

2026 Maine Cancer Snapshot

A REPORT BY THE MAINE CANCER REGISTRY

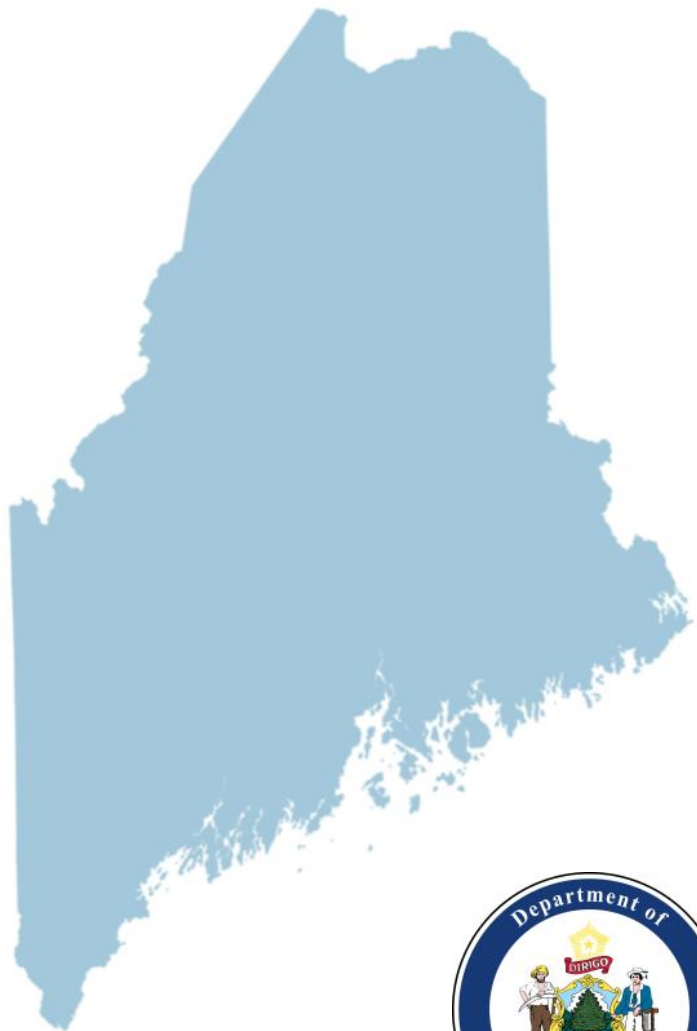
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Maine Cancer Registry

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Key Findings

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Among Maine residents in 2023, there were 10,623 new malignant cancer cases and 3,439 cancer deaths.

Cancer Incidence

- In 2023, the overall age-adjusted cancer incidence rate for Maine was 491.2 per 100,000, significantly higher than the U.S. (455.0).
- The overall cancer incidence rate in Maine declined significantly from 2006-2012 but rates have been stable since.
- The four most common newly diagnosed cancers in Maine are female breast, prostate, lung and bronchus, and colon and rectum.
- Washington County has significantly higher overall cancer incidence rates compared to the state (2021-2023).
- Late-stage lung and bronchus incidence rates have seen recent improvements, while male prostate and colon and rectum have increased.



Cancer Mortality

- The 2023 age-adjusted overall cancer mortality rate in Maine is 153.3 per 100,000, which is significantly higher than the U.S. rate (141.5).
- The overall cancer mortality rate has been decreasing in Maine over the past 20 years yet remains significantly higher than the U.S. rate.
- The leading causes of cancer mortality are cancers of the lung and bronchus, pancreas, colon and rectum, male prostate, and female breast.
- Somerset and Washington Counties have significantly higher overall cancer mortality rates compared to the state rate (2019-2023).

*The 2026 Maine Cancer Snapshot is based on new cancer cases diagnosed in 2023 (cancer incidence) and cancer deaths occurring in 2023 (cancer mortality). This time-lag is consistent with reporting standards used throughout the U.S. to ensure high quality data. The process requires time for a state cancer registry to receive cancer cases from multiple reporting sources (including vital records, hospital reporters, physician offices, and pathology labs), time for follow up and data corrections, as well as time to consolidate state data and perform quality control and analysis. See cautionary note about 2020 incidence on page 20.

Acknowledgements

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Cancer Incidence

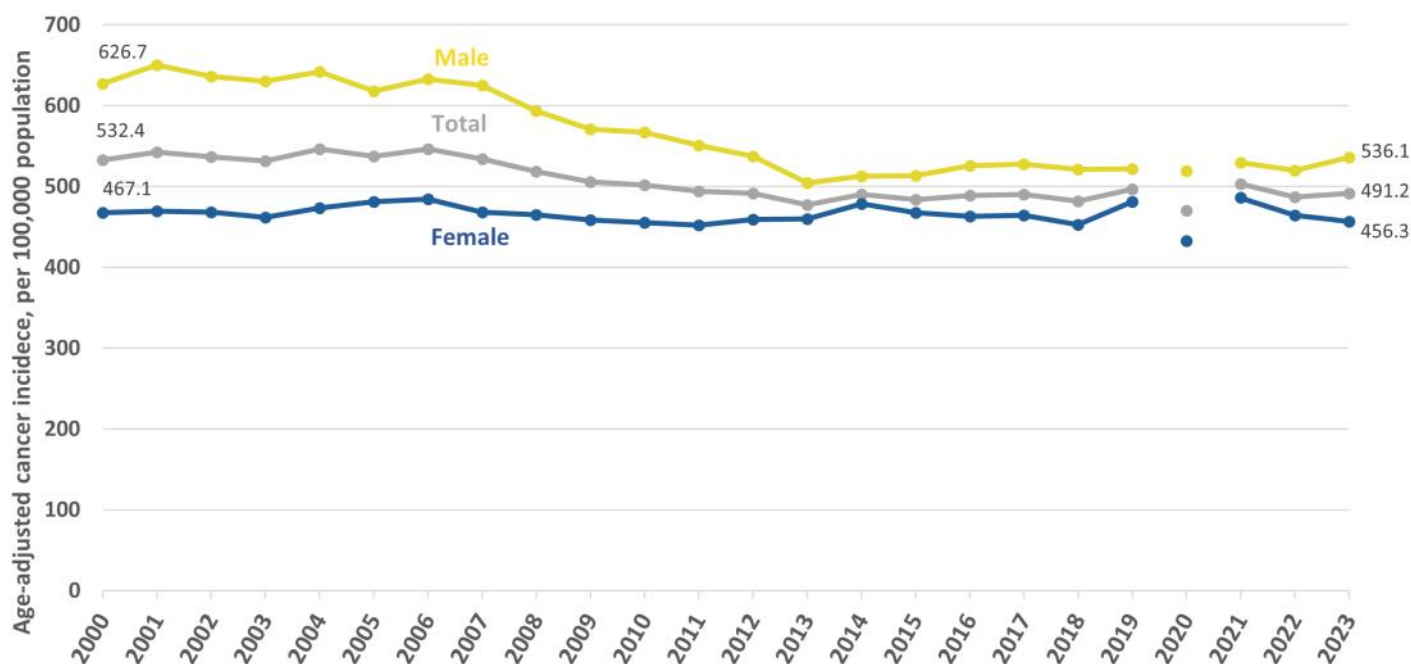
2026 MAINE CANCER SNAPSHOT

Cancer Incidence Key Findings

- Between 2000 and 2013, the overall cancer incidence rate in Maine decreased significantly from 532.4 per 100,000 population to 477.2 per 100,000, but there has been no significant change in trend over the last ten years.
- Over that same time period, the gap between the male and female rates has narrowed, with the male rate decreasing more rapidly, yet remaining higher than females.
- Female breast, lung and bronchus, prostate, and colon and rectum represent just under half of all new cancer diagnoses in Maine.
- Overall cancer incidence rates, as well as incidence rates for lung and bronchus, urinary bladder, and melanoma of the skin, are significantly higher in Maine than the U.S.

Trends by Sex

Figure 1: Cancer Incidence Rate: All Malignant Cancers, by Sex, Maine, 2000-2023



Rates are per 100,000 population, age-adjusted to the Year 2000 U.S. standard population.
Data source: Maine Cancer Registry, based on November 2025 NPCR-CSS data submission.

Note: 2020 data is displayed but not included in trend analysis due to the impact of the COVID-19 pandemic on cancer reporting (see page 20).

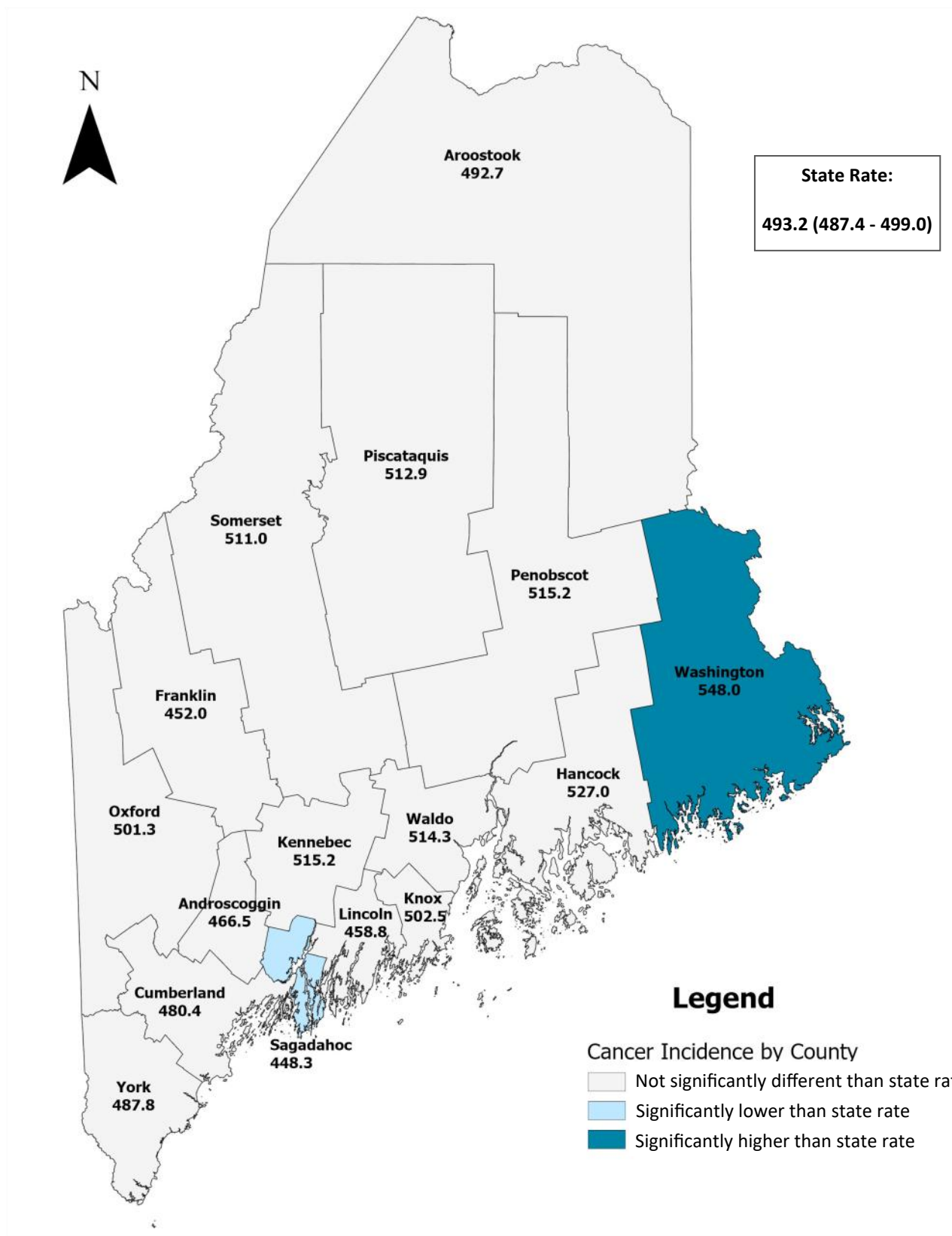
Incidence: Top 10 Cancers, Maine 2023

Red Rate = Maine is significantly higher than U.S.

