COLORECTAL CANCER IN WISCONSIN

A REPORT BY THE WISCONSIN CANCER COLLABORATIVE

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Wisconsin Cancer Collaborative

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For questions about this report, please contact the Wisconsin Cancer Collaborative at **info@wicancer.org.**

Authors: Katie Lepak, MS,[1] Beth Brunner,[1] Lena Swander, MPH,[2] Katelynn Kirkpatrick, MPH,[2] Olivia Steidl, MPH,[1] and Allison Antoine, MPH[1]

1. Wisconsin Cancer Collaborative
2. Wisconsin Department of Health Services

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For more information, or to view the Wisconsin Cancer Plan 2020-2030 for strategies and action steps to improve cancer survival in Wisconsin, visit **www.wicancer.org.**

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DEFINITIONS

Definitions are from the National Cancer Institute Dictionary of Cancer Terms.[1]

- **Age-adjusted rate:** Age adjusting the cancer rates ensures that differences in incidence or deaths from one year to another, or between one geographic area and another, are not due to differences in the age distribution of the populations being compared.

- **Colonoscopy:** Examination of the inside of the colon using a colonoscope, a long, thin, flexible lighted tube with a camera, inserted into the rectum. This test looks for and can remove polyps inside the rectum and entire colon.

- **Colorectal cancer:** Cancer that develops in the colon (the longest part of the large intestine) and/or the rectum (the last several inches of the large intestine before the anus).

- **Confidence intervals (CI):** Confidence intervals demonstrate the variation in the estimation of cancer rates. The width of confidence interval differs based on the amount of variability in the data.

- **Fecal Immunochemical Test (FIT):** A test that checks for occult (hidden) blood in stool. A small sample of stool is placed in a special collection tube or on a card for testing. The test uses an antibody that binds to a protein called hemoglobin to detect any blood. Blood in the stool may be a sign of colorectal cancer or other problems, such as polyps, ulcers, or hemorrhoids. An abnormal result requires a follow-up colonoscopy.

- **Incidence rate:** A measure of the frequency of new cancer cases during a specified interval.

- **Mortality rate:** A measure of the frequency of occurrence of cancer death in a defined population during a specified interval.

- **Polyp:** An abnormal growth that protrudes from a mucous membrane**.**

- **Relative survival rates:** A way of comparing the survival of people who have a specific disease with those who don't, over a certain period of time. This is usually five years from the date of diagnosis or the start of treatment for those with the disease. It is calculated by dividing the percentage of patients with the disease who are still alive at the end of the period of time by the percentage of people in the general population of the same sex and age who are alive at the end of the same time period. The relative survival rate shows whether the disease shortens life.

- **Stage:** The extent of a cancer in the body. Staging is usually based on the size of the tumor, whether lymph nodes contain cancer, and whether the cancer has spread from the original site to other parts of the body.
  - **Distant cancer:** Cancer has spread to distant parts of the body.
  - **Regional cancer:** Cancer has spread to nearby lymph nodes, tissues, or organs.
  - **Localized cancer:** Cancer is limited to the place where it started, with no sign that it has spread.

- **Stool-DNA:** Also referred to as sDNA-FIT. This test combines a FIT test with a test that can detect altered DNA in the stool. This test collects an entire stool sample that is sent to a lab where they check for blood or altered DNA in the stool. This test should be done every 3 years and an abnormal result requires a follow-up colonoscopy.

DATA SOURCES, METHODS, AND CONSIDERATIONS

Wisconsin incidence data in this report are from the Wisconsin Cancer Reporting System (WCRS) at the Wisconsin Department of Health Services. All health care facilities in Wisconsin are required to report cancers to the WCRS as mandated by Wis. Stat. § 255.04. All tumors with malignant cell types are reportable except basal cell and squamous cell carcinomas of the skin and in situ cervical cancer. Colon and rectum cancers and deaths were defined by SEER Site Recode ICD-O-3/WHO 2008 and SEER Cause of Death Recode 1969+ only and are referred to as "colorectal cancers" throughout the narrative of this report.

All analyses on colorectal cancer incidence and mortality were performed in SEER*Stat version 9.042.0 and Joinpoint version 5.4.0.0. To determine whether Joinpoint annual percentage changes (APCs) were significantly different from zero, a t-test was used.

