



Cancer Facts & Figures for Hispanic/Latino People 2024-2026



Contents

Fast Facts	1	Figure 8. Common Childhood and Adolescent Cancer Incidence Rates by Race and Ethnicity, Ages 0-19 Years, US, 2017-2021	13
Introduction	2	Table 5. Childhood and Adolescent Cancer Incidence Rates and Rate Ratios Comparing Hispanic Versus White People, US, 2017-2021	14
Figure 1. Hispanic and Latino Population Distribution by Ethnic Group, US, 2022	2	Table 6. Current Cigarette Smoking, Electronic Cigarette Use, and Alcohol Consumption (%), Adults 18 Years and Older, US, 2022	15
Figure 2. Hispanic Population Distribution as a Percent of Total County Population	3	Table 7. Tobacco Use and Alcohol Consumption (%), High School Students, US, 2021-2023	16
Table 1. Sociodemographic Characteristics and Health Care Access (%) in Hispanic Versus White People, US, 2017-2022	4	Figure 9. Obesity (%) Trends in Mexican American and White People by Age, US, 1976-2020	16
Figure 3. Leading Sites of New Cancer Cases and Deaths in Hispanic People, US, 2024	5	Figure 10. Excess Body Weight (%) in Hispanics and Whites by Age, US, 2017-2020	17
Table 2. Leading Causes of Death in Hispanic and White People, US, 2022	6	Table 8. Cancer Screening and HPV Vaccination Prevalence (%), US, 2018, 2021, and 2022	18
Figure 4. Trends in Incidence (1998-2021) and Mortality (1990-2022) for All Cancers Combined in Hispanic People, US	7	Research	19
Figure 5. Trends in Incidence (1998-2021) and Mortality (1990-2022) in Hispanic Males for Selected Cancers, US	8	Advocacy	19
Figure 5. Trends in Incidence (1998-2021) and Mortality (1990-2022) in Hispanic Females for Selected Cancers, US (continued)	9	Additional Resources	19
Table 3. Cancer Incidence (2017-2021) and Mortality (2018-2022) Rates and Rate Ratios in Hispanic Versus White People, US	10	Data Methods and Limitations	20
Table 4. Cancer Incidence (2017-2021) and Mortality (2016-2020) Rates for Selected Cancers, Puerto Rico	11	References	22
Figure 6. Stage Distribution for Selected Cancers in Hispanic and White People, US, 2017-2021	12	American Cancer Society Recommendations for the Early Detection of Cancer in Average-risk Asymptomatic People	24
Figure 7. Five-year Relative Survival Rates (%) in Hispanic and White People, US, 2014-2020	13		

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Fast Facts

- In 2024, an estimated 195,300 cancer cases will be diagnosed in Hispanic people and 50,400 Hispanic people in the United States will die from the disease (Figure 3).
- The most commonly diagnosed cancers in Hispanic people are prostate (25%) and colorectal (10%) cancers in men and breast (30%) and uterine corpus (9%) cancers in women (Figure 3).
- Compared to White people, Hispanic people have 36% higher incidence of cervical cancer and about 2 times higher incidence of stomach and liver cancers, all of which are associated with infectious agents and largely preventable. (Table 3).
- Breast cancer incidence increased in Hispanic women by 1.6% annually from 2012 through 2021 versus 1.1% annually in White women (Figure 5).
- Uterine corpus cancer incidence and mortality increased over the past decade by about 2%-3% per year in Hispanic women versus 1% per year in White women (Figure 5).
- Hispanic people are less likely than White people to be diagnosed with localized-stage cancer overall (42% versus 46%) and for most common sites, with the largest disparity observed for melanoma (65% versus 78%; Figure 6).
- The largest disparity in 5-year relative survival is for melanoma, which is 83% in Hispanic people versus 94% in White people, reflecting later stage and more aggressive disease, as well as barriers to care (Figure 7).
- Some cancer disparities reflect less access to care; among adults 18-64 years of age, 28% of Hispanic people are uninsured compared to 8% of White people (Table 1).
- Leukemia incidence (mostly lymphoid leukemia) is higher in Hispanic children and adolescents than in any other racial or ethnic group. It is nearly 2 times higher than in those who are Black (59.4 versus 30.2 per million), who have the lowest rates, and about 30% higher than those who are White. (Figure 8).
- Smoking prevalence among Hispanic women is nearly 3 times higher in US-born (8%) compared to foreign-born women (3%), whereas among men it is similar (12% versus 11%; Table 6).
- Although cigarette smoking prevalence is about 40% lower (in relative terms) in Hispanic adults compared to White adults (8% versus 13%; Table 6), it is similar among high school students for both cigarettes (2%) and e-cigarettes (10% versus 11%; Table 7).
- In 2021, 65% of Hispanic adolescents ages 13-17 years were up to date with HPV vaccinations in comparison to 60% of White adolescents (Table 8).
- Cancer screening prevalence is lower in Hispanic people compared to White people for cervical (69% versus 80%), breast (60% versus 65%), and colorectal (52% versus 61%; Table 8) cancers.
- Breast cancer is diagnosed at an early (localized) stage in only 60% of Hispanic women versus 68% of White women (Figure 6).

Introduction

Hispanic people make up the second largest and youngest racial and ethnic group in the US, with a population size of approximately 64 million – accounting for 19% of the total population.¹ In addition, 99% of the more than 3 million Americans who reside in Puerto Rico identify as Hispanic.¹ The majority of Hispanic people in the US identify as Mexican (59%), followed by Puerto Rican (9%), Salvadoran (4%), Cuban (4%), and Dominican (4%; **Figure 1**).² However, the distribution of these ethnic groups varies substantially by state. For example, Mexican people comprise more than 80% of the Hispanic population in both Texas and California, but only 15% in Florida, where more than half of the Hispanic population identifies as Cuban or Puerto Rican. In contrast, metropolitan areas in the Northeast have more diverse Hispanic origins. For example, in New York and Boston, no group accounts

for more than 30% of the population.² Nationally, the Hispanic population is mostly concentrated in the Southwest and Florida (**Figure 2**).

Cancer is caused by external factors, such as tobacco, infectious agents, and an unhealthy diet, and internal factors, such as inherited genetic mutations, hormones, and certain medical conditions. Most variations in cancer occurrence between population groups result from differences in the prevalence of risk factors and access to health care, not in biology. For example, Hispanic people often have a higher incidence of infection-related cancers, such as stomach, than White people likely due in part to a higher prevalence of cancer-causing infections (e.g., *Helicobacter pylori*) in Hispanic countries of origin. Approximately one-third of Hispanic people in the US were foreign-born (i.e.,

Figure 1. Hispanic and Latino Population Distribution by Ethnic Group, US, 2022

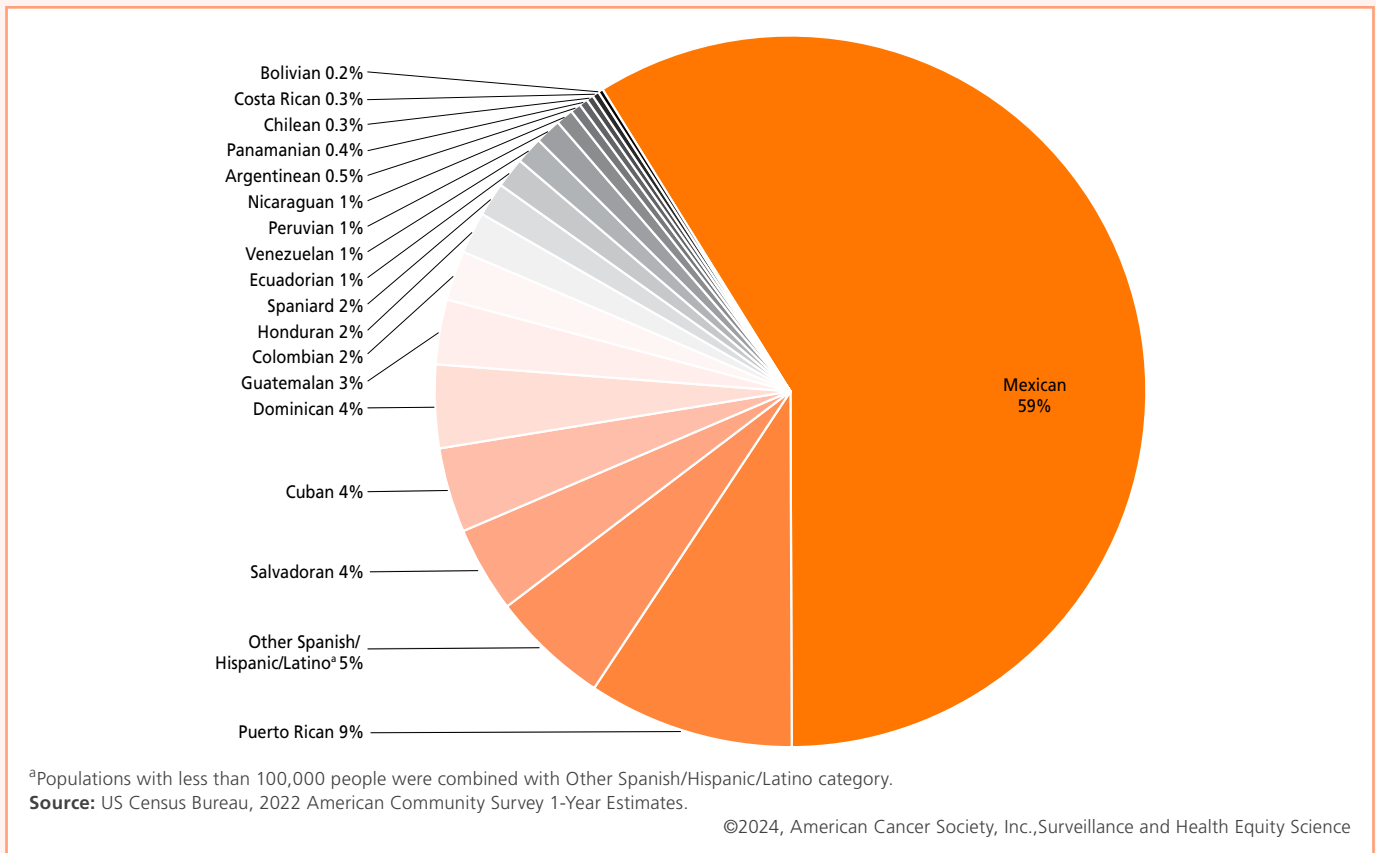
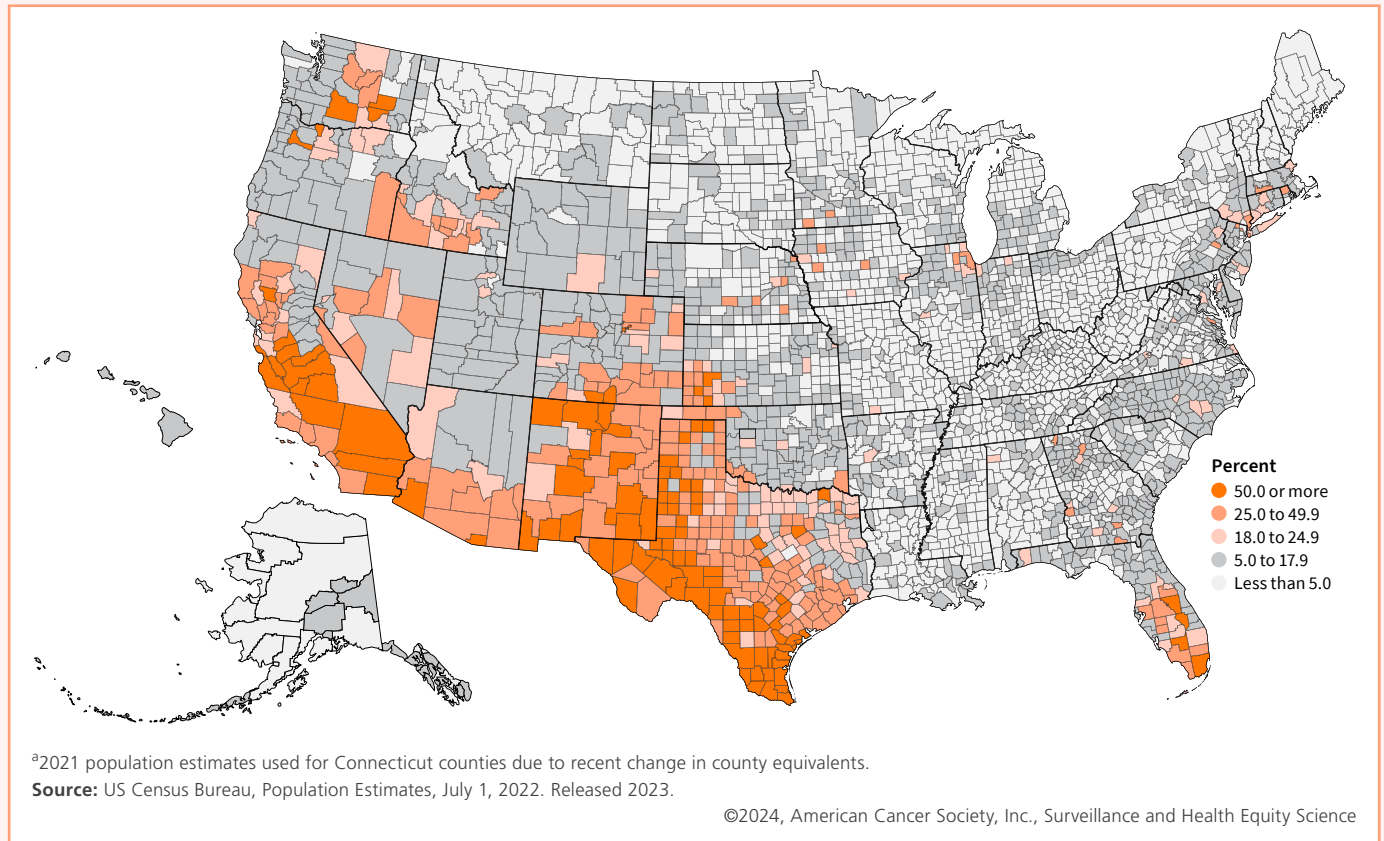