Cancer Type	2023 Maine (all sexes)				2023 U.S.		
	Count	AA Rate	AA Lower 95% CI	AA Upper 95% CI	AA Rate	AA Lower 95% CI	AA Upper 95% CI
All Sites	10,623	491.2	481.3	501.3	455.0	454.3	455.7
Female Breast	1,490	138.8	131.3	146.7	135.2	134.7	135.7
Prostate	1,473	126.3	119.7	133.2	121.8	121.3	122.3
Lung and Bronchus	1,448	60.8	57.6	64.1	50.1	49.9	50.3
Colon and Rectum	772	39.4	36.5	42.5	37.9	37.7	38.1
Urinary Bladder	635	27.8	25.6	30.2	18.0	17.9	18.2
Melanoma of the Skin	571	27.7	25.3	30.2	24.9	24.7	25.0
Non-Hodgkin Lymphoma	372	17.6	15.8	19.6	18.0	17.9	18.2
Kidney and Renal Pelvis	356	16.6	14.8	18.6	18.4	18.2	18.5
Female Corpus and Uterus, NOS	355	29.9	26.7	33.5	28.7	28.5	28.9
Pancreas	323	14.1	12.5	15.8	13.9	13.8	14.1
	Maine Females				U.S. Females		
All Sites	5,020	456.3	442.7	470.2	433.7	432.8	434.6
Female Breast	1,490	138.8	131.3	146.7	135.2	134.7	135.7
Lung and Bronchus	718	56.7	52.5	61.2	47.3	47.0	47.6
Colon and Rectum	365	34.9	31.2	39.1	33.5	33.3	33.8
Uterus (Corpus and Uterus, NOS)	355	29.9	26.7	33.5	28.7	28.5	28.9
Melanoma of the Skin	239	24.3	21.1	28.0	20.4	20.2	20.6
Urinary Bladder	160	12.8	10.8	15.2	7.8	7.7	7.9
Thyroid	153	19.3	16.1	22.9	20.0	19.8	20.2
Non-Hodgkin Lymphoma	146	12.9	10.8	15.4	15.0	14.9	15.2
Pancreas	143	11.4	9.5	13.5	12.4	12.3	12.6
Kidney and Renal Pelvis	140	12.6	10.4	15.1	12.6	12.4	12.7
	Maine Males				U.S. Males		
All Sites	5,601	536.1	521.4	551.2	487.9	486.9	488.9
Prostate	1,473	126.3	119.7	133.2	121.8	121.3	122.3
Lung and Bronchus	729	65.3	60.4	70.5	54.0	53.6	54.3
Urinary Bladder	475	45.3	41.1	49.8	30.8	30.5	31.0
Colon and Rectum	407	44.6	40.1	45.0	42.8	42.5	43.1
Melanoma of the Skin	332	32.7	29.1	36.7	30.9	30.7	31.2
Non-Hodgkin Lymphoma	226	22.9	19.8	26.3	21.7	21.4	21.9
Oral Cavity and Pharynx	217	21.3	18.3	24.6	18.3	18.1	18.5
Kidney and Renal Pelvis	216	21.3	18.4	24.6	24.9	24.6	25.1
Leukemia	193	20.1	17.2	23.4	17.9	17.7	18.1
Pancreas	180	17.2	14.7	20.1	15.7	15.6	15.9

Leading cancer types are ordered by descending Maine incidence counts. AA: Age-adjusted to the year 2000 U.S. standard population. Rates are per 100,000. 95% CI: 95% Confidence interval. Overall Maine rates calculated using all sexes combined. Data sources: Maine data: Maine Cancer Registry. U.S data: NPCR and SEER Incidence analytic file - U.S. Cancer Statistics Public Use Database. See technical notes on page 20 for a full definition.

All Malignant Cancer Incidence Rates by County, Maine, 2021-2023

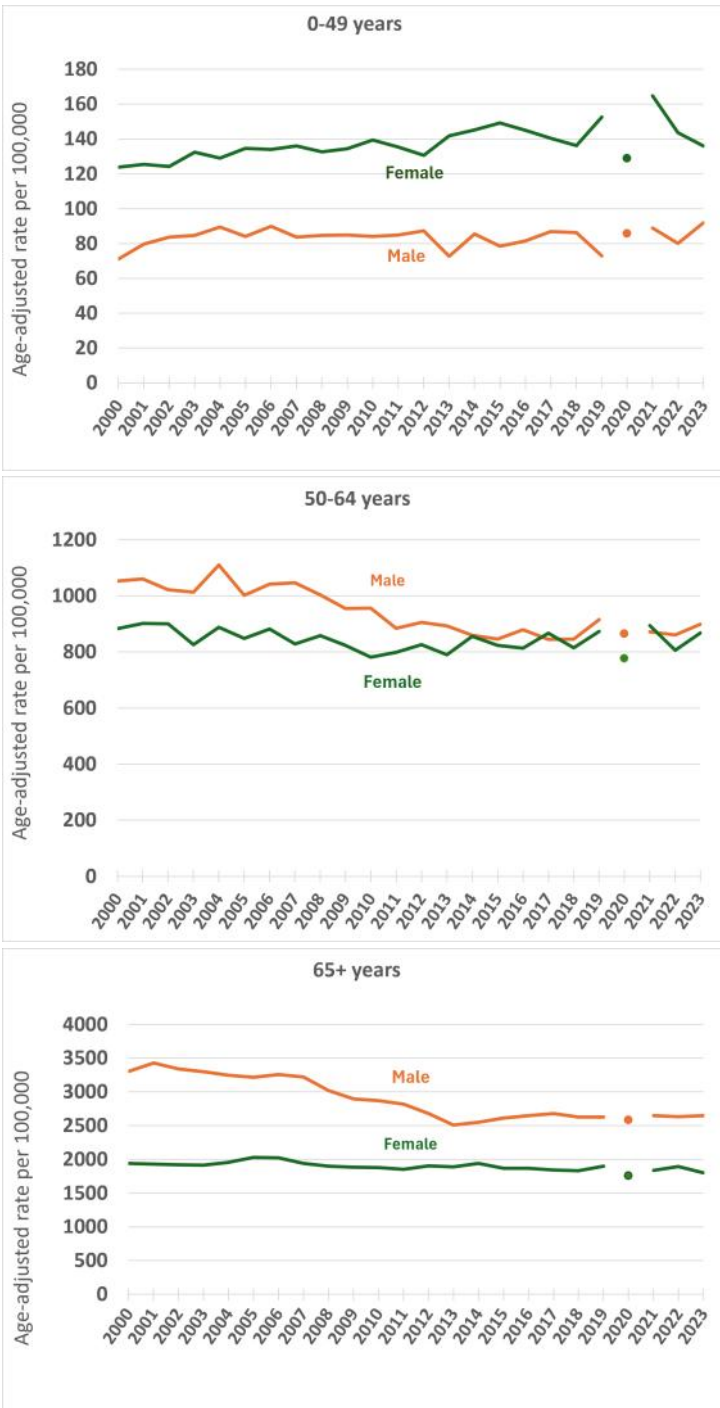


Rates are per 100,000 population, age-adjusted to the year 2000 U.S. standard population. Significance based on 95% confidence interval. Data source: Maine Cancer Registry, based on November 2025 NPCR-CSS data submission. See supplemental table 2 on page 23 for detailed information.

Cancer Incidence By Sex and Age Group

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Figure 2: Trends in Age Adjusted Cancer Incidence Rates per 100,000 Population, by Sex and Age Group, Maine, 2000-2023



Mainers Age 0-49

- Among Mainers under 50 years old, cancer rates among females have recently decreased, but are higher than male rates which are stable.
- Cancer diagnoses among Mainers under 50 represent less than 10% of new diagnoses in 2023.

Mainers Age 50-64

- Among Mainers 50-64 years old, male and female rates have converged over the last twenty years.
- Just over one quarter of new diagnoses in 2023 were among Mainers 50-64 years or older.

Mainers Age 65+

- Among Mainers 65 years old and older, male rates decreased and then more recently plateaued in the last decade while rates among females have declined more slowly since 2000.
- 65% of new cancer diagnoses in 2023

Rates are per 100,000 population, age-adjusted to the year 2000 U.S. standard population. Data source: Incidence: Maine Cancer Registry, based on November 2025 NPCR-CSS data submission. *Note: 2020 data is displayed but not included in trend analysis due to the impact of the COVID-19 pandemic on cancer reporting (see page 20). See supplemental table 1 on page 22 for detailed information.*