All colorectal cancer rates are age-adjusted and expressed per 100,000 using the 2000 U.S. standard population in 20 age groups. Ninety-five percent CIs around age-adjusted cancer incidence rates use the Tiwari et al., 2006 modification and are displayed as lines on bar graphs.[2]

To protect confidentiality, counts, rates, and percentages in all figures and tables are suppressed when there are fewer than six cases or 10 deaths.

Finally, this report includes data on cancer cases diagnosed in 2020, when the COVID-19 pandemic disrupted health services, leading to delays and reductions in cancer screening and diagnoses and may have contributed to the decline in new colorectal cancer diagnoses during this year.

WCRS supports online public portals with cancer surveillance data for free. Data for common cancer sites is available at the county-level.

www.dhs.wisconsin.gov/wcrs/data-pubs.htm

KEY POINTS

- *Colorectal cancer incidence and mortality in Wisconsin has continued to decline since 2000.*
- *Colorectal cancer screening can find precancerous polyps so they can be removed before they turn into cancer. Screening tests can also find cancer at an earlier stage, when there are more treatment options.*
- *Adults age 45 to 75 who are at average risk should be screened for colorectal cancer. People at an increased risk of getting colorectal cancer should talk to their doctor about when to begin screening.*
- *Non-Hispanic (NH) American Indian / Alaska Native (*AI/AN*) populations in Wisconsin had the highest incidence rate of colorectal cancer from 2018-2022. NH Black populations had the second highest incidence rate.*
- *Young-onset colorectal cancer (YO-CRC), defined as colorectal cancer diagnosed before the age of 50, is increasing in incidence in Wisconsin, across the United States, and globally.*

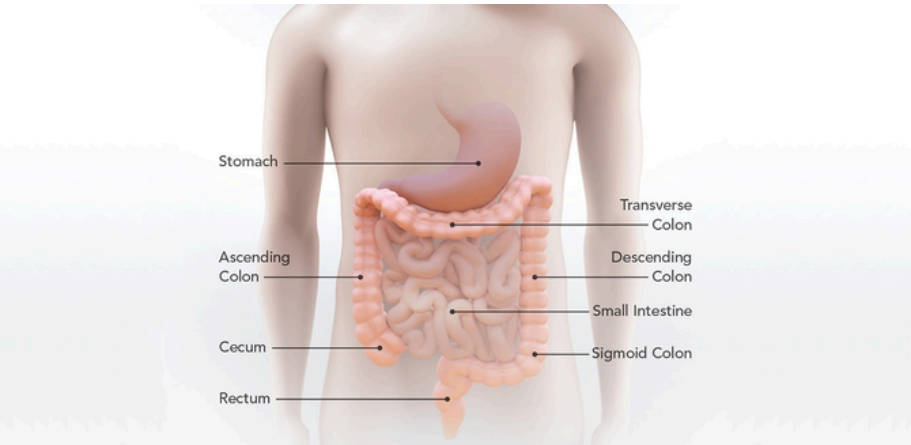
INTRODUCTION

Colorectal cancer is a type of cancer that develops in the colon or rectum. The colon and rectum make up the large intestine, the final segment of the gastrointestinal (GI) system. Most colorectal cancers begin as a noncancerous growth in the inner lining of the colon or rectum called a polyp. Polyps are common, and most do not become cancerous. Polyps grow slowly, which allows for cancer prevention through colorectal cancer screening. In addition to screening, more than half of all colorectal cancers are attributable to modifiable risk factors, such as smoking, an unhealthy diet, high alcohol consumption, physical inactivity, and excess body weight.

This report provides an overview of Wisconsin's colorectal cancer landscape. It also offers insights into how colorectal cancer affects different populations in Wisconsin, highlights important risk factors, and underscores the importance of screening and treatment. Understanding the data set is critical to implementing effective public health strategies and improving outcomes for those affected by colorectal cancer.