Figure 2. Hispanic Population Distribution as a Percent of Total County Population^a



born outside the US and its territories) in 2021.³ Alternatively, the overall cancer death rate among US-born Hispanic men is about 15% higher than their foreign-born counterparts because of acculturation and the adoption of unhealthy behaviors that increase cancer risk (e.g., smoking).⁴

Structural racism, a higher likelihood of poverty, and language barriers, which are all obstacles to health care access, each contribute to differences in cancer occurrence and outcomes among Hispanic people. These conditions were exacerbated by the COVID-19 pandemic, which disproportionately affected the Hispanic community, not only in terms of incidence and mortality, but also in secondary harms, including loss of employment and health insurance. Life expectancy among Hispanic people declined by 4 years in 2020 as a result of the pandemic.⁵ In 2021, COVID-19 was the leading cause of death in Hispanic people but ranked third in White people.

This report summarizes statistics on cancer occurrence, risk factors, and screening for the Hispanic population in the continental US and Hawaii, as well as incidence and mortality for the US territory of Puerto Rico. Although cancer occurrence data are limited to Hispanic people in aggregate, masking important differences between populations according to nativity status (i.e., foreign- versus US-born), degree of acculturation, and country of origin, risk factor and screening data are available separately for limited groups. Data for other population groups provided for comparison are all confined to non-Hispanic origin (e.g., non-Hispanic White) and are referred to by the race (e.g., White) for simplicity. Information herein is intended to inform community leaders, public health and health care workers, cancer control advocates, and others interested in cancer prevention, early detection, and treatment for Hispanic people.

Table 1. Sociodemographic Characteristics and Health Care Access (%) in Hispanic Versus White People, US, 2017-2022

- Sociodemographic characteristics, such as low educational attainment and poverty, are associated with higher cancer mortality because of their influence on risk factors and access to preventive care, early detection, and treatment. In the US, approximately 17% of Hispanic people overall, and 20% of Puerto Rican and Dominican people, live in poverty compared to 9% of White people.
- The percentage of Hispanic people who are foreign-born ranges from 2% among Puerto Rican people to 61% among South American people. Though the risk of developing cancer overall is lower among foreign-born Hispanic people, the risk of infection-related cancers varies among this group.⁶
- Among adults 18-64 years of age, 28% of Hispanic people are uninsured compared to 8% of White people.
- Foreign-born (37%) Hispanic adults are more than 3 times as likely to be uninsured as their US-born counterparts (11%).

Socioeconomic characteristics, 2018-2022	Hispanic							White
	All	Mexican	Puerto Rican	Cuban	Central American	South American	Dominican	All
Foreign-born	32	29	2	55	56	61	52	4
Speak English "not well" or "not at all" ^a , ages >5 years	16	15	7	24	28	17	25	10
Less than high school diploma, adults >25 years	28	32	18	17	39	12	26	6
Income below federal poverty level	17	17	20	14	19	12	20	9

Health care access characteristics, 2017-2022	Hispanic						White
	All	Mexican	Puerto Rican	Cuban	Central/South American	Dominican	All
No health care coverage							
By age:							
<18 years (not age adjusted)	7	8	-	-	10	-	3
18-64 years	28	30	11	21	28	14	8
By nativity (18 years and older):							
US-born	11	13	8	14	-	-	6
Foreign-born	37	37	-	22	28	10	7
No usual source of medical care (18 to 64 years)^b							
Overall	21	25	19	29	28	14	13
Men	26	30	21	30	34	22	17
Women	16	19	17	28	22	9	9

White=Non-Hispanic White. Some estimates are not provided due to instability. ^aAmong respondents >5 years who indicated that a language other than English was spoken at home. Respondents were asked to rank English-speaking ability as "not at all," "not well," "well," or "very well." ^bExcluding care from a hospital emergency room.

Source: Socioeconomic Characteristics – US Census Bureau, American Community Survey, Public Use Microdata File, 2018-2022. Available at: <https://data.census.gov/mdat/#/>. Accessed March 21st, 2024. Healthcare Access Characteristics – National Health Interview Survey, 2017-2022.

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Figure 3. Leading Sites of New Cancer Cases and Deaths in Hispanic People, US, 2024

- In 2024, an estimated 195,300 cancer cases will be diagnosed in Hispanic people in the US and 50,400 Hispanic people will die from the disease.
- The most commonly diagnosed cancers are prostate (25%), colorectal (10%), and kidney (8%) cancers in Hispanic men and breast (30%), uterine corpus (9%), and colorectal (8%) cancers in Hispanic women.
- Similar to the general population, the leading causes of cancer death in Hispanic men and women combined are lung, colorectal, and pancreatic cancers.