Late-Stage Cancer Incidence By Site

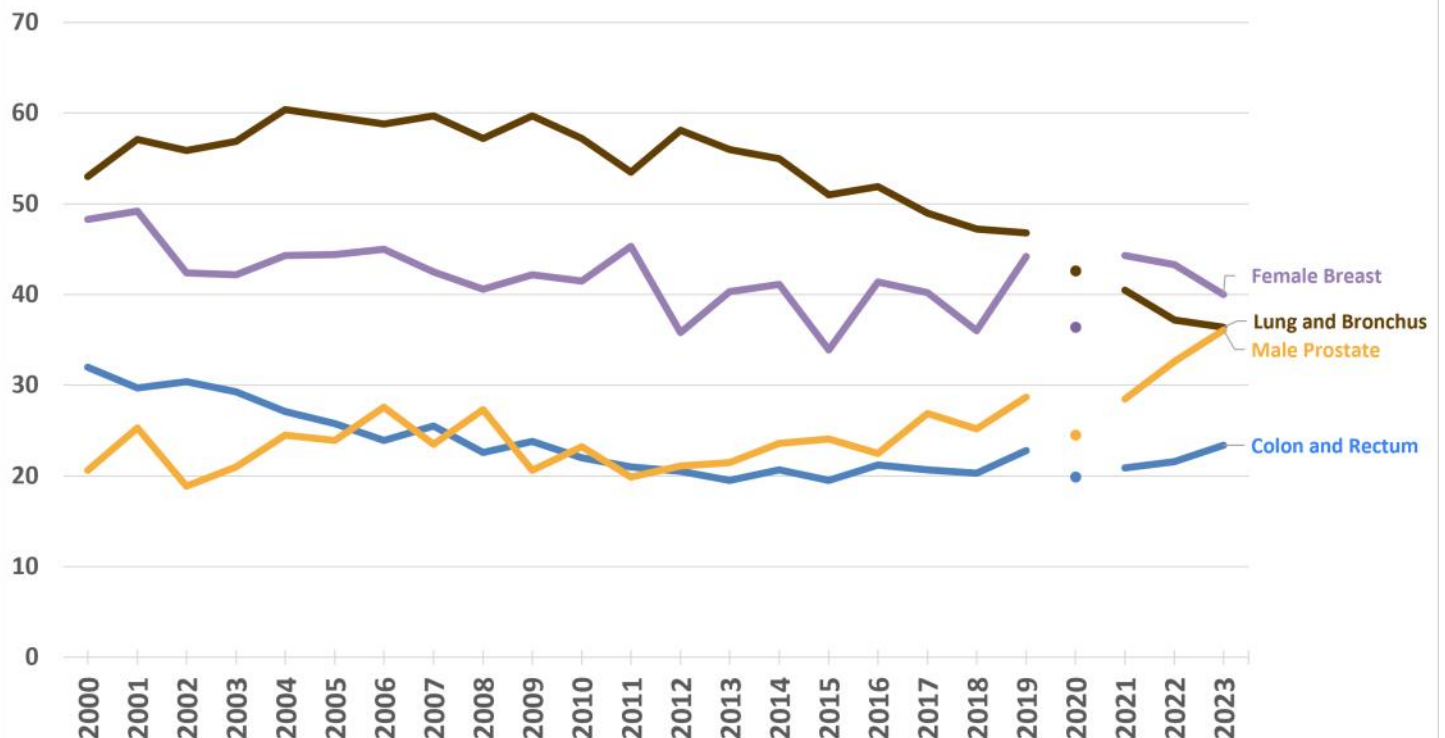
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Key Trends in Late-Stage Cancer Incidence Rates

Trends in late stage (regional or distant) cancer incidence rates can indicate the effectiveness of cancer screening and early intervention efforts (see page 20 for staging information). Finding cancer at an early stage greatly increases survival, reduces mortality, and allows for more treatment options. Tracking these trends helps guide screening policies and comprehensive cancer control in Maine.

- **Female breast:** Rates declined roughly 1.3% each year between 2000-2015, with no significant change in late-stage rates since 2015.
- **Lung and Bronchus:** Rates were stable in the early 2000s but have seen an accelerated decline, decreasing 6.2% each year since 2019.
- **Male Prostate:** Rates were stable from 2000-2011, but have significantly increased by 4.6% each year since 2011.
- **Colon and Rectum:** Rates declined 3.6% each year between 2000-2012, yet rates have been significantly increasing by 1.4% a year since.

Figure 3: Age adjusted Late-Stage Cancer Incidence Rates, by Leading Sites, Maine, 2000-2023

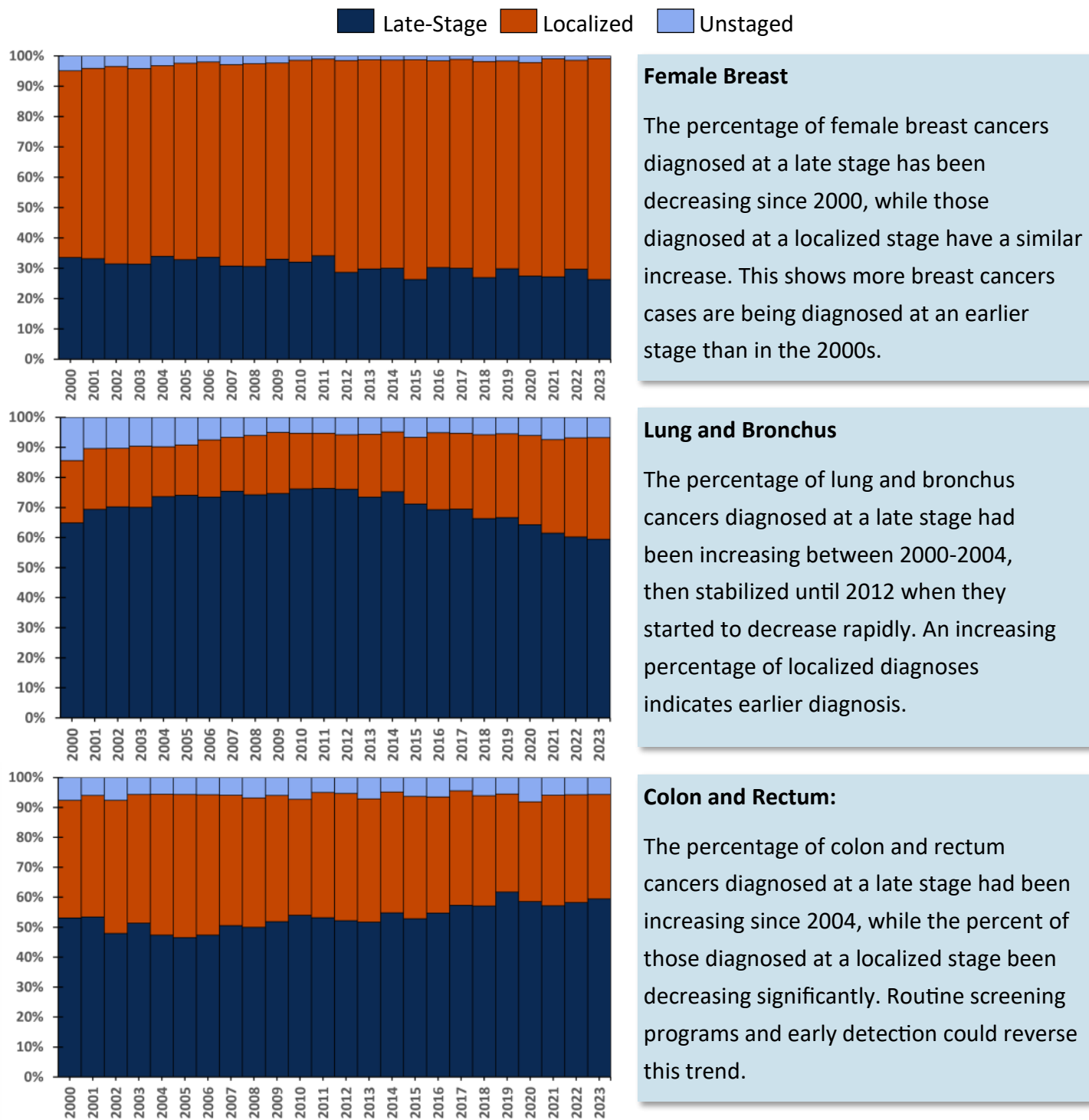


Late-stage rates are per 100,000 population, age-adjusted to the year 2000 U.S. standard population. Late-stage incidence rates calculated using cases where stage at diagnosis is either distant or regional stage. Trends in late stage calculated using Joinpoint Software, see page 20. Data source: Incidence: Maine Cancer Registry, based on November 2025 NPCR-CSS data submission. 2020 data is displayed but not included in trend analysis due to the impact of the COVID-19 pandemic on cancer reporting (see page 20).

Late-Stage Cancer Incidence By Site

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Figure 4. Trends in Stage at Diagnosis for Leading Sites in Maine, 2000-2023



Figures above show single year trends in cancer incidence rates, by stage at diagnosis shown as a percent, Maine, 2000-2023. Late-stage is calculated using cases where stage at diagnosis is either distant or regional stage. Percents calculated using counts of all malignant cancers, not including in situ. Data source: Incidence: Maine Cancer Registry, based on November 2025 NPCR-CSS data submission. See page 20 for staging information.

Cancer Mortality

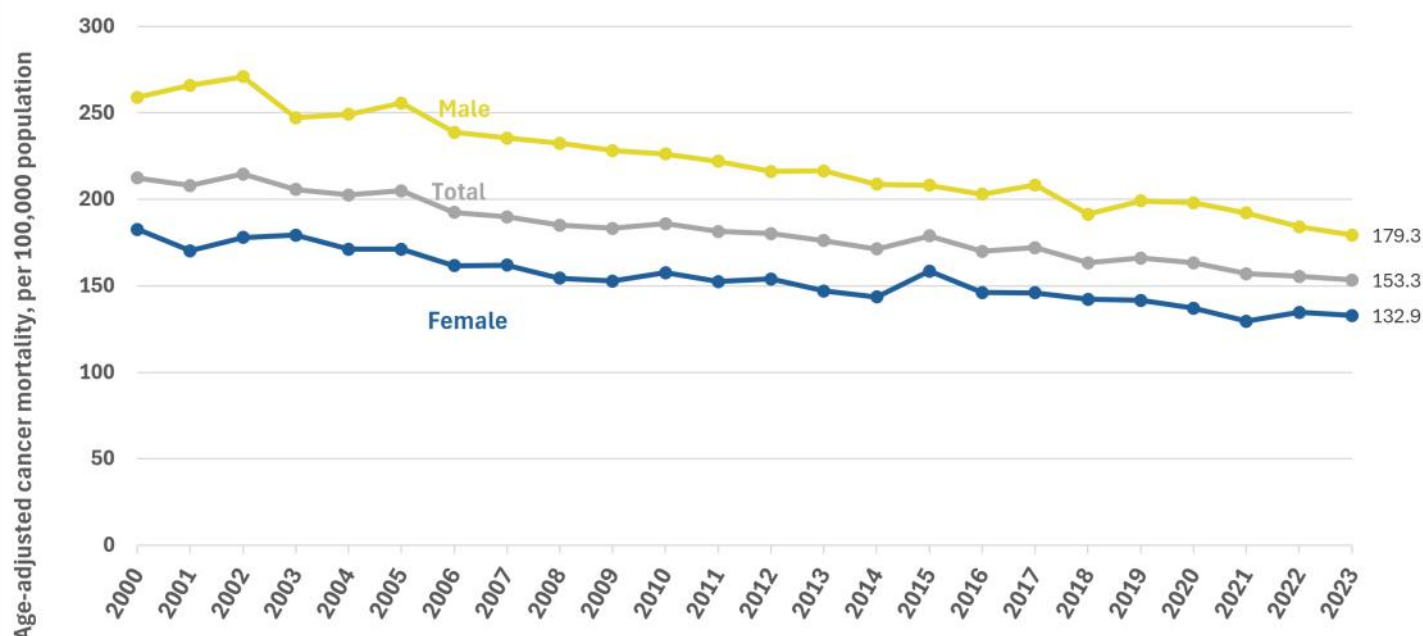
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Cancer Mortality Key Findings

- In 2023, there were 3,439 cancer deaths among Maine residents. The 2023 age-adjusted cancer mortality rate in Maine is 153.3 per 100,000, which is significantly higher than the U.S. cancer mortality rate (141.5).
- From 2000-2023, the overall cancer mortality rate significantly decreased by 1.4% per year, while male and female rates decreased by 1.6% and 1.3%.
- Maine males have a significantly higher age-adjusted cancer mortality rates than females.
- Lung and bronchus, prostate, esophageal, and urinary bladder cancer mortality rates in Maine are significantly higher than the U.S.
- Somerset and Washington Counties have significantly higher overall cancer mortality rates compared to the state overall. Cumberland County has a significantly lower cancer mortality rate compared to the state overall.

