

FOREWORD

When the Europe Against Cancer programme was launched at a meeting of the Heads of State or Government of the European Economic Community countries in Milan, Italy, in 1985, it undertook an ambitious target to reduce cancer deaths in the Member States by 15% by the year 2000. During the lifespan of the Europe Against Cancer programme, cancer mortality in the (fifteen) Member States of the European Union started to decline and there were just over 935,000 cancer deaths in the European Union in 2000. This was about 98,000 (9.5%) fewer cancer deaths than expected had the original mortality rates not changed (Boyle, 2008) and it has been confirmed that downward trends are continuing in the current, enlarged, European Union (Bosetti et al, 2008).

Such progress against cancer is very reassuring.

The mortality rates of most cancers are falling in most countries, and in some countries rates which were rising have stabilised. While this is good news, it is tinged with the sad realisation that the stable rate achieved among men in Hungary is twice as high as that in Sweden (Quinn et al, 2003). These high rates are just part of the frightening picture of health disparities between “old” Europe (the first 15 Member States of the European Union: Austria, Belgium, Denmark, Finland, France, Germany, Greece, Ireland, Italy, Luxemburg, Netherlands, Portugal, Spain, Sweden and the United Kingdom) and “new” Europe (Bulgaria, Czech Republic, Estonia, Hungary, Latvia, Lithuania, Poland, Romania, Slovakia and Slovenia).

Professor Witold Zatonski (Warsaw) has undertaken and completed a major study in central and eastern Europe (HEM Closing the Gap Project, EC action number 2003121) demonstrating that there is a huge gap in health between the ten accession countries in central and eastern Europe and the 15 Member States in western and northern Europe. These differences are frequently in evidence when the maps of cancer mortality presented in this atlas are examined. At the beginning of the 21st century, the extent of inequality in health status between new EU members from central and eastern Europe and the old EU members is not acceptable. The European Union is moving towards a “Single Europe”, but there is an obvious two-speed track in Public Health which requires urgent and serious attention.

The issue is compounded by the ageing of the population in the European Union. Given the strong association of cancer incidence and mortality with age, this will lead to a substantial increase in the cancer burden (Quinn et al, 2003). There was an increase in the estimated number of cases of cancer diagnosed in Europe (all Europe, not only the EU) of 300,000 between 2004 (Boyle and Ferlay, 2005) and 2006 (Ferlay et al, 2007).

The decreasing risk of dying from most forms of cancer in the European Union is a major success but does not allow any room for complacency. The disparity between the health status in the populations of western and northern Europe compared with these of central and eastern Europe requires significant

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and speedy remedial intervention. There is an urgent need to undertake research in central and eastern Europe to identify the causes of the excess cancer (and other chronic disease) mortality rates; to monitor through time changes in biomarkers of chronic disease in response to public health policy; and to create resources for capacity building in research and training of researchers in the whole of Europe. In addition, it is almost too late to take action to be in a position to cope with the increasing cancer burden which will arise throughout Europe due to the ageing population.

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EDITORS' FOREWORD

Cancer is the second-most common cause of death (after cardiovascular diseases) in the majority of European countries and cancer control is clearly one of the biggest challenges of the 21st century. It is an international issue and, thankfully, cancer epidemiology is one of the most fruitful areas of international cooperation in cancer research. The development of several new areas of cancer control, and in particular in cancer epidemiology and prevention, in Europe during the last few decades is closely related to co-operation among institutions and scientists from many countries.

One of the most interesting features of cancer in Europe is its geographical patterns. Studies of the geographical patterns of cancer distribution in Europe have been carried out for over twenty years now. After several national atlases published in the 1980s, international atlases were published in the early 1990s, covering the countries of the European Economic Community (Boyle, Smans and Muir, 1994) and those of central and eastern Europe (Zatonski et al, 1996). One clear message emerges from these works: that cancer risk does not respect national frontiers.

This atlas is the result of the collaboration of a Scientific Committee and the National Vital Statistics Offices in each of the 28 countries covered. The five years covered by the atlas (1993-1997) provide mortality rates based on 5.5 million cancer death, representing the cancer experience in a population with 2.2 billion person-years of risk. The aim of this publication is not only to present cancer patterns in Europe but also to stimulate further studies on cancer epidemiology and generate hypotheses for analytical epidemiological studies.

Modern cancer mapping and the introduction of international cancer atlases owe much to the pioneering ideas of Calum S Muir, formerly Chief of Descriptive Epidemiology at the International Agency for Research on Cancer. Many of the key participants in this project worked on the developments of cancer mapping with Calum. It is great pleasure to acknowledge his important contribution and to dedicate this atlas to his memory.

It was never our idea when mapping cancer to produce pictures suitable merely for a coffee table book. It is our intention and desire that this publication should draw the attention of medical practitioners, scientists, and politicians involved in public health care to important features of cancer in Europe, stimulate further study and lead to steps being taken to prevent the disease. Increasing prospects for prevention is, after all, a major goal in research on cancer.

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