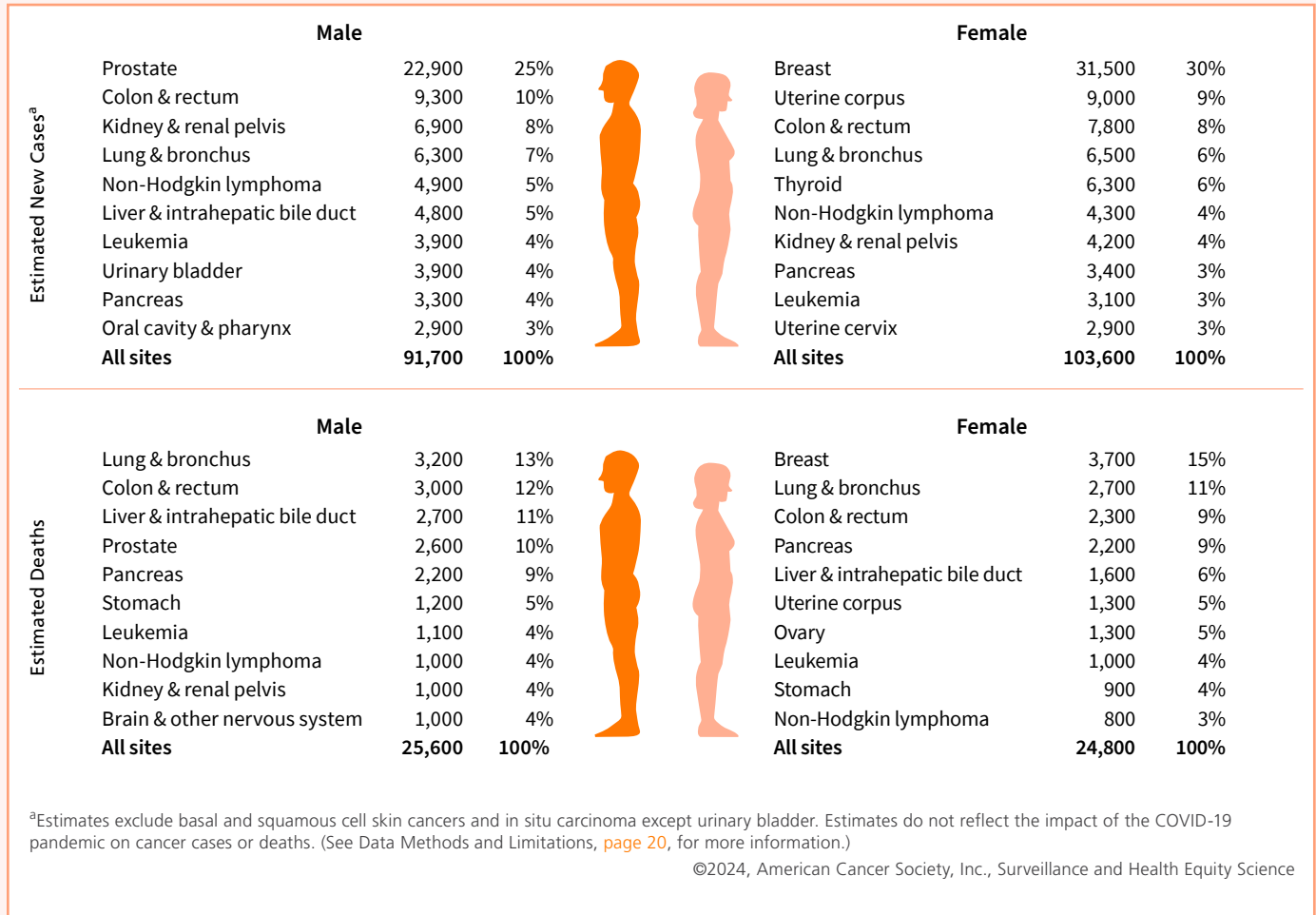
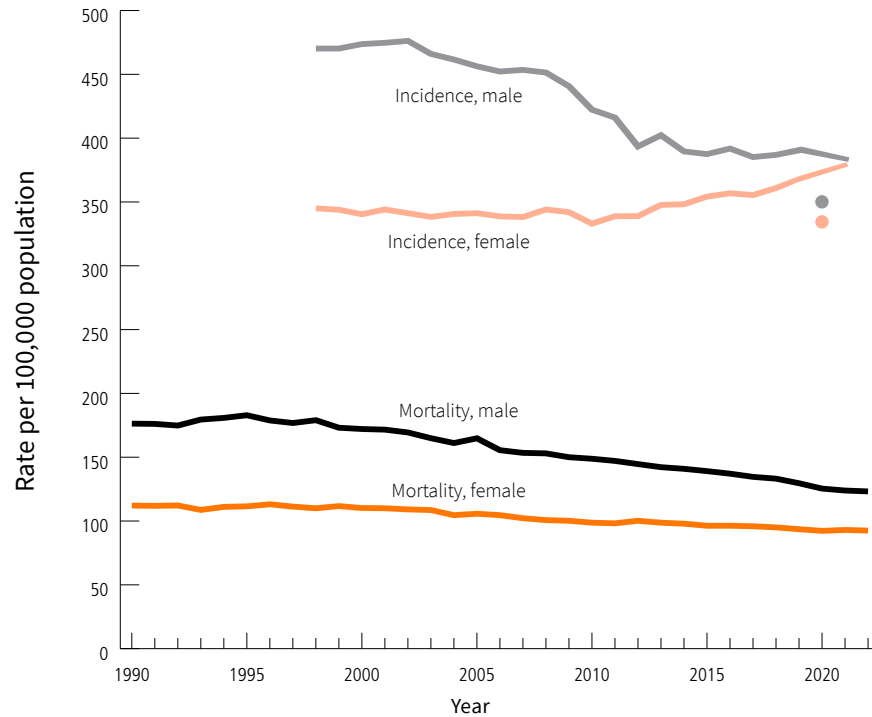


Table 2. Leading Causes of Death in Hispanic and White People, US, 2022

- Cancer was the leading cause of death in the US Hispanic population from 2009 to 2019, but ranked second in 2022 after heart diseases, similar to White people. Heart diseases and cancer each account for approximately 17% of deaths in the US Hispanic population.
- COVID-19 was the leading cause of death in US Hispanic people in 2020 and 2021 (followed by heart diseases and cancer), but dropped to fourth in 2022, the same ranking as in White people.

	Hispanic				White			
	Rank	Number of deaths ^a	Percent of total deaths	Death rate ^b	Rank	Number of deaths ^a	Percent of total deaths	Death rate ^b
Heart diseases	1	47,712	17	115.4	1	539,198	22	172.3
Cancer	2	47,020	17	105.0	2	464,045	19	147.7
Accidents (unintentional injuries)	3	28,699	10	48.8	3	153,663	6	67.6
COVID-19	4	20,498	7	47.6	4	135,836	6	43.7
Cerebrovascular diseases	5	14,224	5	35.6	6	120,205	5	38.2
Diabetes mellitus	6	12,508	5	28.5	8	64,902	3	21.2
Alzheimer's disease	7	9,552	3	27.2	7	97,044	4	30.5
Chronic liver disease and cirrhosis	8	8,933	3	17.0	9	38,942	2	14.5
Chronic lower respiratory disease	9	5,615	2	14.4	5	127,319	5	39.4
Nephritis, nephrotic syndrome, & nephrosis	10	5,299	2	12.5	10	38,885	2	12.4
All causes		275,674	100	618.4		2,455,321	100	818.0

White=Non-Hispanic White.
^aExcludes unknown ages.
^bRates are per 100,000 and age adjusted to the 2000 US standard population.
 Death rates are not directly comparable to those published in prior years due to updated population denominator data.
Source: National Center for Health Statistics, Centers for Disease Control and Prevention, 2024.
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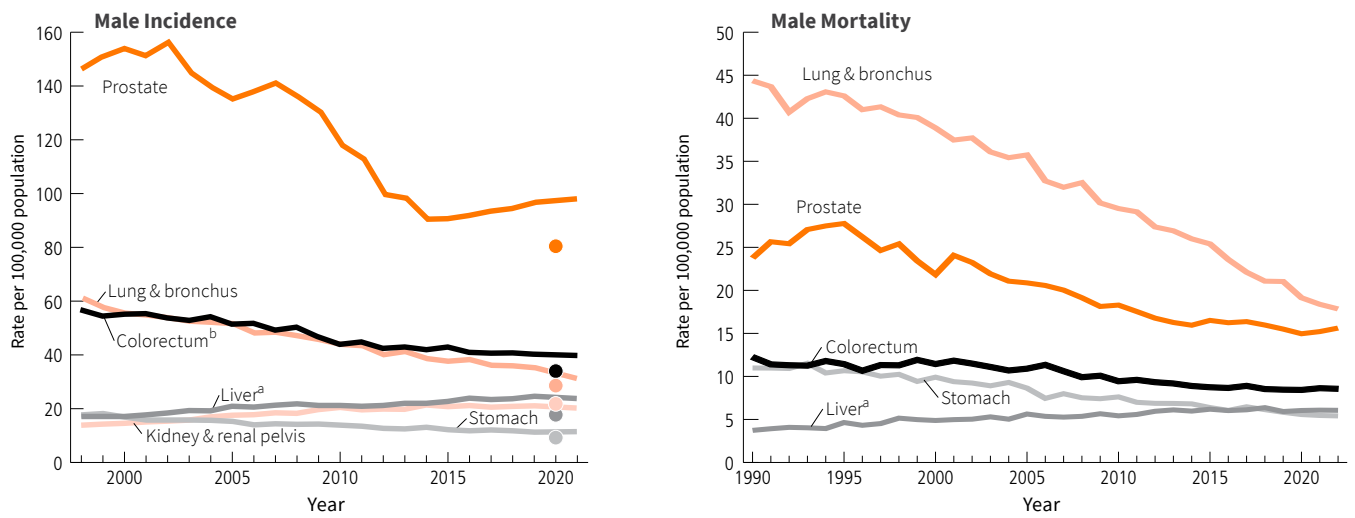
Rates are age adjusted to the 2000 US standard population. Incidence rates are adjusted for delays in reporting, and trend lines for incidence exclude 2020. Mortality data in Louisiana, New Hampshire, and Oklahoma were excluded from overall death rates for years in which information on Hispanic origin were not available. (See Data Methods and Limitations, [page 20](#), for more information.)

Sources: Incidence – North American Association of Central Cancer Registries 2024. Mortality – National Center for Health Statistics, Centers for Disease Control and Prevention, 2024.

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Figure 4. Trends in Incidence (1998-2021) and Mortality (1990-2022) for All Cancers Combined in Hispanic People, US

- Incidence rates in Hispanic men generally decreased from the early 2000s until 2012, then stabilized through 2021, similar to the trend in White men. In contrast, rates in Hispanic women have increased by about 1% per year since 2011, largely reflecting rising trends in breast and uterine corpus cancers. In comparison, rates in White women increased by 0.3% per year since at least 1998.
- During 2013-2022, the death rate for all cancers combined decreased by an average of 1.7% and 0.7% per year in Hispanic men and women, respectively, compared to 1.6% and 1.3% per year in White men and women, respectively.



Rates are age adjusted to the 2000 US standard population. Incidence rates are adjusted for delays in reporting, and trend lines for incidence exclude 2020. Mortality data in Louisiana, New Hampshire, and Oklahoma were excluded from overall death rates for years in which information on Hispanic origin were not available. (See Data Methods and Limitations, page 20, for more information.) ^aIncludes liver and intrahepatic bile duct. ^bColorectum excludes appendiceal cancer. Figures are shown on different scales to emphasize trends.

Sources: Incidence – North American Association of Central Cancer Registries, 2024. Mortality – National Center for Health Statistics, Centers for Disease Control and Prevention, 2024.

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Figure 5. Trends in Incidence (1998-2021) and Mortality (1990-2022) in Hispanic Males for Selected Cancers, US

- Prostate cancer incidence among Hispanic men generally declined from the early 2000s until 2014 but has since increased by about 1% per year. Similarly, incidence rates have increased by 2%-4% per year in men of other racial and ethnic groups. Rising incidence likely contributes to stabilized mortality over the past decade after steep declines during the 2000s.
- In the past decade, lung cancer trends were similar in Hispanic and White men; incidence and mortality rates decreased by about 3% per year and 4%-5% per year, respectively.
- Over the past decade, colorectal cancer incidence and mortality decreased by about 1% per year and 1.5% per year, respectively, in Hispanic men, similar to trends in White men.
- During the past decade, liver cancer mortality decreased by about 1% per year in Hispanic men and stabilized in White men.