Trends by Sex

Figure 5: Cancer Mortality Rate: All Malignant Cancers, by Sex, Maine, 2000-2023



Rates are per 100,000 population, age-adjusted to the Year 2000 U.S. standard population. Data Source: Maine Cancer Registry. Data, Research, and Vital Statistics. Maine CDC. Mortality SEER*Stat Analytic file Last updated August 2026.

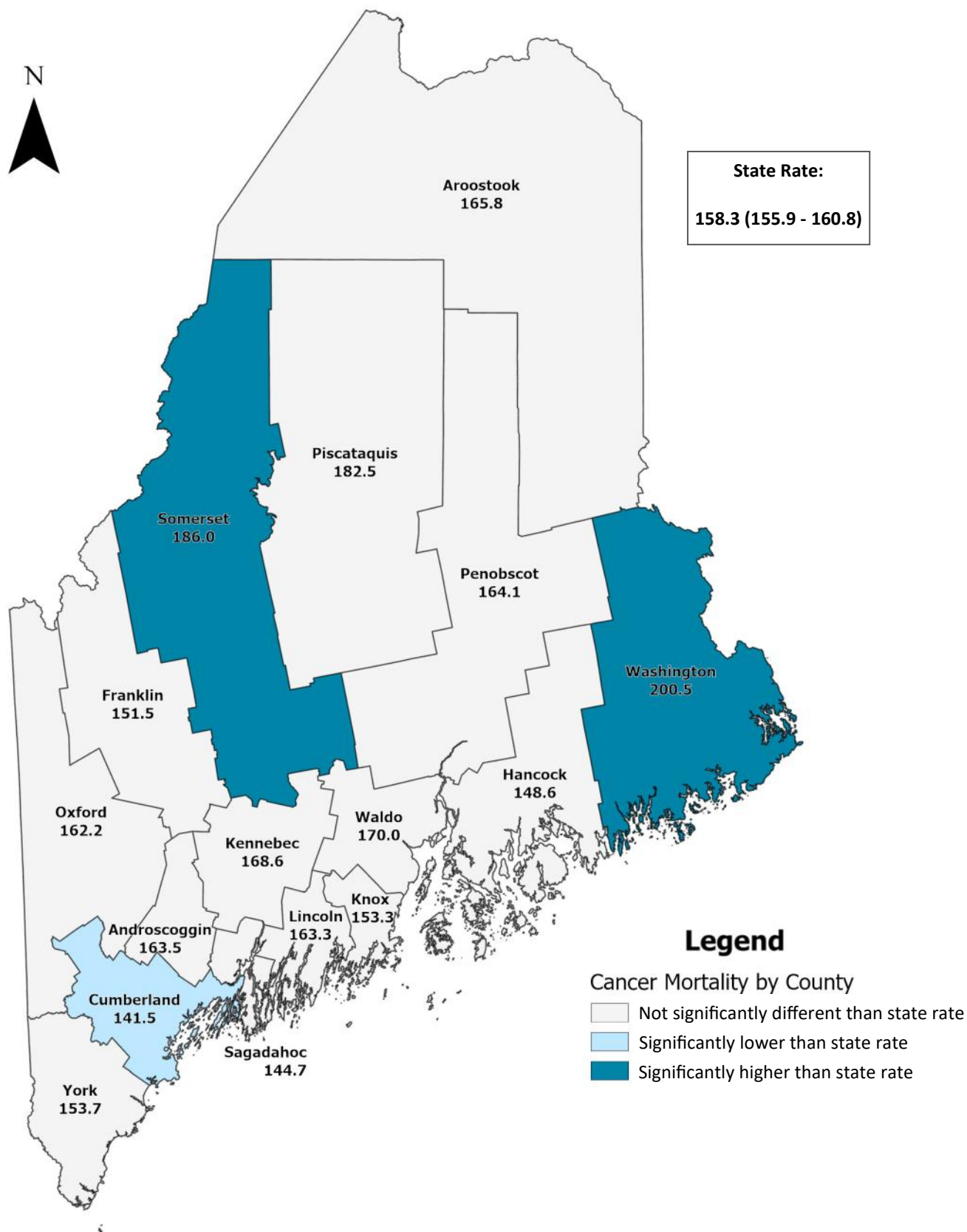
Mortality: Top 10 Cancers, Maine 2023

Red Rate = Maine is significantly higher than U.S.

Cancer Type	Maine (all sexes)				2023 U.S.		
	Count	AA Rate	AA Lower 95% CI	AA Upper 95% CI	AA Rate	AA Lower 95% CI	AA Upper 95% CI
All Sites	3439	153.3	148.0	158.6	141.5	141.1	141.8
Lung and Bronchus	815	34.7	32.3	37.2	29.3	29.2	29.5
Pancreas	267	11.4	10.0	12.8	11.2	11.1	11.3
Colon and Rectum	247	11.6	10.1	13.2	12.7	12.6	12.8
Prostate	209	22.0	18.9	25.0	18.6	18.4	18.8
Female Breast	206	17.8	15.2	20.4	18.6	18.4	18.8
Leukemia	131	6.2	5.1	7.4	5.6	5.6	5.7
Non-Hodgkin Lymphoma	125	5.7	4.7	6.7	4.7	4.6	4.8
Liver and Intrahepatic Bile Duct	121	5.2	4.3	6.2	6.6	6.6	6.7
Esophagus	119	5.2	4.2	6.2	3.6	3.6	3.7
Urinary Bladder	117	5.3	4.3	6.2	4.0	4.0	4.1
Maine Females				U.S. Females			
All Sites	1616	132.9	126.2	139.6	123.6	123.2	124.1
Lung and Bronchus	418	33.1	29.9	36.4	25.7	25.5	25.9
Female Breast	206	17.8	15.2	20.4	18.6	18.4	18.8
Pancreas	119	9.4	7.7	11.1	9.8	9.7	10.0
Colon and Rectum	116	9.6	7.8	11.4	10.7	10.6	10.8
Uterus (Corpus Uteri and Uterus NOS)	65	5.3	4.1	6.7	5.6	5.5	5.7
Ovary	61	5.2	4.0	6.7	5.5	5.4	5.6
Leukemia	53	4.3	3.2	5.6	4.2	4.1	4.3
Brain and Other Nervous System	52	4.4	3.3	5.8	3.6	3.6	3.7
Non-Hodgkin Lymphoma	47	3.7	2.8	5.0	3.5	3.4	3.6
Urinary Bladder	38	3.0	2.1	4.1	2.0	2.0	2.1
Maine Males				U.S. Males			
All Sites	1823	179.3	170.7	187.8	165.4	164.9	166.0
Lung and Bronchus	397	36.6	32.9	40.3	34.0	33.7	34.3
Prostate	209	22.0	18.9	25.0	18.6	18.4	18.8
Pancreas	148	13.8	11.5	16.1	12.8	12.6	12.9
Colon and Rectum	131	13.6	11.2	16.1	15.1	14.9	15.3
Esophagus	89	8.6	6.9	10.5	6.3	6.2	6.4
Liver and Intrahepatic Bile Duct	83	7.6	6.1	9.5	9.3	9.2	9.4
Urinary Bladder	79	8.4	6.7	10.5	6.8	6.7	7.0
Non-Hodgkin Lymphoma	78	8.1	6.4	10.1	6.2	6.1	6.3
Leukemia	78	8.4	6.6	10.5	7.5	7.4	7.6
Oral Cavity and Pharynx	52	5.4	3.8	6.6	4.1	4.0	4.2

Leading types of cancer mortality are ordered by descending Maine counts. AA: Age-adjusted to the year 2000 U.S. standard population. Rates are per 100,000. 95% CI: 95% Confidence interval. Overall rates calculated using male and female only to match US sex classification. Data source: Maine Center for Disease Control, Data, Research, and Vital Statistics. U.S. data: United States Cancer Statistics - Mortality: 1999 - 2023, WONDER Online Database. United States Department of Health and Human Services, Centers for Disease Control and Prevention; 2025. Accessed at http://wonder.cdc.gov/cancermort-v2022_SR.html.

Mortality by County, Maine, all sexes, 2019 - 2023



Data Source: Maine Mortality: Maine CDC's Data, Research, and Vital Statistics. Rates are calculated per 100,000 population, age-adjusted to the year 2000 U.S. standard population. Significance based on 95% confidence interval. See supplemental table 3 on page 24 for detailed information.

Additional Incidence and Mortality Data for Maine

The following Maine CDC and U.S. dashboards provide additional options for detailed queries by cancer site. Click on headings below for more information.

Maine Cancer Registry (MCR) Website

This website provides additional information about the MCR, reports, procedures for requesting data, and resources related to cancer reporting in Maine.

Maine Cancer Plan

This plan is a ten-year (2021-2030) agenda for cancer prevention, screening, diagnosis, treatment, palliative, and end-of-life care in Maine from the Maine Cancer Coalition.

Maine Shared Community Health Needs Assessment (CHNA) Dashboard

This interactive dashboard shows Maine data for a variety of health behaviors, chronic diseases, and social determinants of health. Data are available for many demographic groups (sex, age, race) and subpopulations (rural residents, veterans), by county and public health district, and major cities. This dashboard is currently undergoing revisions.

Maine Environmental Health Tracking Network Data Portal

This portal allows users to view health and environmental data by geographic region in Maine. Users can compare data across age groups, genders, regions, and time periods and make and download their own customized tables, charts, and maps.

North American Association of Central Cancer Registries (NAACCR) Online Cancer Data

NAACCR Cancer Maps (historically called CiNA+ online) is an interactive mapping tool for U.S. and Canadian cancer incidence statistics for the most current five years of available data.

NAACCR CiNA Explorer Stats is an interactive data visualization tool for quick access to key U.S. and Canadian cancer statistics for major cancer sites by age, sex, stage, race/ethnicity, registry, and data type for the most current five years of available data.

U.S. Cancer Statistics Data Visualizations Tool

This tool provides incidence and death counts, rates, and trend data, survival and prevalence estimates, and state, county, and congressional district data in a user-driven format. Cancer incidence and mortality trend data are presented from 1999 through 2023.

Special Topic: Access to Cancer Care in Maine

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Background:

In this special topic section, we map round trip driving times to cancer facilities in Maine, and assess the impact that accreditation plays on access to care. Accreditations require facilities to monitor the quality of their programs. As financial and workforce challenges mount, many facilities have dropped their accreditations. This strained health care system creates challenges for Mainers who often have to travel outside of their communities for care. With facilities and Mainers experiencing these challenges, quantifying drive times and monitoring changes in accreditation and facility closures is essential.