In Wisconsin, approximately 2,530 new colorectal cancer cases are diagnosed annually, and 880 people die from the disease each year. From 2018-2022, the incidence rate for colorectal cancer for both sexes combined was 34.9 per 100,000 population in Wisconsin.[3] Roughly 1 in 24 men and 1 in 26 women in the U.S. will develop colorectal cancer in their lifetime.[4]

Colorectal cancer is the second most common cause of cancer deaths in the U.S. for men and women combined. From 2019-2023, the colorectal cancer mortality rate for that period was 11.6 per 100,000 population in Wisconsin.[5]



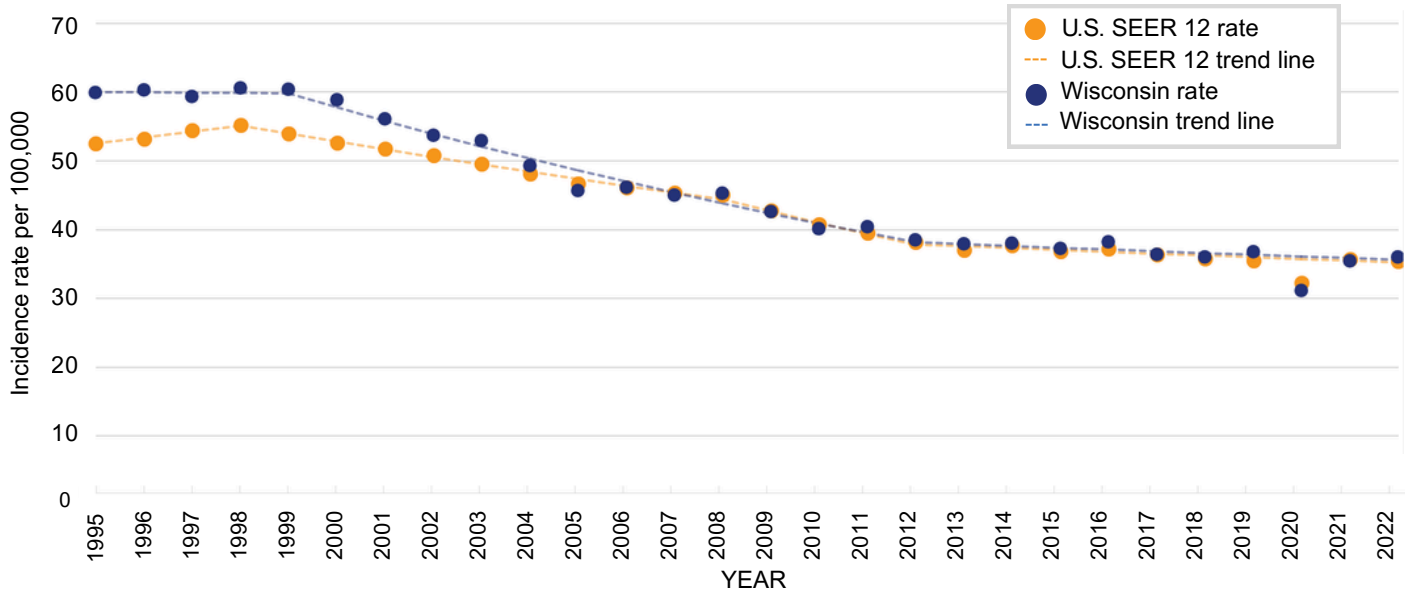
Source: National Center for Chronic Disease Prevention and Health Promotion; Division of Cancer Prevention and Control

TRENDS

Colorectal cancer incidence and mortality rates have continued to decline over the past decade in both the U.S. and Wisconsin. Overall, trends indicate that Wisconsin's colorectal cancer incidence rates have been decreasing at a pace comparable to national trends in recent years (Figure 1).[3,5,7] Similarly, colorectal cancer mortality rates in Wisconsin mirror the rate of decline observed across the nation (Figure 2).[6,7] These parallel trends suggest that risk modification, prevention, early detection and screening, and treatment advancements are having a consistent impact at both the state and national levels.

FIGURE 1.