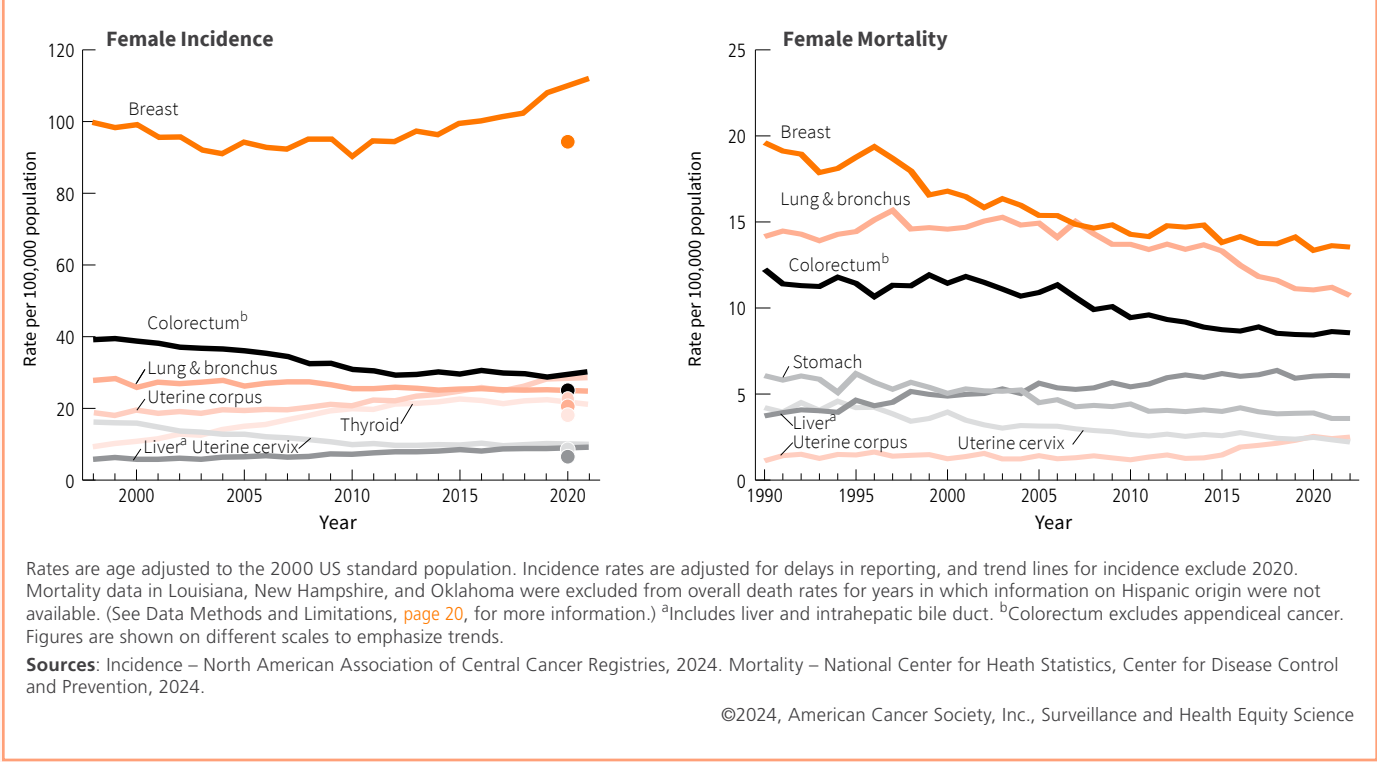


Figure 5. Trends in Incidence (1998-2021) and Mortality (1990-2022) in Hispanic Females for Selected Cancers, US (continued)

- Breast cancer incidence rates have been increasing in the US since the early 2000s overall, with among the steepest increases from 2012-2021 in Hispanic women, 1.6% per year, versus 1% per year in White women. This trend likely reflects declines in fertility rates, a rise in age at first birth, and increasing excess body weight.^{7,8} In contrast, breast cancer death rates continued to decline from 2013-2022 by about 1% per year in both Hispanic and White women.
- Progress against lung cancer is slower in women than in men; in the past decade, incidence and mortality rates in Hispanic women decreased annually by 0.5% and 2.4%, respectively, similar to White women.
- During the most recent 10 years (2012-2021), uterine corpus cancer incidence rates increased annually by an average of 2.8% in Hispanic women. In contrast, incidence rates among White women have remained stable since 2016. Mortality in both Hispanic and White women has increased 2.4% and 1.2% per year, respectively, during 2013-2022.
- Over the past decade, CRC incidence has stabilized in Hispanic women but continued to decrease in White women by about 1% per year, while mortality decreased by 0.8% per year in Hispanic women versus 1.6% per year in White women.

Table 3. Cancer Incidence (2017-2021) and Mortality (2018-2022) Rates and Rate Ratios in Hispanic Versus White People, US

- Hispanic people have lower incidence and mortality than White people for most common cancers, but about 2 times higher rates of stomach and liver cancer and 15%-36% higher rates for cervical cancer, all of which are associated with infectious agents and largely preventable.
- Additionally, Hispanic people have almost 2 times higher rates of gallbladder cancer and acute lymphocytic leukemia for reasons that are not understood. Lymphoid leukemia incidence is also higher among Hispanic children and adolescents (Table 5).
- Breast cancer incidence and mortality rates in Hispanic women are approximately 30% lower than rates in White women, likely due in part to protective factors like a higher number of childbirths and longer breastfeeding,^{9,10} as well as lower historical and contemporary mammography prevalence.¹¹
- Lung cancer incidence and mortality in Hispanic people is half that in White people, consistent with historically lower smoking prevalence, although smoking patterns differ by origin group.

Incidence, 2017-2021	Male			Female			
	Hispanic	White	Rate Ratio	Hispanic	White	Rate Ratio	
Acute lymphocytic leukemia	6.0	3.7	1.59	Acute lymphocytic leukemia	4.7	2.9	1.63
Breast (female)				Breast (female)	104.1	137.9	0.76
Colon & rectum ^a	38.2	40.1	0.95	Colon & rectum ^a	27.5	30.4	0.90
Gallbladder	1.3	0.7	1.94	Gallbladder	2.4	1.0	2.31
Kidney & renal pelvis	23.6	24.3	0.97	Kidney & renal pelvis	13.7	12.2	1.12
Liver & intrahepatic bile duct	20.3	11.2	1.81	Liver & intrahepatic bile duct	8.7	4.3	2.03
Lung & bronchus	33.6	63.9	0.53	Lung & bronchus	24.6	54.5	0.45
Melanoma	5.1	38.1	0.13	Melanoma	5.0	25.9	0.19
Non-Hodgkin lymphoma	20.5	24.2	0.85	Non-Hodgkin lymphoma	15.7	16.4	0.96
Oral cavity & pharynx	10.8	20.7	0.52	Oral cavity & pharynx	4.7	7.3	0.64
Ovary				Ovary	10.1	10.5	0.96
Pancreas	13.1	15.8	0.83	Pancreas	11.5	11.8	0.97
Prostate	92.9	114.5	0.81	Prostate			
Stomach	11.4	7.1	1.60	Stomach	8.0	3.5	2.25
Uterine cervix				Uterine cervix	9.8	7.2	1.36
Uterine corpus				Uterine corpus	26.7	28.1	0.95
All sites	378.5	513.0	0.74	All sites	359.6	454.0	0.79

Mortality, 2018-2022	Male			Female			
	Hispanic	White	Rate Ratio	Hispanic	White	Rate Ratio	
Acute lymphocytic leukemia	0.7	0.4	1.68	Acute lymphocytic leukemia	0.6	0.3	1.88
Breast (female)				Breast (female)	13.7	19.4	0.70
Colon & rectum	13.4	15.2	0.88	Colon & rectum	8.5	10.9	0.78
Gallbladder	0.5	0.3	1.56	Gallbladder	1.0	0.5	1.89
Kidney & renal pelvis	4.7	5.3	0.88	Kidney & renal pelvis	2.1	2.2	0.93
Liver & intrahepatic bile duct	12.6	8.4	1.50	Liver & intrahepatic bile duct	6.1	3.8	1.61
Lung & bronchus	19.4	41.2	0.47	Lung & bronchus	11.1	31.0	0.36
Melanoma	0.8	3.8	0.22	Melanoma	0.5	1.7	0.29
Non-Hodgkin lymphoma	5.4	6.9	0.79	Non-Hodgkin lymphoma	3.5	3.9	0.88
Oral cavity & pharynx	2.4	4.3	0.56	Oral cavity & pharynx	0.8	1.5	0.52
Ovary				Ovary	4.8	6.3	0.76
Pancreas	9.7	13.2	0.73	Pancreas	8.2	9.8	0.84
Prostate	15.4	18.1	0.85	Prostate			
Stomach	5.7	2.8	2.04	Stomach	3.8	1.4	2.64
Uterine cervix				Uterine cervix	2.4	2.1	1.15
Uterine corpus				Uterine corpus	2.4	2.9	0.82
All sites	126.8	179.0	0.71	All sites	93.2	131.0	0.71

White=Non-Hispanic White.

All rate ratios presented were statistically significant (p < 0.05). Rates are per 100,000 and age adjusted to the 2000 US standard population. Incidence is adjusted for delays in reporting. Rate ratios are the unrounded rates in Hispanic people divided by the unrounded rates in Whites.

^aExcludes appendix.

Source: Incidence – North American Association of Central Cancer Registries, 2024. Mortality – National Center for Health Statistics, Centers for Disease Control and Prevention, 2024.