Methods:

MCR utilized tumor-level cancer cases between 2018-2022 (n=44,106), reporting facility locations, public roadway data, and ArcGIS Pro mapping software to estimate round trip driving time to the closest cancer facility. MCR cancer cases were mapped to their population-weighted U.S. census block group centroids using address at time of diagnosis. Roughly 20% of records we excluded due to missing address data (see page 21). Access to care was mapped using only cancer reporting facilities in Maine. The analysis was performed for any cancer reporting facility (n=33), accredited facilities (n=8), and breast cancer accredited facilities (n=3). The breast cancer analysis examined drive time to breast cancer accredited facilities for all Maine women 30 or older using 2020 census population data, not cancer cases (see page 21).

Results:

Access to any cancer reporting facility in Maine was relatively even across the state, with 94% of Mainers with cancer living within a 1 hour round trip drive of any reporting facility at the time of diagnosis. However 40% of cases in Washington County lived greater than or equal to a 2 hour round trip drive, the lowest access in the state. Access to accredited care was more limited, with only 63% of Mainers with cancer living within a 1 hour round trip drive, and roughly 5% living greater than a 4 hour round trip. Washington and Aroostook counties had the most limited access to accredited care, with 32% and 75% of individuals with cancer being greater than a 4 hour round trip drive. Access to breast cancer facilities was even more limited given their concentration in the southern part of the state. Only 33% of women 30 or older lived within a 1 hour round trip, and nearly 15% of women lived greater than a 4 hour round trip drive from the closest breast cancer accredited facility. These results highlight the county-level disparities in access to accredited cancer care in Maine. Other factors like weather, physical limitations, and socioeconomic factors make the challenges of a cancer diagnosis even more difficult to manage.

Drive Time to Any Cancer Reporting Facility

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Key Findings

- Figure 6 shows drive time to all facilities reporting cancer cases to the MCR, with accredited cancer facilities in blue and non-accredited in red. It's important to note that non-accredited facilities may vary greatly from accredited facilities in their capacity, diagnostic, and treatment capabilities for cancer.
- Less than 1% of Mainers with cancer have exceptionally long drive times (more than a 2 hour round trip) to any cancer reporting facility, with almost 58% living within a 30-minute round trip, and 94% within 1 hour.

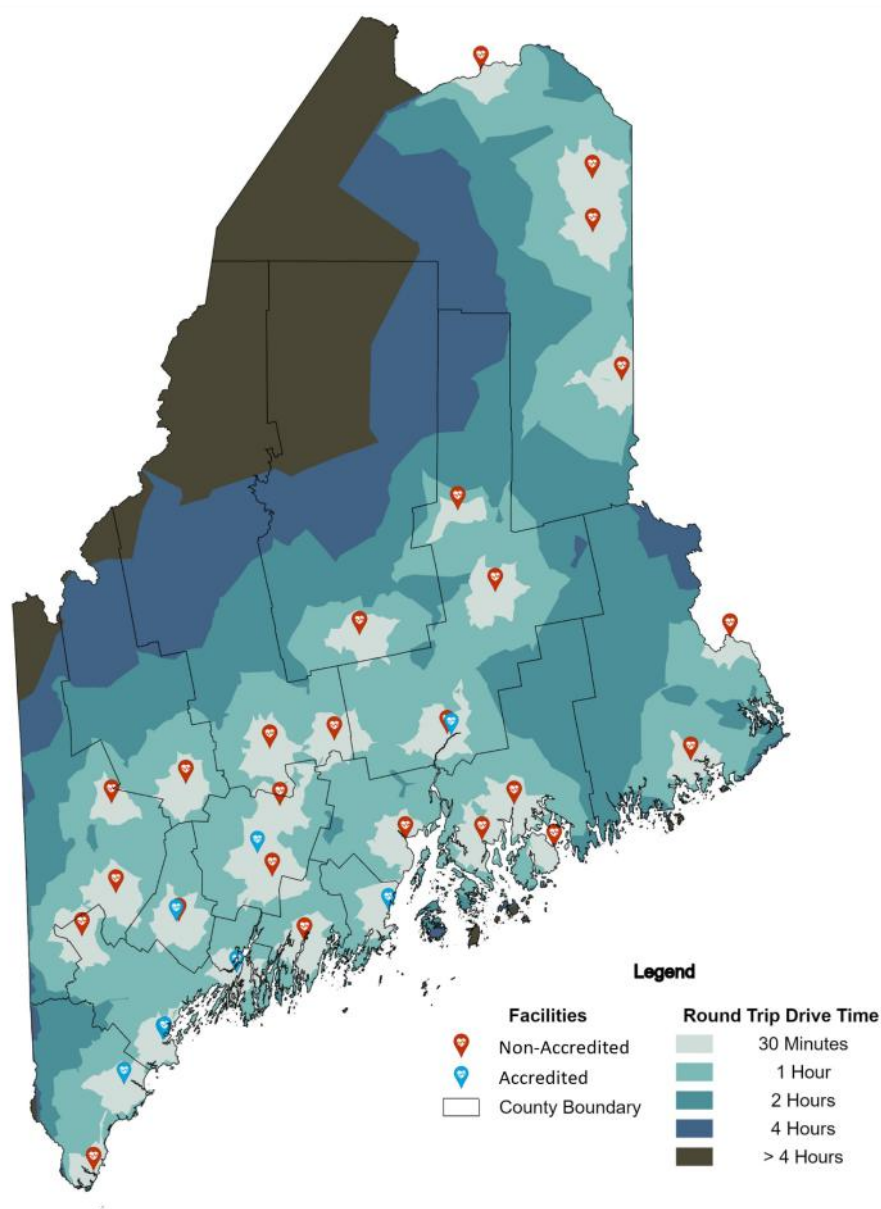


Figure 6: Distribution of round-trip drive time to any cancer reporting facility among Mainers diagnosed with cancer (2018-2022)

- 58% (25,433) are within a **30-minute round trip**
- 94% (41,557) are within a **1 Hour round trip**
- 99.4% (43,860) are within a **2 Hour round trip**
- 99.9% (44,093) are within a **4 Hour round trip**

Figure 6: Shows any cancer reporting facility in Maine (n=33), colored by accreditation status. Round trip drive time categories from all facilities is mapped, county boundaries are visible. Percent of cancer cases in each drive time are summarized to the state level (2018-2022).

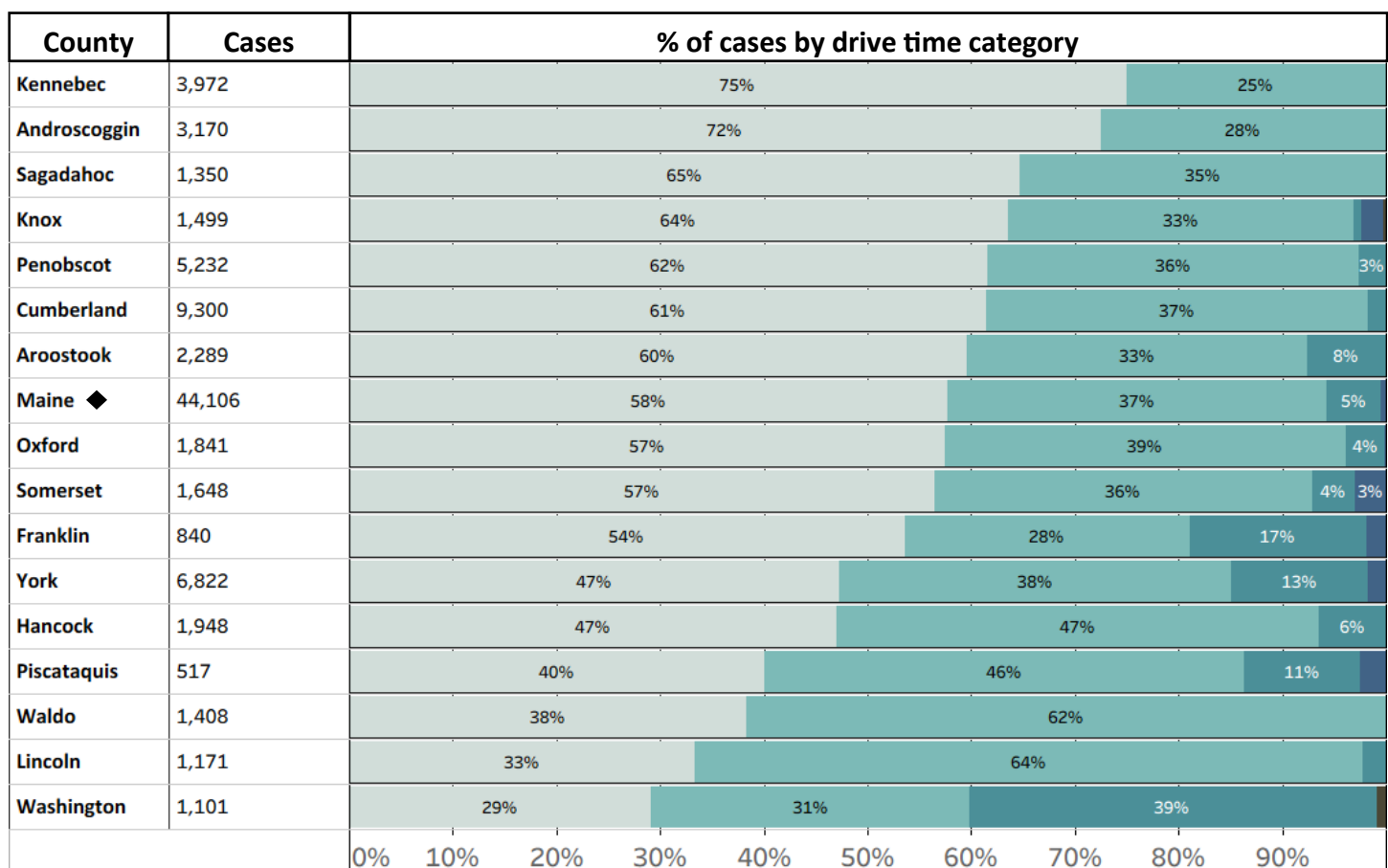
Drive Time to Any Cancer Reporting Facility by County

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Figure 7: Distribution of round trip drive time to any cancer reporting facility among Mainers diagnosed with cancer, by county (2018-2022)

- Access to any cancer reporting facility did not differ greatly by county. While there are more cancer reporting facilities in the southern and central parts of the state, rural coverage remains high, although it does not reflect the quality or type of care available at each facility.
- Washington County in the far eastern portion of the state had 40% of records greater than or equal to a 2 hour round trip, the highest proportion of any county. Washington County is also the only county to have a significantly higher cancer incidence rate than the state (2019-2023).

30 Minutes 1 Hour 2 Hours 4 Hours > 4 Hours



The chart shows the percent of cancer cases in each drive time category to the closest cancer reporting facility, by county (2018-2022). Counties differ greatly in number of cases reported each year. Counties are sorted in sequential descending order by percent and by drive time category. Labels for percents less than 3% are not displayed.