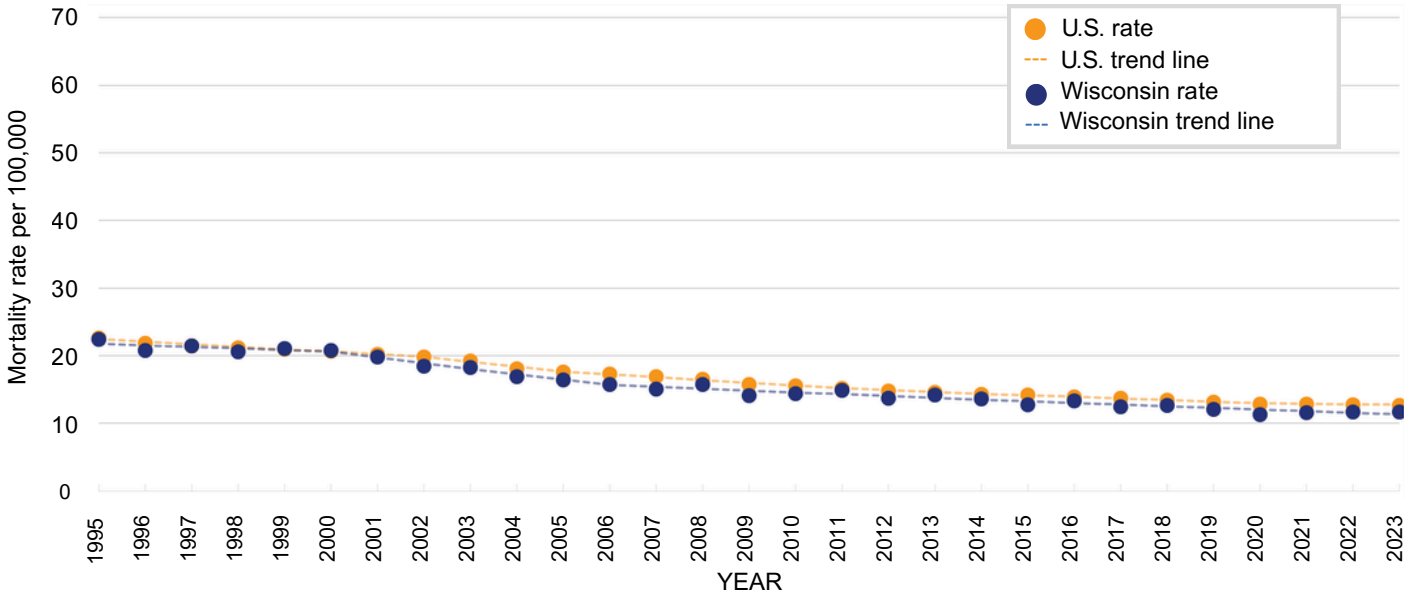
Trends in colorectal cancer age-adjusted incidence rates per 100,000 population, U.S. and Wisconsin (1995-2022).[3,5,7]



The COVID-19 pandemic disrupted access to medical care. This resulted in a drop in cancer diagnoses for the year 2020, particularly for cancers diagnosed before symptoms develop. This drop should not be interpreted as a reduction in the underlying colorectal cancer burden.

FIGURE 2.

Trends in colorectal cancer age-adjusted mortality rates per 100,000 population, U.S. and Wisconsin (1995-2023).[6,7]