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Table 4. Cancer Incidence (2017-2021) and Mortality (2016-2020) Rates for Selected Cancers, Puerto Rico

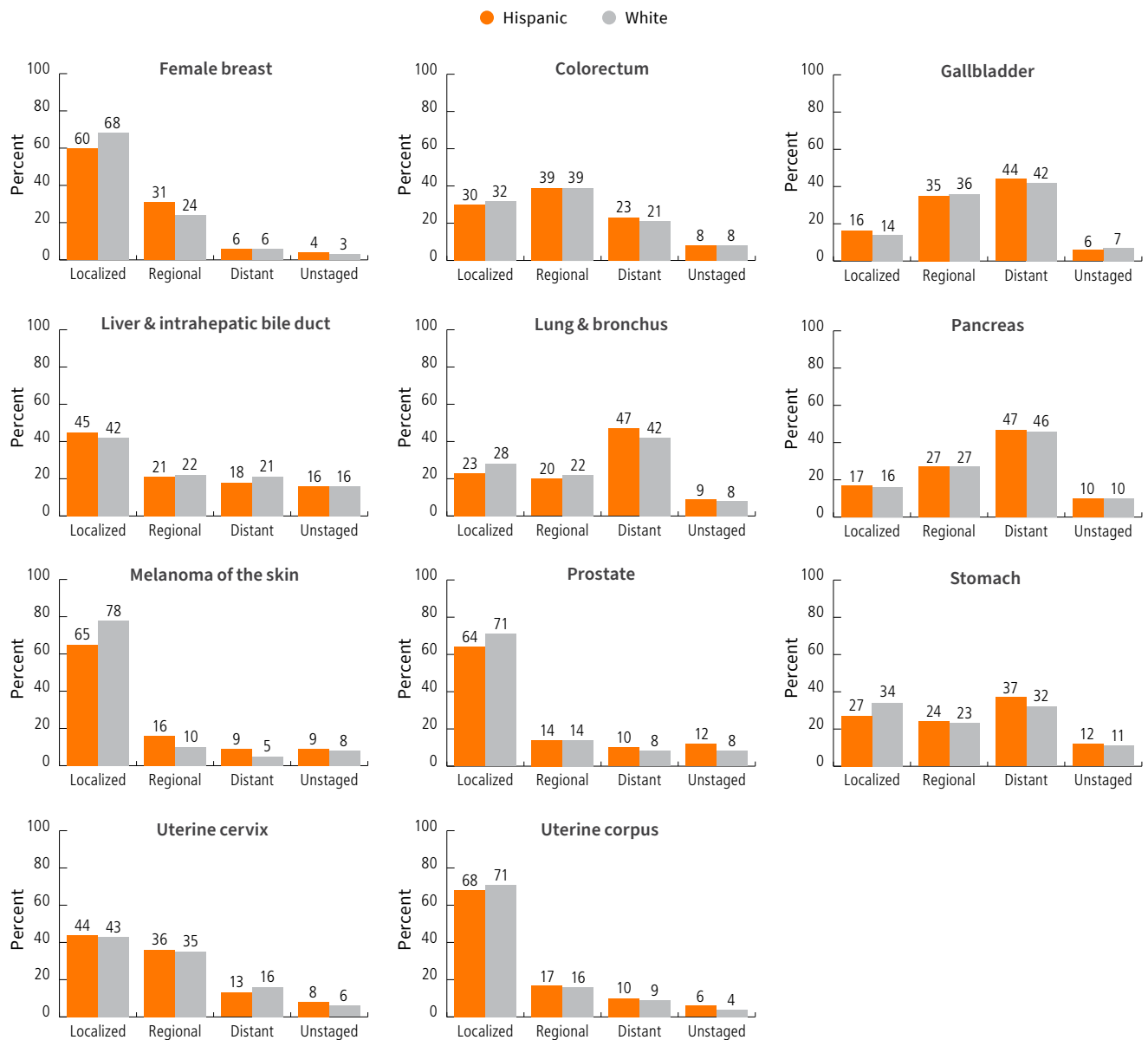
	Incidence	Mortality ^a
All sites	347.6	105.5
Male	386.9	132.1
Female	320.1	86.4
Breast (female)	99.0	17.0
Colorectum		
Male	43.6	17.7
Female	29.5	10.7
Kidney & renal pelvis		
Male	13.1	2.5
Female	5.6	1.1
Liver & intrahepatic bile duct		
Male	13.1	10.2
Female	4.0	3.8
Lung & bronchus		
Male	20.1	14.8
Female	11.2	7.2
Prostate (male)	140.3	21.4
Stomach		
Male	7.9	4.6
Female	5.4	2.7
Uterine cervix	11.6	2.2

Rates are per 100,000 and are age adjusted to the 2000 US standard population. Rates for Puerto Rico exclude cases diagnosed in the latter half of 2017 due to the impact of Hurricane Maria. Incidence rates for colorectum cancer exclude appendix. ^aDeath rates for Puerto Rico were obtained from statecancerprofiles.cancer.gov.

Source: Incidence – North American Association of Central Cancer Registries, 2024. Mortality – National Vital Statistics System, National Cancer Institute, 2023.

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- During the most recent five data years (2017-2021), breast cancer incidence rates among Puerto Rican women (99.0 per 100,000) closely mirrored those among Hispanic women in the rest of the US (104.1 per 100,000), whereas prostate cancer incidence was 51% higher than other US Hispanic men and 23% higher than White men, perhaps reflecting a higher prevalence of African ancestry.¹²
- Lung cancer incidence rates for Puerto Rico residents are even lower than those for other US Hispanic people, and one-third the rate of White people, reflecting even lower smoking prevalence in Puerto Rico than mainland Hispanic people. People in Puerto have 3% lower current smoking prevalence in absolute terms compared to mainland US Hispanic people overall.¹³
- Incidence rates for cervical cancer among women in Puerto Rico are about 18% and 61% higher, respectively, compared to Hispanic and White women in the US (Table 3). This is likely due to higher prevalence of HPV and lower screening rates, especially among younger women.^{14, 15}



White=Non-Hispanic White. Percentages may not total 100 due to rounding. Local: an invasive malignant cancer confined entirely to the organ of origin. Regional: a malignant cancer that 1) has extended beyond the limits of the organ of origin directly into surrounding organs or tissues; 2) involves regional lymph nodes; or 3) has both regional extension and involvement of regional lymph nodes. Distant: a malignant cancer that has spread to parts of the body remote from the primary tumor either by direct extension or by discontinuous metastasis to distant organs, tissues, or via the lymphatic system to distant lymph nodes.

Source: North American Association of Central Cancer Registries, 2024.

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Figure 6. Stage Distribution for Selected Cancers in Hispanic and White People, US, 2017-2021

- The gap for breast cancer is also substantial, with only 60% of Hispanic women diagnosed with localized stage compared with 68% of White women, reflecting the lower prevalence of mammography screening (60% versus 65%; [Table 8](#)).
- Melanoma has the largest disparity in stage at diagnosis, with localized disease diagnosed in 65% of Hispanic people versus 78% of White people.

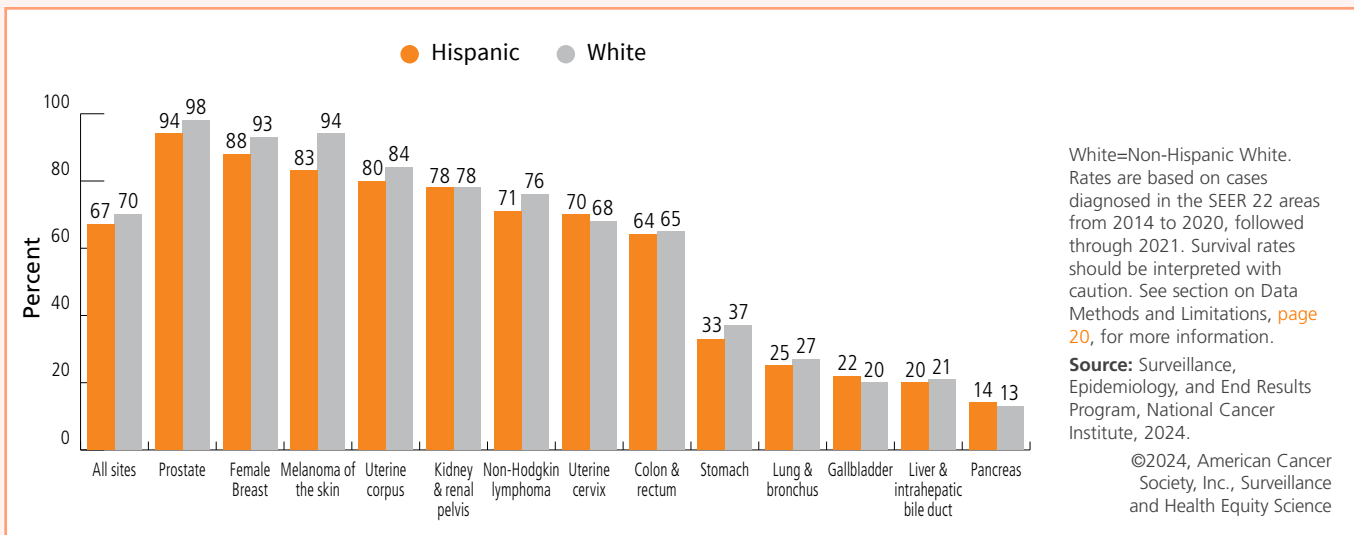


Figure 7. Five-year Relative Survival Rates (%) in Hispanic and White People, US, 2014-2020

- Five-year relative survival in Hispanic people is only slightly lower than in White people for cancer overall (67% versus 70%); however, survival data for Hispanic people are known to be overestimated because of less successful patient follow-up, and are also influenced by the younger age of the Hispanic population.¹⁶
- The largest survival disparity is for melanoma (94% versus 83%), at least in part reflecting later stage at diagnosis (Figure 6), more aggressive subtypes¹⁷ and longer time to surgical treatment due to barriers to care.¹⁸
- Five-year survival among Hispanic versus White people is 5% lower for breast cancer and 4% lower for prostate cancer in absolute terms, also reflecting later-stage diagnosis. (Figure 6).

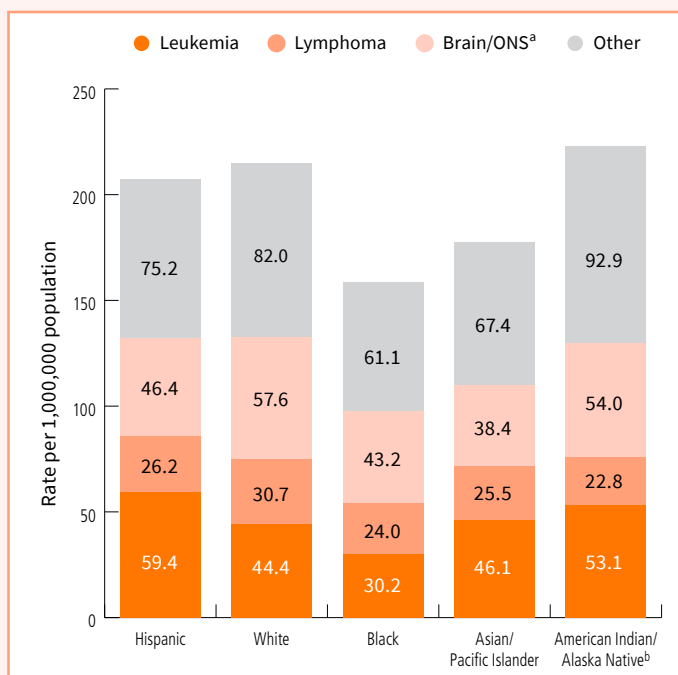


Figure 8. Common Childhood and Adolescent Cancer Incidence Rates by Race and Ethnicity, Ages 0-19 Years, US, 2017-2021

- Leukemia incidence (mostly lymphoid leukemia) is higher in children and adolescents who are Hispanic than in any other racial or ethnic group, almost 2 times higher than in those who are Black (59.4 versus 30.2 per 1,000,000), who have the lowest rates, and about 30% higher than those who are White.
- In contrast, Hispanic children and adolescents have lower rates than their White counterparts for lymphoma and brain and other nervous system tumors.