Drive Time to Accredited Reporting Facilities

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Key Findings

- Figure 8 shows drive time to accredited cancer facilities, which are concentrated in the southern and central part of the state, with the northern most being in Bangor leaving much of eastern and northern Maine far from high quality accredited care programs.
- Nearly two-quarters of Mainers with cancer lived within a 1 hour round trip to accredited care. 5% of Mainers with cancer (2,191) were greater than a 4 hour round trip, with some individuals in the far north living more than an 8 hours round trip drive from the nearest accredited facility.

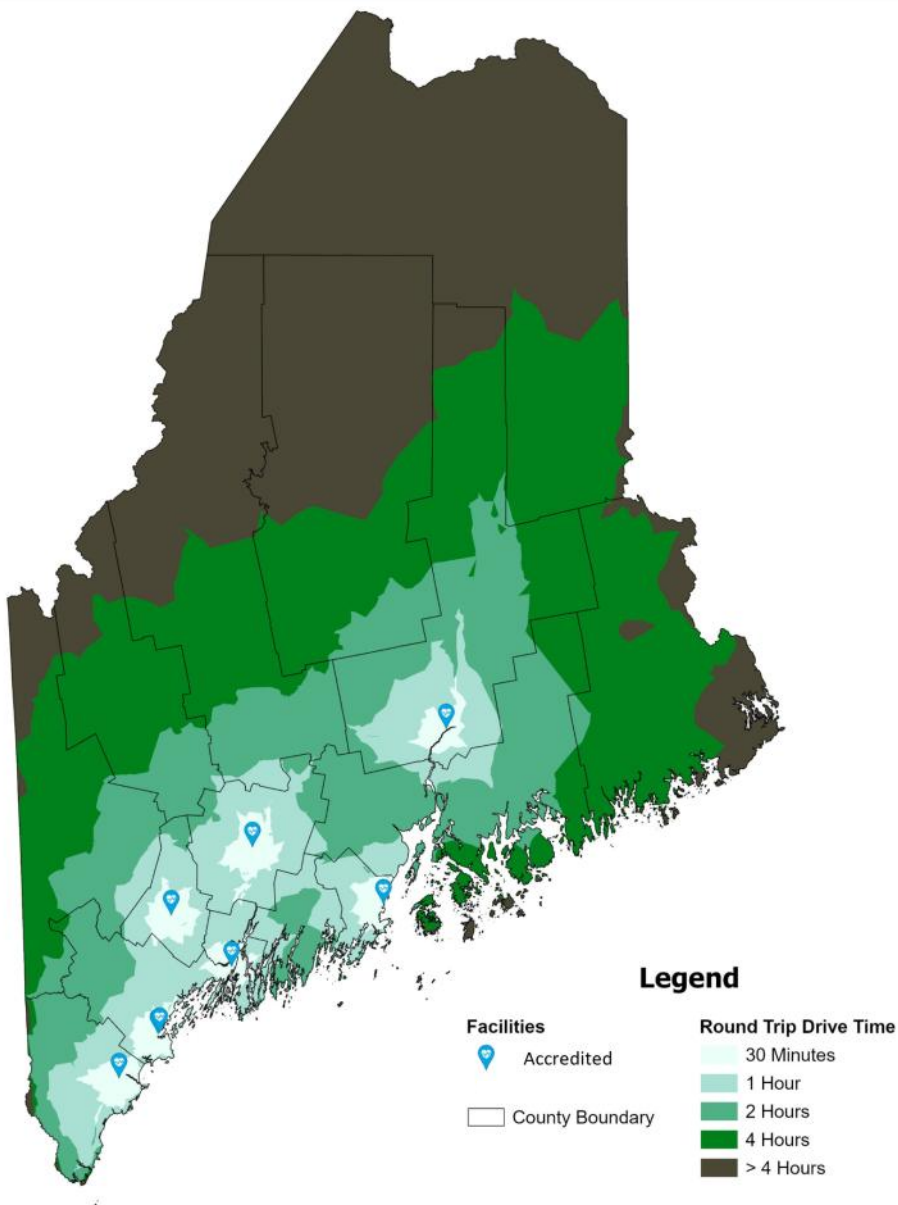


Figure 8: Distribution of round trip drive time to accredited reporting facility among Mainers diagnosed with cancer (2018-2022)

- 34% (15,003) are within a **30-minute round trip**

- 63% (27,847) are within a **1 Hour round trip**

- 87% (38,408) are within a **2 Hour round trip**

- 95% (41,915) are within a **4 Hour round trip**

- 5% (2,191) are more than a **4 Hour round trip**

Figure 8: Shows accredited cancer reporting facility in Maine (n=8). Round trip drive time categories from accredited facilities is mapped, county boundaries are visible. Percent of cancer cases in each drive time are summarized to the state level (2018-2022).

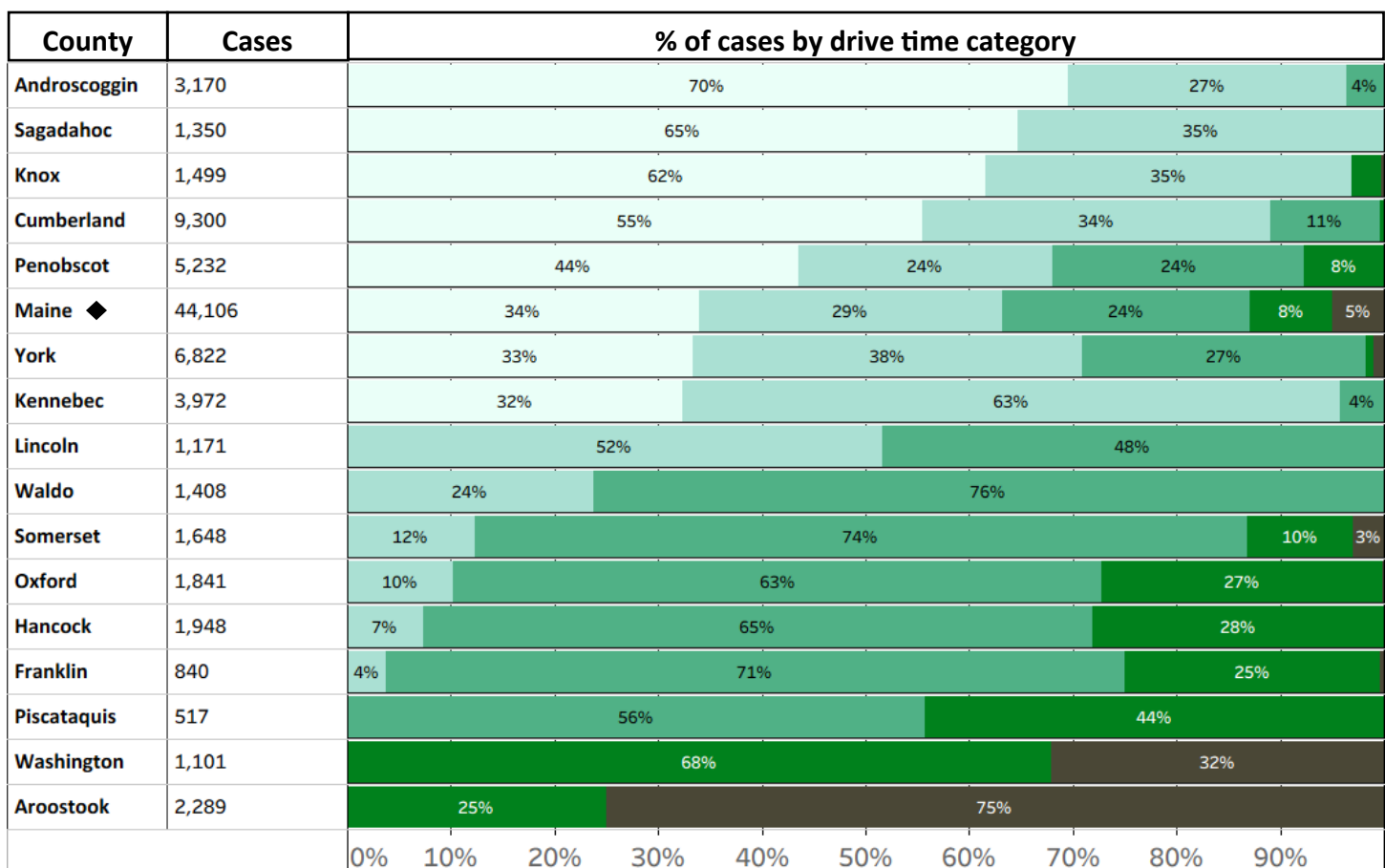
Drive Time to Accredited Reporting Facilities by County

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Figure 9: Distribution of round trip drive time to accredited cancer reporting facilities among Mainers diagnosed with cancer (2018-2022), by county

- Differences in drive time by county highlight the multiple distinct experiences Mainers can face when seeking care. Access to care for southern counties is high and likely underestimated since Mainers in these counties also have easier access to care in New Hampshire and Massachusetts. Some parts of central Maine experience a 2 hour round trip drive but communities here do not experience exceptionally long drive times seen in some northern and northwestern communities. However, 75% of Mainers with cancer in Aroostook and 32% in Washington Counties are greater than a 4 hour round trip drive to the closest accredited facility. Individuals with cancer in some communities have round trip drive times of over 8 hours.

30 Minutes 1 Hour 2 Hours 4 Hours > 4 Hours



The chart shows the percent of cancer cases in each drive time category to the closest accredited cancer facilities, by county (2018-2022). Counties differ greatly in number of cases reported each year. Counties are sorted in sequential descending order by percent and by drive time category. Labels for percents less than 3% are not displayed.

Drive Time to Breast Cancer Accredited Reporting Facilities

2026 MAINE CANCER SNAPSHOT

Key Findings

- Figure 10 shows drive time to National Accreditation Program for Breast Centers (NAPBC) accredited cancer facilities. There are only three facilities in Maine, with two facilities located in Portland and one in Lewiston. These facilities offer comprehensive breast cancer services.
- Access to breast cancer care is limited for the majority of women 30 or older in Maine, with only 33% living within a 1 hour round trip drive to the closest facility.