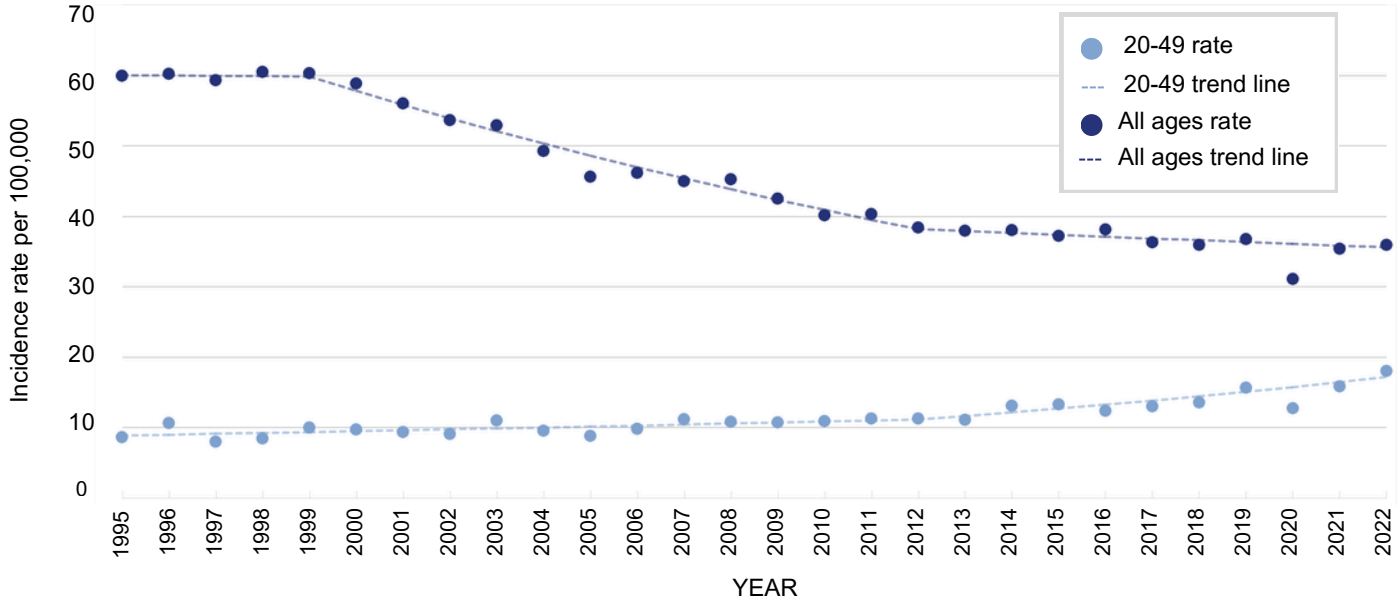
AGE

Age-related trends in colorectal cancer continue to evolve in both the U.S. and Wisconsin. Over the past several decades, sustained declines in colorectal cancer incidence and mortality have been observed largely attributable to improvements in screening uptake, polyp detection and removal, and advances in treatment. These encouraging trends are evident at both the national and state levels.

Historically, colorectal cancer incidence and mortality rates have been highest among older adults, reflecting the strong association between cancer development and advancing age. The median age at diagnosis in Wisconsin is 67 years of age.[3] In contrast, a concerning pattern has emerged among younger adults. Young-onset colorectal cancer (YO-CRC), defined as colorectal cancer diagnosed before the age of 50, is increasing in incidence in Wisconsin (Figure 3), across the United States, and globally. National projections estimate that by 2030, approximately 11% of colon cancers and 23% of rectal cancers will occur among individuals under age 50, signaling a significant shift in the age distribution of disease burden.[8]

FIGURE 3.

Trends in colorectal cancer age-adjusted incidence rates per 100,000 population for 20-49 years and all ages, Wisconsin (1995-2022).[3,7]



Although some YO-CRC cases can be attributed to hereditary cancer syndromes—identified in roughly 20% of young-onset diagnoses—the majority arise in individuals without known genetic predispositions.[9] This suggests that additional environmental, behavioral, or yet-to-be-identified biological factors may be contributing to the upward trend. Further research is needed to clarify the drivers behind these increases and to determine why younger cohorts appear to be disproportionately affected.

Given these trends, individuals under 50 represent an important population for enhanced awareness and monitoring. Current national screening guidelines recommend initiating average-risk screening at age 45, leaving a subset of younger adults outside the routine screening window. This underscores the importance of symptom recognition, risk assessment, and family history evaluation. Identifying individuals at elevated or high risk—whether due to hereditary conditions, significant family history, or other contributing factors—remains critical for guiding earlier or more frequent screening testing.

Understanding the intersecting trends of declining colorectal cancer rates among older adults and rising incidence among younger populations is essential for shaping effective prevention strategies, refining screening recommendations, and ensuring timely diagnosis and treatment across all age groups.

SEX

Both men and women are at risk of developing colorectal cancer during their lifetime. However, colorectal cancer incidence in Wisconsin is higher for men than women (Figure 4).[3] Men, starting after age 44, also have higher colorectal cancer mortality among 10-year age groups compared to women (Figure 5).[6] The reasons for observed differences between men and women in colorectal cancer incidence and mortality are complex, and likely involve a combination of multiple environmental, biological, and behavioral factors.

FIGURE 4.