ONS=other nervous system. Rates are per 1,000,000 and age adjusted to the 2000 US standard population. ^aIncludes benign and borderline brain tumors. ^bData based on Indian Health Service Contract Health Service Delivery Area counties. Rates should be interpreted with caution due to small case numbers.

Source: North American Association of Central Cancer Registries, 2024.

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Table 5. Childhood and Adolescent Cancer Incidence Rates and Rate Ratios Comparing Hispanic Versus White People, US, 2017-2021

- Hispanic children and adolescents have lower overall cancer incidence, but higher rates of leukemia and germ cell tumors. Lymphoid leukemia incidence among Hispanic adolescents is almost 2 times higher than among White adolescents (30.5 versus 15.0 per 1,000,000) for reasons that are mostly unknown but appear to be in part due to genetic abnormalities.¹⁹
- While risk factors for childhood cancer are not well understood, known causes include inherited genetic abnormalities, radiation exposure (typically due to cancer treatment), and certain viral infections.

	Ages 0-14 years			Ages 15-19 years		
	Hispanic	White	Rate Ratio	Hispanic	White	Rate Ratio
Leukemia	63.5	49.4	1.28 ^b	47.6	29.8	1.60 ^b
Lymphoid leukemia	51.0	39.4	1.29 ^b	30.5	15.0	2.03 ^b
Acute myeloid leukemia	8.3	6.7	1.23 ^b	9.1	8.5	1.06
Brain & other central nervous system^a	42.8	55.3	0.77 ^b	57.1	64.7	0.88 ^b
Astrocytomas	13.5	21.2	0.64 ^b	8.5	15.0	0.57 ^b
Lymphomas	20.8	22.2	0.94 ^b	42.1	55.9	0.75 ^b
Hodgkin lymphoma	5.1	5.7	0.90	24.2	35.2	0.69 ^b
Non-Hodgkin lymphoma (except Burkitt lymphoma)	8.0	7.9	1.02	14.3	15.8	0.91
Burkitt lymphoma	1.9	3.3	0.56 ^b	1.4	2.7	0.50 ^b
Soft-tissue sarcomas	10.1	11.0	0.92	15.4	14.6	1.06
Neuroblastoma	8.3	13.8	0.60 ^b	1.2	1.1	1.10
Bone tumors	7.2	7.6	0.95	13.4	15.0	0.89
Osteosarcoma	4.2	3.9	1.10	7.9	7.2	1.10
Renal tumors	7.0	8.5	0.82 ^b	1.5	2.0	0.75
Germ cell tumors	6.5	4.8	1.35 ^b	39.4	24.1	1.63 ^b
Malignant gonadal germ cell tumor	3.3	1.8	1.84 ^b	31.8	18.3	1.73 ^b
Retinoblastoma	4.3	3.5	1.23 ^b	-	-	-
Hepatic tumors	3.9	3.2	1.21 ^b	1.4	1.5	0.89
All sites^a	184.3	191.3	0.96^b	275.3	284.8	0.97^b

White=Non-Hispanic White. Some estimates are not provided due to fewer than 25 cases.

Rates are per 1,000,000 and age adjusted to the 2000 US standard population. Rate ratios are the unrounded rates in Hispanic people divided by the unrounded rates in White people.

^aIncludes benign and borderline brain.

^bIndicates statistical significance (p < 0.05).

Source: North American Association of Central Cancer Registries, 2024.

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Table 6. Current Cigarette Smoking, Electronic Cigarette Use, and Alcohol Consumption (%), Adults 18 Years and Older, US, 2022

- Cigarette smoking has historically been lower among Hispanic than non-Hispanic adults, especially among women.¹¹ In 2022, 8% of Hispanic adults smoked compared to 13% of White adults, although prevalence in 2017-2018 ranged from 6% in Central/South Americans to 17% in Puerto Ricans.
- By nativity, smoking prevalence among Hispanic women is nearly 3 times higher among those who are US-born (8%) compared to those who are foreign-born (3%). In contrast, the rates among US-born and foreign-born Hispanic men is similar (12% versus 11%).
- Similar to smoking, Hispanic adults are half as likely as Whites to use e-cigarettes (4% versus 8%) and to drink alcohol heavily (4% versus 8%).

	Hispanic			White		
	Male	Female	Total	Male	Female	Total
Cigarette smoking^a	11	5	8	14	12	13
Origin ^b (2017-2018)						
Puerto Rican ^c	17	16	17			
Mexican	14	6	10			
Cuban	7	12	9			
Dominican	-	-	-			
Central / South American	9	4	6			
Education (25 years and older)						
≤12 years, no diploma	16	7	11	35	44	39
GED	-	-	14	41	31	37
HS diploma	13	3	8	22	21	22
Some college	10	9	9	14	16	15
College degree	8	-	6	5	4	5
Poverty Status ^d						
Poor	15	8	11	33	32	32
Near poor	14	5	10	26	22	24
Non poor	9	4	7	11	9	10
Health Insurance Status (18 to 64 years)						
Uninsured	17	5	11	33	23	29
Insured	9	5	7	13	12	13
Immigration Status ^e						
US-born	12	8	10	13	12	13
Foreign-born	11	3	7	17	8	12
E-cigarette use^f	5	3	4	9	8	8
Alcohol consumption^g	69	58	63	76	74	75
Heavy	5	3	4	7	9	8

White=Non-Hispanic White. Some estimates are not provided due to instability. GED=General Educational Development high school equivalency. HS=high school. ^aEver smoked 100 cigarettes in lifetime and smoking every day or some days at time of survey. ^bEstimates based on 2017-2018 National Health Interview Survey data combined. ^cPuerto Rican individuals were from the 50 states or the District of Columbia at the time of survey. ^dPoor: <100% of poverty threshold. Near poor: 100% to ≤199% of poverty threshold. Non poor: ≥200% of poverty threshold. ^eUS-born includes those born in a US territory. ^fUsing e-cigarettes every day or some days at time of survey. ^gCurrent consumption: 1+ drinks in lifetime and ≥1 drink in past year. Heavy: 1+ drinks in lifetime and (male) >14 drinks/week in past year or (female) >7 drinks/week in past year.

Estimates in this report may differ from earlier reports due to revised weights issued for the National Health Interview Survey.

Sources: National Health Interview Survey, 2017, 2018, and 2022.

Table 7. Tobacco Use and Alcohol Consumption (%), High School Students, US, 2021-2023

- In contrast with adults, cigarette smoking prevalence is similar among Hispanic (2%) and White (2%) high school students, as is e-cigarette use (10% versus 11%), which is much more common. However, current use of any combustible product and e-cigarettes is reported to be higher among Hispanic versus White

middle school students (3.7% versus 1.3% and 6.6% versus 3.1%, respectively).²⁰

- Although the prevalence of current alcohol use and binge drinking is lower in Hispanic than White high school students, drinking before age 13 is higher among Hispanic youth (18% versus 14%).

	Hispanic			White		
	Male	Female	Total	Male	Female	Total
Current tobacco use^a (2023)						
Cigarette smoking	2	3	2	2	3	2
E-cigarette	12	8	10	14	9	11
Alcohol consumption (2021)						
Current alcohol use ^b	18	27	23	23	30	26
Binge drinking ^c	8	12	10	12	15	13
Began before age 13 years ^d	19	18	18	13	14	14

White=Non-Hispanic White. ^aSmoked cigarettes or used e-cigarettes on one or more of the 30 days preceding the survey. ^bHad one or more drinks of alcohol on one or more of the 30 days preceding the survey. ^cHad five or more drinks of alcohol in a row within a couple of hours on one or more of the 30 days preceding the survey. ^dOther than a few sips.

Sources: Tobacco Use: Tobacco Product Use Among U.S. Middle and High School Students—National Youth Tobacco Survey, 2023 | MMWR (cdc.gov) National Youth Tobacco Survey (NYTS) 2023.

Alcohol Use: Youth Risk Behavior Surveillance System (YRBSS) 2021.

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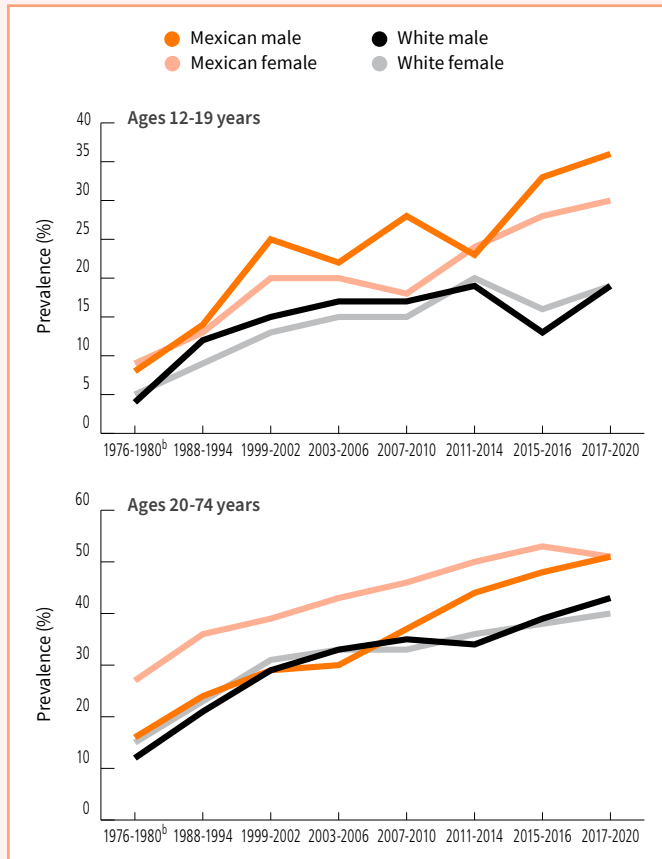