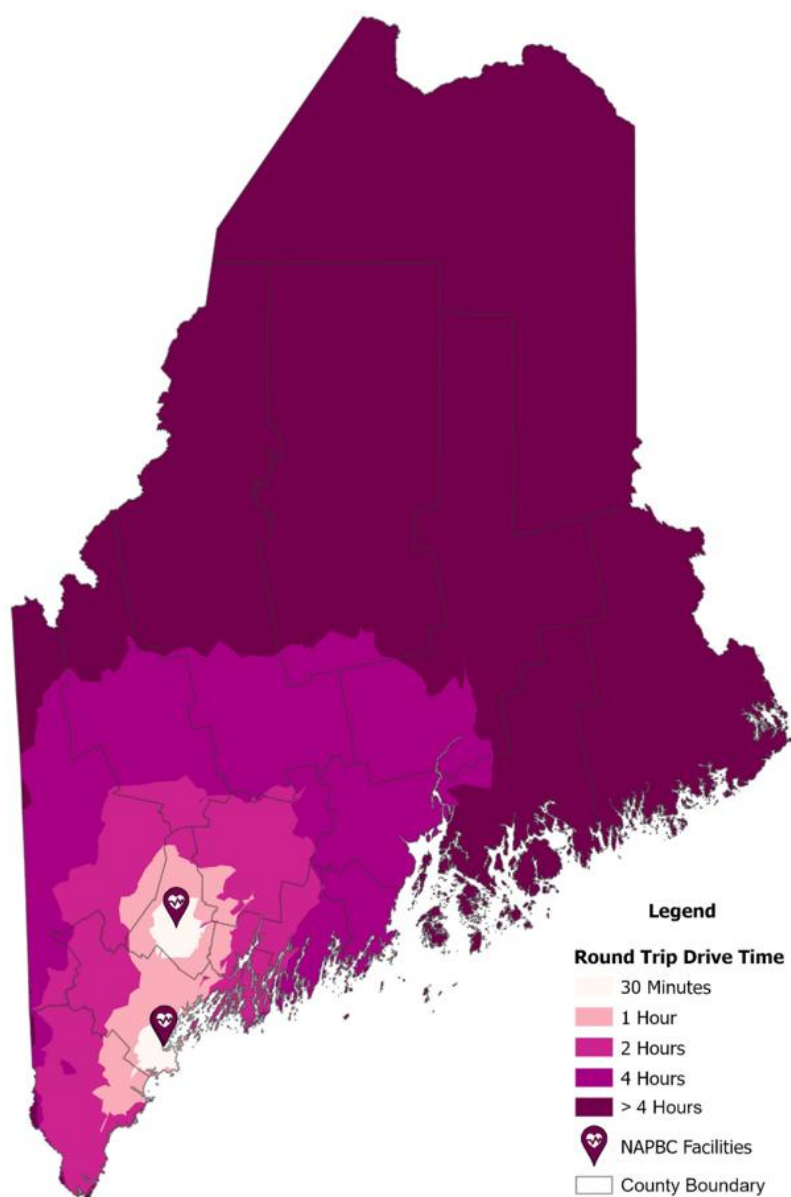


Figure 10: Distribution of round trip drive time to breast cancer accredited reporting facility among women 30 or older

- 16% (77,755) within a **30-minute round trip**
- 33% (160,112) within a **1 Hour round trip**
- 61% (295,755) within a **2 Hour round trip**
- 85% (409,945) are within a **4 Hour round trip**
- 15% (71,051) are more than a **4 Hour round trip**

Figure 10. Shows breast cancer accredited cancer reporting facilities (NAPBC) in Maine (n=3). Round trip drive time categories from NAPBC accredited facilities is mapped, county boundaries are visible. Percent of female population 30 or older in each drive time category is summarized to the state level. See page 21 for more information.

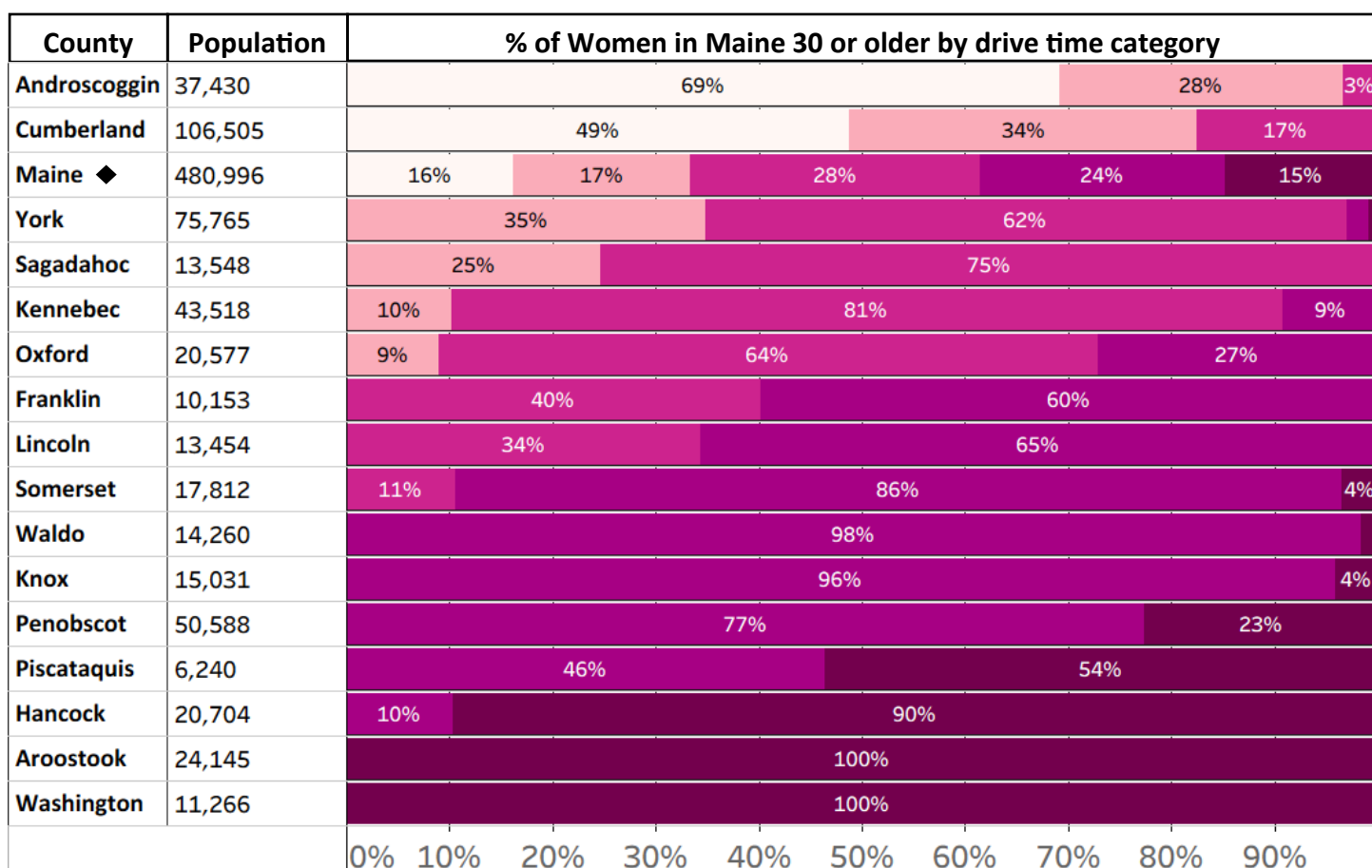
Drive Time to Breast Cancer Accredited Reporting Facilities by County

2026 MAINE CANCER SNAPSHOT

Figure 11: Distribution of round trip drive time to breast cancer accredited reporting facilities among Mainers diagnosed with cancer (2018-2022), by county

- Some counties that have good access to accredited cancer facilities experience significant increases in round trip drive time to breast cancer care, such as Piscataquis and Knox counties.
- 100% of women 30 or older in Aroostook and Washington Counties are greater than a 4 hour round trip drive from accredited breast cancer care, compared to 15% for Maine overall.
- Penobscot County, the home to Maine's third largest city, has almost one-quarter (23%) of its population of women 30 or older living greater than a 4 hour round trip drive.

30 Minutes 1 Hour 2 Hours 4 Hours > 4 Hours



The chart shows the percent of women in Maine 30 or older living within each drive time to the closest NAPBC accredited cancer facility, by county. Counties differ greatly in the total 2020 population of women 30 or older (see column 2). Counties are sorted in sequential descending order by percent and by drive time category. Labels for percents less than 3% are not displayed.

Technical Notes— Maine Cancer Incidence and Mortality

Case Definitions: Incidence data presented in this report are based on the Surveillance, Epidemiology, and End Results (SEER) Program site recode ICD-O-3/WHO 2008 definitions, Version 2008 and are determined by primary site and histology available from [Site Recode ICD-O-3/WHO 2008 - SEER Data Reporting Tools \(cancer.gov\)](#). The primary site reported is the site of origin and not the metastatic site. Incidence rates do not include recurrences. The number of cancers may include multiple primary cancers occurring in one patient. Mortality case definitions for single cancers and “all sites” are based on the primary cancer site listed in the underlying cause of death and coded using the International Classification of Diseases, Tenth Edition (ICD-10) and coded using the SEER Cause of Death Recode 1969+ (03/01/2018) available from [SEER Cause of Death Recode 1969+ \(03/01/2018\) \(cancer.gov\)](#).

Malignant Behavior Coding: To align with SEER methodology, the MCR now uses “Behavior code ICD-O-3” rather than the “Behavior recode for analysis” field in SEER*Stat and any published statistics.

Rates: Incidence and mortality rates were calculated per 100,000 population. The year 2000 U.S. standard population was used for age adjustment. Incidence counts and rates presented in this report were produced using the Surveillance, Epidemiology, and End Results (SEER) Program, Surveillance Research Program, National Cancer Institute, SEER*Stat 9.0.43.0 software. Maine incidence counts and rates were produced from the Maine Cancer Registry dataset based on November 2025 data submission file; U.S. incidence counts and rates produced from the National Program of Cancer Registries and Surveillance, Epidemiology and End Results Program SEER*Stat Database: NPCR and SEER Incidence - U.S. Cancer Statistics Public Use Research Database, 2025 Submission (2001-2023). United States Department of Health and Human Services, Centers for Disease Control and Prevention and National Cancer Institute. Released June 2026. Accessed at www.cdc.gov/cancer/uscs/public-use. Maine mortality counts and rates were produced using SAS Enterprise Guide 8.5 using data retrieved from the Maine CDC, Data, Research, and Vital Statistics. Historic mortality data in Maine, Figure 5 (page 9) shows trends in Maine mortality rates by sex uses a Seer*Stat mortality file that uses 20 age groups to age adjust, other than 19 for the other rates in the report. This may result in slight variations in rates. Data Source: Maine Cancer Registry. Data, Research, and Vital Statistics. Maine CDC. Mortality SEERStat Analytic file Last updated August 11, 2026.

Confidence Intervals: Ninety-five percent confidence intervals are provided for all rates.

Statistical Significance: For Maine comparison to U.S. data and Maine county comparisons to Maine rates, incidence rates were considered similar if the 95 percent confidence intervals for two rates overlapped. If the confidence intervals did not overlap, the rates were considered to be significantly different. Maine rates that are significantly higher than the national rate are highlighted in red text. County rates significantly higher or lower than the Maine rate are displayed on the maps.

Rates by County: The number of new cancer cases reported in a county varies from year to year, and some of this variation is due to chance. County level cancer rates are more likely to vary on an annual basis than state level rates, especially counties with smaller populations. In this report, multiple years of data are combined when producing the county rates. Although combining years can make the rates more reliable, caution must still be used when interpreting county rates because of small populations. Beginning in 2022, the MCR uses the SEER field “County at DX Analysis”, the county of the patient's residence at the time of diagnosis, derived from geocoded county data when available, instead of “County at DX”.