Colorectal cancer age-adjusted incidence rates per 100,000 population by sex and age at diagnosis, Wisconsin (2018-2022).[3]

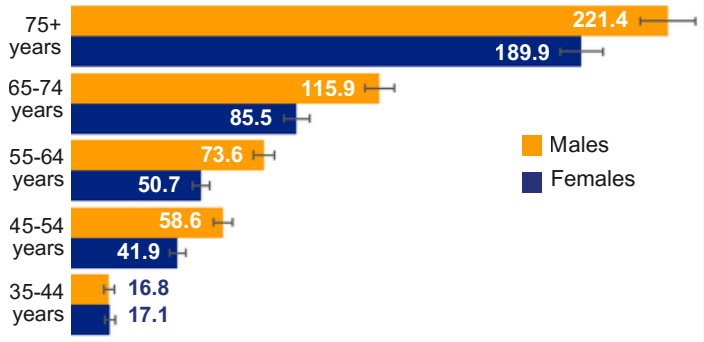
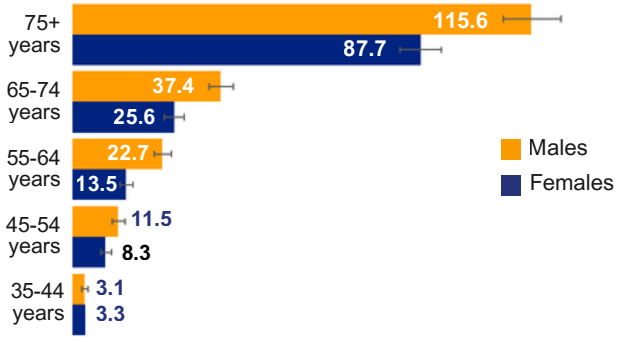


FIGURE 5.

Colorectal cancer age-adjusted mortality rates per 100,000 population by sex and age at death, Wisconsin (2019-2023).[6]



RACE AND ETHNICITY

The burden of colorectal cancer incidence and mortality varies considerably by race and ethnicity. Non-Hispanic (NH) American Indian/Alaska Native (AI/AN) populations in Wisconsin had the highest incidence of colorectal cancer, with 47.8 cases per 100,000 population, 1.3 times higher than the statewide rate. NH Black populations had the second highest rate at 44.9 cases per 100,000 population (Figure 6).[3]

Colorectal cancer mortality rates also reflect significant disparities. NH Black individuals had the highest mortality rate, at 18.2 deaths per 100,000 population. NH AI/AN populations had the second-highest mortality rate, at 13.4 deaths per 100,000 population (Figure 7).[6]

FIGURE 6.

Colorectal cancer age-adjusted incidence rates per 100,000 population by race, Wisconsin (2018-2022).[3]

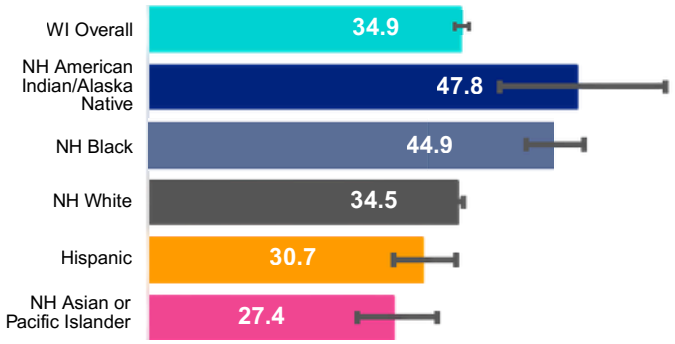
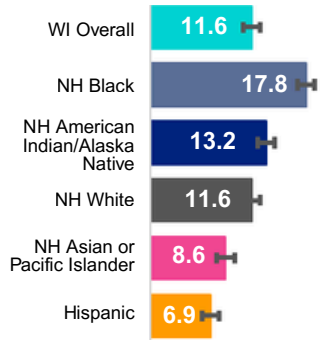


FIGURE 7.

Colorectal cancer age-adjusted mortality rates per 100,000 population by race, Wisconsin (2019-2023).[6]



In addition, the average age at diagnosis varied substantially across racial and ethnic groups. These data highlight that NH AI/AN, NH Black, NH Asian/Pacific Islander (API), and Hispanic populations in Wisconsin are diagnosed with colorectal cancer at younger ages than NH White populations.