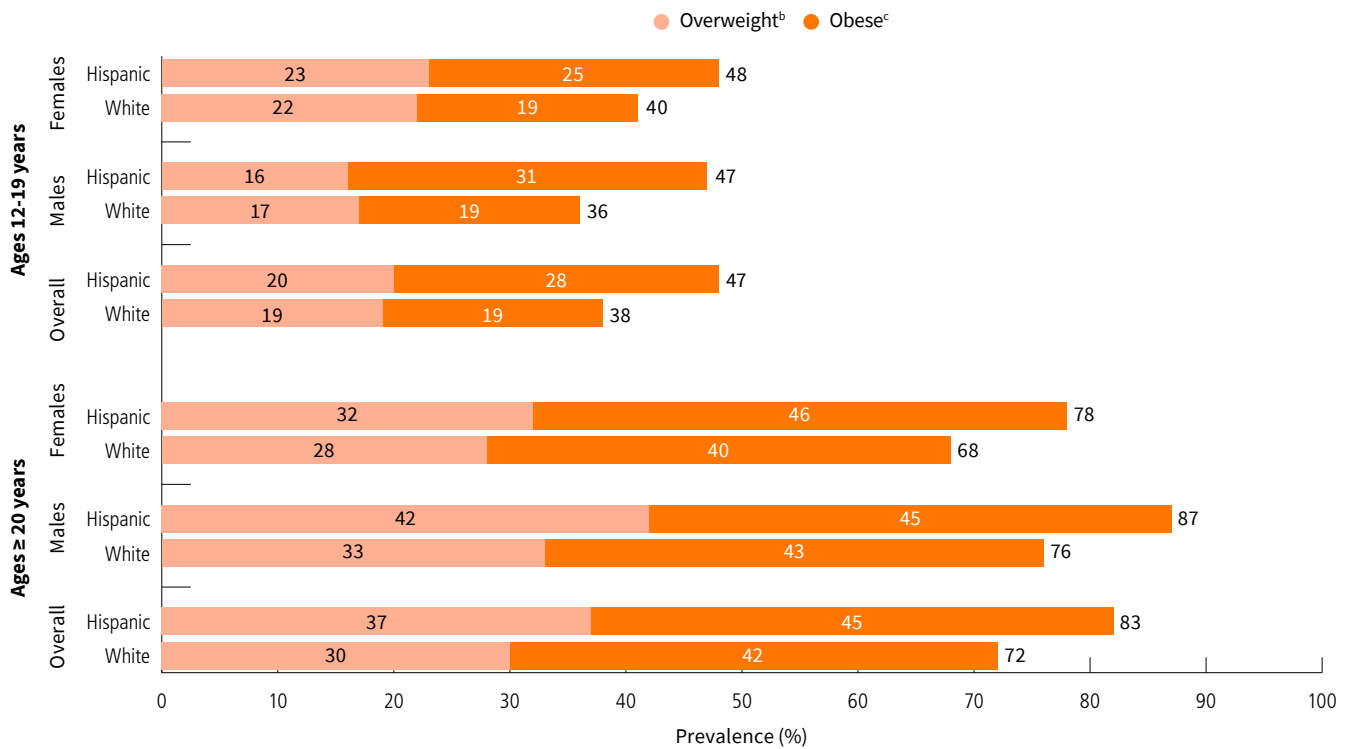
Figure 9. Obesity^a (%) Trends in Mexican American and White People by Age, US, 1976-2020

- Long-term data on obesity (defined as body mass index [BMI] ≥ 30.0 kg/m²) prevalence among Hispanic people are only available for the Mexican American population, among whom obesity prevalence has been consistently higher than White people for both men and women since the late 2000s.^{11, 21}
- The prevalence of obesity has almost tripled among both Mexican and White adolescents since the late 1970s, although increases have generally been exclusive to Mexican American people in the past decade.²¹
- In 2017-2020, 51% of Mexican men and women were obese compared to 40%-43% of White adults.

White=Non-Hispanic White. ^aIn ages 20-74 years, body mass index (BMI) of 30.0 kg/m² or greater. In ages 12-19 years, BMI at or above the 95th percentile from the 2000 Centers for Disease Control and Prevention growth charts. ^bData for Mexican Americans are for 1982-84.

Sources: Health, United States, 2016; National Health and Nutrition Examination Survey Data, 2015-2020.

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White=Non-Hispanic White. ^aOverweight or obese. ^bIn ages ≥20 years, 25.0 kg/m² ≤ BMI < 30.0 kg/m². In ages 12-19 years, BMI at or above 85th percentile but below 95th percentile of Centers for Disease Control and Prevention growth chart. ^cIn ages ≥20 years, BMI ≥30.0 kg/m². In ages 12-19 years, BMI at or above 95th percentile of CDC growth chart.

Sum of estimates for overweight and obese may not equal total excess body weight value presented due to rounding.

Sources: National Health and Nutrition Examination Survey Data, 2017-2020.

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Figure 10. Excess Body Weight^a (%) in Hispanics and Whites by Age, US, 2017-2020

- Among adults in 2017-2020, the prevalence of excess body weight (overweight or obese) was higher among Hispanic adults (men: 87%; women: 78%) than among White adults (men: 76%; women: 68%).
- Obesity prevalence in Hispanic adolescents ages 12-19 years is higher than in White adolescents among both boys (31% versus 19%) and girls (25% versus 19%).

Table 8. Cancer Screening and HPV Vaccination Prevalence (%), US, 2018, 2021, and 2022

- Cancer screening prevalence is lower in Hispanic people compared to White people for cervical (69% versus 80%), breast (60% versus 65%), and colorectal (52% versus 61%) cancers.
- In 2021, 65% of Hispanic adolescents ages 13-17 years were up to date with HPV vaccinations in comparison to 60% of White adolescents.
- Barriers to cancer prevention are not mutually exclusive and interact at multiple levels, including public policy, health system, health care provider, community, and individual. Culturally appropriate interventions, including patient navigation, engagement with community health workers, and tailored small media, are effective strategies to increase screening among Hispanic adults.^{22,23}

	Hispanic (2021)		White (2021)		Hispanic Origin ⁱ (2018)				
	All	Uninsured (≤64 years)	All	Uninsured (≤64 years)	Mexican	Puerto Rican	Cuban	Central/South American	Dominican
Cervical cancer screening (women 25-65 years)^a									
Up-to-date ^b	69	61	80	60	81	80	89	88	92
Cotesting Pap test and HrPV test in the past five years	37	31	39	34	42	41	48	44	-
Pap test within the past three years	66	57	75	49	79	76	81	88	88
Breast cancer screening (women 45+ years)									
Up-to-date ^c	60	38	65	24	59	60	60	68	-
Colorectal cancer screening (adults 45+ years)									
Up-to-date ^d	52	15	61	24	45	62	50	54	-
Males	52	13	60	19	46	61	-	49	-
Females	52	17	62	29	45	64	47	58	-
Ages 45-49 years	18	-	20	-	9	-	-	-	-
Ages 50-54 years	41	16	51	24	30	-	-	32	-
Colonoscopy	46	12	57	21	38	59	47	45	-
Stool-based test	14	-	9	3	13	9	11	15	-
Lung cancer screening (adults 50-79) (2022)^e									
Up-to-date ^f	14	-	14	2					
Prostate Cancer Screening (Males 50+)^g									
Ages 50+ within the past year - American Cancer Society	28	-	38	8	29	29	-	15	-
Ages 55-69 within the past year - USPSTF	26	-	38	13	33	-	-	-	-
HPV vaccination (adolescents 13-17 years) (2022)									
Overall ^h									
≥ 1 dose	79	65	74	48					
Up-to-date	65	41	60	32					
Females									
≥ 1 dose	79	62	76	46					
Up-to-date	66	40	63	35					
Males									
≥ 1 dose	79	68	71	49					
Up-to-date	64	42	57	30					

White=Non-Hispanic White. Some estimates were not provided due to instability. ^aAmong women with an intact uterus. ^bPap test in the past 3 years OR Pap test and HPV test within the past 5 years among women 25-65 years of age. Primary HPV testing estimates are not available due to questionnaire limitations. ^cMammogram in the past year for women 45-54 years of age. Mammogram every other year in women ages 55 and older. ^dFecal occult blood test (FOBT) in the past year, stool DNA in the past 3 years, sigmoidoscopy in the past 5 years, or colonoscopy in the past 10 years, or computed tomography colonography every 5 years. ^eLCS: The American Cancer Society recommends annual screening for lung cancer with a low-dose CT (LDCT) scan for people ages 50-80 years who smoke or used to smoke and have at least a 20 pack-year history of smoking. Due to survey questionnaire limitations, estimates are among individuals ages 50-79 years instead of among ages 50-80 years. ^fLDCT within the past year. ^gPSA: Prostate cancer screening is defined among males who have not been diagnosed with prostate cancer. ^hAdolescents with ≥3 doses, and those with 2 doses when the first HPV vaccine dose was initiated at age <15 years and there was ≥5 months minus 4 days between the first and second dose (<https://www.cdc.gov/vaccines/programs/iis/cdsi.html>). ⁱHispanic origin estimates from 2018 are not comparable to Hispanic estimates in 2021 due to restructuring of NHIS questionnaire in 2019. Visit this [link](#) for more information.

Sources: National Health Interview Survey, 2018 and 2021, National Immunization Survey (NIS) Teen, 2022, Behavioral Risk Factor Surveillance System (BRFSS) 2022. ©2024, American Cancer Society, Inc., Surveillance and Health Equity Science

Research

The American Cancer Society is committed to improving the lives of people with cancer and their families by advancing breakthrough research that will help us end cancer as we know it, for everyone. Over the past 20 years, our Extramural Discovery Science department has funded more than 700 cancer health equity and health disparities grants totaling over \$350 million. This includes grants to evaluate health insurance expansion on preventive cancer care among Latino populations and to test a tailored patient-decision aid aimed at overcoming barriers to shared decision-making for breast cancer screening among Latina women with dense breasts. Our intramural research program, which includes the Surveillance and Health Equity Science and Population Science departments, prioritizes health equity research and investigates disparities in access to care and cancer risk factors, trends, occurrence, and outcomes for marginalized and medically underserved populations, including the Hispanic population. Visit cancer.org/research to learn more.

Advocacy

As the American Cancer Society's advocacy affiliate, the American Cancer Society Cancer Action NetworkSM (ACS CAN) advocates for evidence-based policies to reduce the cancer burden for everyone. Visit fightcancer.org for information about how ACS CAN's work supports the US Hispanic population, including work to protect provisions under the Affordable Care Act and state and federal funding for the Centers for Disease Control and Prevention's (CDC's) National Breast and Cervical Cancer Early Detection Program (NBCCEDP), including efforts to ensure that Puerto Rico is not disincentivized for providing treatment services for women served by the NBCCEDP as a result of inadequate Medicaid funding.

Additional Resources

Intercultural Cancer Council (ICC)

The Intercultural Cancer Council promotes policies, programs, partnerships, and research to eliminate the unequal burden of cancer among racial and ethnic minorities and medically underserved populations in the United States and its associated territories. Visit interculturalcancerCouncil.org for more information.