COVID-19: In 2020, the COVID-19 pandemic disrupted access to medical care and contributed to delays in hospital reporting of cancer cases. This resulted in a drop in cancer diagnoses for the year 2020. This drop reflects changes in medical screening and care and should not be interpreted as a reduction in the underlying cancer burden. 2020 incidence rates are excluded from trend analysis. COVID-19 did not have a similar impact on cancer mortality rates, thus 2020 rates are included in trend analysis.

Trend Analysis: The trend analysis referenced in the text is based on Joinpoint regression analysis. Joinpoint is a software developed by the National Cancer Institute that allows one to test trends over a time period, if a trend has changed (increasing, decreasing or not significantly different from 0) and the significance of a given change. Our trend analyses followed National Cancer Institute guidance that recommends against including 2020 data in regression models for analysis of cancer incidence trends due to the lower than expected case counts that year as a result of the COVID-19 pandemic (Howlader. 2021).

Stage at diagnosis: Stage at diagnosis describes the location of cancer at the time of diagnosis. Invasive stages include localized, regional, and distant. Localized cancer describes cases where cancer is only present on the primary site. Regional cancer is when the cancer has spread from the original site to tissue or lymph nodes, and distant cancer is when it has spread to other organs or more distant part of the body. Some records are unstaged or unknown. The term late-stage includes any cancers where the stage at diagnosis is regional or distant. In situ or non-invasive cancers were not include in this analysis. [Stage at Diagnosis | U.S. Cancer Statistics | CDC](#).

Technical Notes—Special Topic

Maine Cancer Registry (MCR) Records: Records used in this analysis contained information such as, identifying fields, date of diagnosis, primary site, histologic type (ICD-O-3), behavior code (ICD-O-3), sex, age at diagnosis, and geocoded address fields (Zip code, census tract, block groups, latitude and longitude). Records include invasive cancers among Maine residents diagnosed between 2018-2022. At the time of analysis, 2023 data was preliminary and was not included in the sample. Records included in this analysis represent tumors, not individuals. Annually, MCR data are geocoded using the [Geocodio](#) geocoder and prior to 2024, the [Aggie geocoder](#). These geocoders assign census values, such as block group, census tract, and county, corresponding to the record's address at time of diagnosis. Quality scores are assigned to each record to aid in filtering records that had low quality address data, such as missing street address.

Cancer Reporting Facility Locations: Facility locations were determined using internal resources at the MCR, location data from the U.S Centers for Medicare & Medicaid Services [Hospital General Information dataset](#), and individual hospital websites where necessary. The US Census Bureau's Census Geocoder was used convert address data into accurate longitude and latitude values for each hospital. Google Maps was used in some cases to ensure facility points were accurate down to the exact street address which provides a more accurate estimation of drive time.

Road Network Data: The Maine Department of Transportation's [public roadway dataset](#) was used in this analysis. This dataset is a comprehensive network of Maine public roadways that includes details such as height restrictions, ferries, gravel roads, one-way roads, speed limits, travel modes, and other information needed to calculate drive times. Some locations in the network that do not have posted speed limits or where the speed limit might not be updated, specifically on local roads. Private roadways are not included in the dataset. The analysis was set to prefer primary roads in the network dataset, prioritizing arterial road over local roads.

Accreditation: This analysis defined accredited hospitals as those which that hold a Commission on Cancer ([CoC](#)) or Quality Oncology Practice Initiative ([QOPI](#)) accreditation. Breast cancer accredited facilities are those that met requirements for the National Accreditation Program for Breast Centers ([NAPBC](#)). Accreditation is important to consider as it can indicate quality care or access to specific cancer treatments or support programs. Accreditations can be costly for facilities, often resulting in dropped accreditations. Tracking changes to this landscape is essential in measuring access to care in Maine. The analysis for NAPBC facilities used 2020 census population of women 30 or older, rather than MCR cancer records. While screening for breast cancer generally starts at 40 year old, women between 30 and 40 may start screening earlier if they have heightened risk.

Analysis: The [Generate Service Areas tool](#) in ArcGIS Pro (Version 3.3.5) utilized the Maine DOT road network dataset to calculate drive times from facilities, using the road network to create areas or polygons in ArcGIS Pro corresponding to the area of land that is reachable by car within each specified drive time cutoff. MCR records and created drive time areas were run through a [summarize within tool](#) in ArcGIS Pro's geoprocessing toolkit, which overlays an input summary feature (cancer cases or population points) onto the drive time polygon layers. This was repeated for all facilities, accredited, and breast cancer accredited facilities. Each analysis summarized records by county at diagnosis, providing a county-level stratification of drive times, as well as statewide estimates of access to care.

Limitations:

- (1) MCR cannot track where a patient accessed care, thus records cannot be traced to certain facilities. This analysis calculates drive time to the closest facility, not where a case was diagnosed or treated. MCR does have access to residential history, only the address at the time of the cancer diagnosis.
- (2) Cancer facilities from nearby states were not included in this analysis, though Mainers with cancer may often travel out of state for specialized care.
- (3) 20% of records between 2018-2022 were excluded from the analysis due to poor quality address information. These records primary consist of P.O box only address and records missing street and town information.
- (4) Maine's unique geographic and infrastructure challenges, such as island communities and limited public roads in rural communities, lowers the accuracy in these areas of the state.

References:

Howlader et al. How to Handle 2020 and 2021 Incidence Rates in the Joinpoint Trend Model. Surveillance Research Program, NCI, Technical Report #2024-01.

Surveillance Research Program, National Cancer Institute (2026). Joinpoint Regression Software, Version 6.0.1 - March, 2026. <http://surveillance.cancer.gov/joinpoint>.

Appendix: Supplemental Age Charts

Table 1: Age Adjusted Incidence Rates per 100,000 population for All Malignant Cancers, by Year, Sex, and Age Group in Maine (2000-2023)

	00-49		50-64		65+	
Year	Male	Female	Male	Female	Male	Female
2000	71.1	123.9	1052.3	882.5	3302.5	1939.6
2001	79.7	125.4	1060.2	901.5	3427.7	1927.8
2002	83.6	124.2	1021.8	900.4	3340.9	1921.8
2003	84.7	132.4	1012.6	826.3	3297.6	1914.8
2004	89.5	129.0	1109.7	887.5	3248.2	1953.2
2005	84.1	134.6	1002.0	848.8	3217.0	2026.0
2006	89.8	134.1	1041.0	881.3	3255.5	2020.4
2007	83.6	136.1	1046.6	828.7	3222.4	1941.6
2008	84.7	132.6	1002.7	858.4	3017.4	1900.1
2009	84.8	134.4	954.2	823.0	2896.1	1882.2
2010	84.0	139.4	955.9	781.8	2868.6	1875.6
2011	84.9	135.4	884.6	798.3	2820.7	1851.2
2012	87.2	130.7	905.6	826.4	2678.0	1904.6
2013	72.8	141.8	893.2	789.6	2511.2	1887.8
2014	85.5	145.3	859.8	855.3	2548.9	1940.2
2015	78.4	149.2	845.3	823.6	2611.3	1867.5
2016	81.5	145.1	879.0	813.8	2646.5	1867.5
2017	86.9	140.5	844.0	867.4	2676.4	1840.7
2018	86.3	136.2	845.9	814.5	2624.5	1834.0
2019	72.9	152.7	915.1	872.7	2625.2	1897.3
2020	85.7	128.9	865.2	776.6	2585.6	1758.7
2021	88.9	164.8	871.2	894.5	2645.6	1837.5
2022	80.0	143.7	860.4	806.6	2631.2	1892.6
2023	91.8	136.0	899.0	868.5	2649.9	1800.8

Data source: Maine Cancer Registry, based on November 2025 NPCR-CSS data submission.

AA: Age-adjusted to the year 2000 U.S. standard population.

Appendix: Supplemental County Incidence Charts

Table 2: Age Adjusted Incidence Rates per 100,000 population for All Malignant Cancers, by County, Maine, All Sexes (2021-2023)

County	AA Rate	SE	AA Lower 95% CI	AA Upper 95% CI	Count	Population
Androscoggin	466.5	10.5	446.2	487.5	2,160	340,664
Aroostook	492.7	13.3	467.0	519.7	1,639	201,461
Cumberland	480.4	6.3	468.1	492.9	6,313	926,719
Franklin	452.0	18.9	415.6	491.0	665	91,695
Hancock	527.0	15.1	497.8	557.7	1,488	169,840
Kennebec	515.2	10.1	495.5	535.6	2,876	380,854
Knox	502.5	16.8	470.2	536.8	1,091	123,373
Lincoln	458.8	17.1	426.0	494.0	918	108,747
Oxford	501.3	14.1	474.1	529.9	1,475	178,344
Penobscot	515.2	9.3	497.0	533.8	3,383	464,529
Piscataquis	512.9	26.7	461.8	568.9	465	52,080
Sagadahoc	448.3	16.7	416.2	482.5	831	112,114
Somerset	511.0	15.7	480.7	543.0	1,223	152,986
Waldo	514.3	17.7	480.2	550.4	998	120,676
Washington	548.0	20.8	507.9	590.7	856	94,166
York	487.8	7.4	473.4	502.6	4,898	651,251
Maine	493.2	3.0	487.4	499.0	31,285	4,169,499

Data source: Maine Cancer Registry, based on November 2025 NPCR-CSS data submission.

AA: Age-adjusted to the year 2000 U.S. standard population. Rates are per 100,000. 95% CI: 95% Confidence interval.

Appendix: Supplemental County Mortality Charts

Table 3: Age Adjusted Mortality Rates per 100,000 population for All Malignant Cancers, by County, Maine, All Sexes (2019-2023)

County	AA Rate	SE	AA Lower 95%	AA Upper 95%	Count	Population
Androscoggin	163.5	4.7	154.2	172.9	1,248	554,646
Aroostook	165.8	5.4	155.2	176.3	1,021	335,324
Cumberland	141.5	2.6	136.5	146.6	3,142	1,516,026
Franklin	151.5	8.2	135.4	167.6	376	151,174
Hancock	148.6	5.8	137.3	159.9	743	279,494
Kennebec	168.6	4.3	160.1	177.1	1,606	622,542
Knox	153.3	6.7	140.1	166.5	576	202,948
Lincoln	163.3	7.1	149.3	177.3	583	177,959
Oxford	162.2	6.0	150.4	174.0	794	294,136
Penobscot	164.1	3.9	156.4	171.9	1,825	765,584
Piscataquis	182.5	11.3	160.2	204.7	290	85,849
Sagadahoc	144.7	6.9	131.2	158.1	463	183,877
Somerset	186.0	7.0	172.3	199.8	757	254,111
Waldo	170.0	7.6	155.2	184.8	557	200,411
Washington	200.5	9.2	182.4	218.6	533	156,965
York	153.7	3.1	147.6	159.8	2,575	1,066,616
Maine	158.3	1.3	155.9	160.8	17,094	6,847,662

Data Source: Maine Mortality: Maine CDC's Data, Research, and Vital Statistics.

AA: Age-adjusted to the year 2000 U.S. standard population. Rates are per 100,000. 95% CI: 95% Confidence interval.



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