008 Sep 26; 8:271.


## NWCIS <br> North West Cancer Intelligence Service

## 为 <br> KING'S LONDON



West Midlands Cancer Intelligence Unit

## Trent W/HS

Cancer Registry
ecrı̇c
Fighting cancer with information

CANCER RESEARCH UK
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NHS
Northern and Yorkshire Cancer Registry and Information Service


Office for
National Statistics


[^0]:    ${ }^{1} \mathrm{http}: / / \mathrm{www} . c o m m u n i t i e s . g o v . u k / c o m m u n i t i e s / n e i g h b o u r h o o d r e n e w a l / d e p r i v a t i o n / d e p r i v a t i o n 07 / ~$