National Hispanic Council on Aging (NHCOA)

The National Hispanic Council on Aging is the leading national organization working to improve the lives of older Hispanic adults, their families, and caregivers. The organization has been a strong voice dedicated to promoting, educating, and advocating for research, policy, and practice in the areas of economic security, health, and housing for more than 50 years. Visit nhcoa.org to learn more.

National Hispanic Medical Association (NHMA)

The National Hispanic Medical Association is a nonprofit association representing the interests of 50,000 licensed Hispanic physicians in the United States. The mission of the organization is to empower Hispanic physicians to lead efforts that improve the health of Hispanic and other underserved populations in collaboration with Hispanic state medical societies, residents, medical students, and other public and private sector partners. Visit nhmamd.org for more information.

National Alliance for Hispanic Health

The National Alliance for Hispanic Health is the premier science-based and community-driven organization that focuses on the best health for all. Community-based members provide services to more than 15 million Hispanic people throughout the United States every year, and national organization members provide services to more than 100 million people annually. Visit healthyamericas.org for more information.

Data Methods and Limitations

Estimated new cancer cases and deaths in 2024. The estimated number of new cancer cases diagnosed among Hispanic people in the US in 2024 was calculated by estimating complete case counts during 2006 to 2020 in all 50 states and the District of Columbia that were then projected forward 4 years based on the most recent 4-year average annual percent change (AAPC). Case counts were estimated by applying a spatiotemporal model that considers state variation in sociodemographic lifestyle factors, medical settings, and cancer screening behaviors, as well as delays in case reporting, to high-quality incidence data from the North American Association of Central Cancer Registries (NAACCR). Counts for 2020 were adjusted for the deficit in cases during March through May due to health care closures because of the COVID-19 pandemic based on data from 2018 and 2019. For more information on this method, please see Miller et. al. and Lui et. al.^{24, 25}

The estimated number of US cancer deaths among Hispanic people living in the continental US or Hawaii in 2024 was calculated by fitting the number of cancer deaths from 2008 through 2022 to the same statistical model used to produce estimated cases and then similarly forecasting the number of deaths expected to occur in 2024 based on the most recent 4-year AAPC. Original mortality data were based on underlying cause of death reported on death certificates obtained from the National Center for Health Statistics (NCHS) of the CDC.²⁶

Important note about estimated cancer cases and deaths for the current year. Estimates do not include Hispanic people living in US territories due to data limitations. While the projections provide a reasonably accurate estimate of the cancer burden in 2024, they cannot be used to track cancer trends because they may vary from previous years for reasons other than changes in cancer occurrence. Age-adjusted incidence and mortality rates are the preferred statistics for tracking cancer trends in the US. For more information, see Siegel et al.²⁷

Incidence rates. Incidence rates (calculated as the number of people newly diagnosed with cancer during a given time period divided by the population at risk) were age adjusted to the 2000 US standard population based on 19 age groups and reported per 100,000 people. Long-term incidence trends (1998 to 2021) were based on delay-adjusted data from the NAACCR, which cover 99% of the Hispanic population in the continental US and Hawaii. Incidence trends exclude data for 2020 due to pandemic-associated disruptions in cancer screening, diagnoses, and treatment.^{28, 29} NAACCR incidence data were also the source for the 5-year average annual age-adjusted incidence rates and stage distribution for cases diagnosed during 2017 to 2021.

Death rates. Similar to the incidence rates, death rates herein are age adjusted to the 2000 US standard population and presented per 100,000 people. Death rates in this publication are based on counts of cancer deaths compiled by the NCHS and population data from the US Census Bureau.²⁶ Five-year average annual cancer death rates for Puerto Rico (2016-2020) were previously published elsewhere.³⁰ Mortality trends from 1990 onward exclude states during the years they did not collect Hispanic ethnicity data: Louisiana (1990), New Hampshire (1990-1992), and Oklahoma (1990-1996).

Survival. This report presents survival in terms of 5-year relative survival rates for patients diagnosed in all 22 SEER registries (excluding Illinois and Massachusetts), representing 42% of the US population, during 2014 to 2020, with all patients followed through 2021.³¹

Risk factor and screening prevalence. The prevalence of cancer screening, alcohol consumption, e-cigarette use, and cigarette smoking among Hispanic people was obtained from the CDC's National Health Interview Survey (NHIS). The NHIS has monitored the health of the nation since 1957 and is designed to provide national estimates. Data are gathered through a computer-assisted in-person interview of adults ages 18 years and older living in households in the US ([cdc.gov/nchs/nhis.htm](https://www.cdc.gov/nchs/nhis.htm)). The NHIS ceased the disaggregation of data for Hispanic people by country of origin in 2019, so all estimates provided by origin are averaged over survey years

2017-2018. The prevalence of overweight, defined as body mass index (BMI) 25.0-29.9 kg/m² and obesity, defined as body mass index (BMI) ≥30.0 kg/m², was obtained from the National Health and Nutrition Examination Survey (NHANES) and is historically only available for Hispanic people of Mexican origin, although NHANES has begun to report data for all Hispanic people combined in recent years ([cdc.gov/nchs/nhanes/index.htm](https://www.cdc.gov/nchs/nhanes/index.htm)).

HPV vaccination data were obtained from the National Immunization Survey – Teen. Data are gathered through a random-digit-dialing telephone survey of parents or guardians of teens ages 13 to 17 years, followed by a mailed survey to the teens’ immunization providers. Tobacco use and alcohol consumption data for high school students were obtained from the National Youth Tobacco Survey (NYTS) and the Youth Risk Behavioral Surveillance System (YRBSS). The NYTS ([cdc.gov/mmwr/volumes/72/wr/mm7244a1.htm](https://www.cdc.gov/mmwr/volumes/72/wr/mm7244a1.htm)) has provided nationally representative data on tobacco-related beliefs, attitudes, behaviors, and exposure to pro- and anti-tobacco influences for middle and high school students since 1999. Data are collected from cross-sectional, school-based, self-administered questionnaires administered to US middle (grades 6-8) and high school (grades 9-12) students. The YRBSS ([cdc.gov/HealthyYouth/yrbs/index.htm](https://www.cdc.gov/HealthyYouth/yrbs/index.htm)) conducts national, state, territorial, tribal government, and local school-based surveys of representative samples of 9th- through 12th-grade students biannually. All cancer screening and risk factor estimates were adjusted to broad age groups according to CDC standards.

Limitations. Comparison of cancer incidence, death, and survival rates between racial and ethnic groups, particularly those involving groups other than White or Black Americans, should be interpreted with caution for several reasons. First, because of how cancer data are collected, we cannot present most cancer statistics according to country of origin and nativity status, masking important differences within the aggregated Hispanic population. In addition, ethnicity and race are not always classified uniformly in medical records, death certificates, and the US decennial census, so incidence and mortality rates for populations other than White and Black people are likely to be underestimated.

Survival rates presented in this report are from the Surveillance, Epidemiology, and End Results (SEER) program cancer registry areas, which do not include some states where a large proportion of the US Hispanic population resides (e.g., Florida). Further, according to population-based data, Hispanic patients in the SEER registry areas have similar, or sometimes higher, cancer survival rates than non-Hispanic Whites for some cancer sites, despite having lower socioeconomic indicators. This counterintuitive scenario, sometimes referred to as the “Hispanic paradox,” may reflect incomplete or biased data instead of a true survival advantage.^{16, 32, 33} As a result of the greater difficulties in the accurate recording of cancer deaths for immigrant populations, one study found that survival rates for Hispanic patients may be artificially inflated and should be interpreted with caution.¹⁶

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American Cancer Society Recommendations for the Early Detection of Cancer in Average-risk Asymptomatic People*

Cancer Site	Population	Test or Procedure	Recommendation
Breast	Women, ages 40-54	Mammography	Women should have the opportunity to begin annual screening between the ages of 40 and 44. Women should undergo regular screening mammography starting at age 45. Women ages 45 to 54 should be screened annually.
	Women, ages 55+		Transition to biennial screening, or have the opportunity to continue annual screening. Continue screening as long as overall health is good and life expectancy is 10+ years.
Cervix	Women, ages 25-65	HPV DNA test, OR Pap test & HPV DNA test	Preferred: Primary HPV test alone every 5 years with an FDA-approved test for primary HPV screening. Acceptable: Co-testing (HPV test and Pap test) every 5 years or Pap test alone every 3 years.
	Women, ages >65		Discontinue screening if results from regular screening in the past 10 years were negative, with the most recent test within the past 5 years.
	Women who have been vaccinated against HPV		Follow age-specific screening recommendations (same as unvaccinated individuals).
	Women who have had a total hysterectomy		Individuals without a cervix and without a history of cervical cancer or a history of CIN2 or a more severe diagnosis in the past 25 years should not be screened.
Colorectal†	Men and women, ages 45+	Guaiac-based fecal occult blood test (gFOBT) with at least 50% sensitivity or fecal immunochemical test (FIT) with at least 50% sensitivity, OR	Annual testing of spontaneously passed stool specimens. Single stool testing during a clinician office visit is not recommended, nor are “throw in the toilet bowl” tests. In comparison with guaiac-based tests for the detection of occult blood, immunochemical tests are more patient-friendly and are likely to be equal or better in sensitivity and specificity. There is no justification for repeating FOBT in response to an initial positive finding.
		Multi-target stool DNA test, OR	Every 3 years
		Flexible sigmoidoscopy (FSIG), OR	Every 5 years alone, or consideration can be given to combining FSIG performed every 5 years with a highly sensitive gFOBT or FIT performed annually
		Colonoscopy, OR	Every 10 years
		CT Colonography	Every 5 years
Endometrial	Women at menopause		Women should be informed about risks and symptoms of endometrial cancer and encouraged to report unexpected bleeding to a physician.
Lung	Men and women, ages 50-80 who have a 20+ pack-year smoking history	Low-dose helical CT (LDCT)	The American Cancer Society recommends annual LDCT screening in generally healthy adults who have a 20-pack year smoking history, regardless of time since quitting if applicable.
Prostate	Men, ages 50+	Prostate-specific antigen test with or without digital rectal examination	Men who have at least a 10-year life expectancy should have an opportunity to make an informed decision with their health care provider about whether to be screened for prostate cancer, after receiving information about the potential benefits, risks, and uncertainties associated with prostate cancer screening. Prostate cancer screening should not occur without an informed decision-making process. African American men should have this conversation with their provider beginning at age 45.

CT-Computed tomography. *All individuals should become familiar with the potential benefits, limitations, and harms associated with cancer screening.
†All positive tests (other than colonoscopy) should be followed up with colonoscopy.

The American Cancer Society's mission is to improve the lives of people with cancer and their families through advocacy, research, and patient support, to ensure everyone has an opportunity to prevent, detect, treat, and survive cancer.



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