Average age at diagnosis:[3]

- NH American Indian/Alaska Native (age=61 years)
- NH Black (age=61 years)
- NH Asian/Pacific Islander (API) (age=58 years)
- Hispanic (age=57 years)
- NH White (age=69 years)

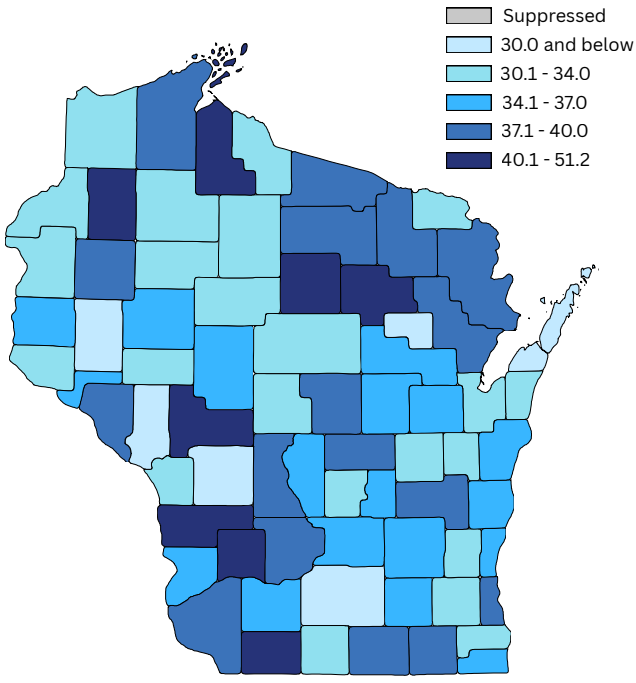
GEOGRAPHY

Everyone living in Wisconsin is at risk of developing colorectal cancer at some point in their lives. However, colorectal cancer incidence, mortality, and stage at diagnosis vary by geography across Wisconsin.

The causes of the geographic variability of colorectal cancer incidence, mortality, and late-stage diagnosis are complex and include variability in the known modifiable risk factors, age, genetic predisposition, family history, and access to screening and follow-up care.

FIGURE 8.

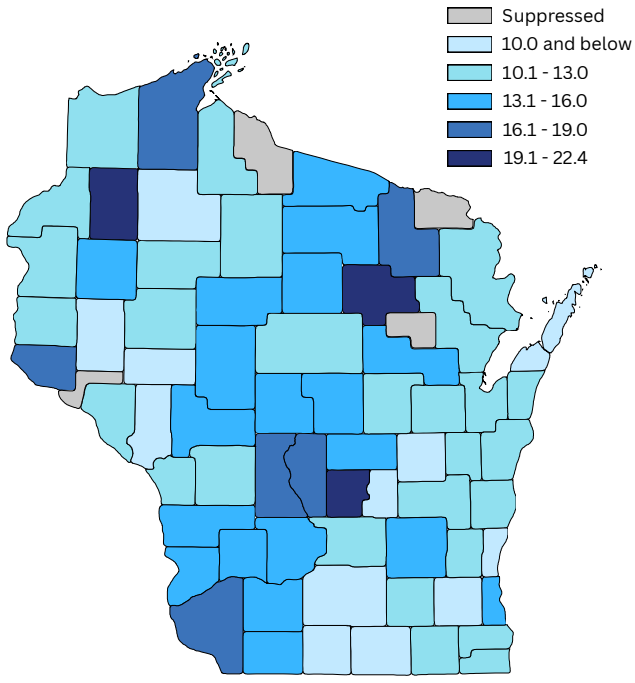
Colorectal cancer age-adjusted incidence rates per 100,000 population by county, Wisconsin (2018-2022).[3]



Wisconsin Age-Adjusted Colorectal Cancer Incidence Rate: 34.9

FIGURE 9.

Colorectal cancer age-adjusted mortality rates per 100,000 population by county, Wisconsin (2019-2023).[6]



Wisconsin Age-Adjusted Colorectal Cancer Mortality Rate: 11.6

SCREENING

Colorectal cancer almost always develops from precancerous polyps (abnormal growths) in the colon or rectum. Screening tests can find precancerous polyps, so they can be removed before they turn into cancer, and also find colorectal cancer early. On-time colorectal cancer screening is an effective tool to reduce cancer deaths.

In 2024, 71.6% of adults age 45-75 in Wisconsin reported being up-to-date with colorectal cancer screening (Figure 10).[10]

Researchers estimated that increasing on-time colorectal cancer screening rates to 80% nationwide would reduce incidence rates by 17% and mortality rates by 19%, resulting in 277,000 averted new cancers and 203,000 averted colorectal cancer deaths from 2013 through 2030 in the U.S.[11]

There are several test options to screen for colorectal cancer (Table 1). It is recommended that adults at average risk for colorectal cancer begin screening at age 45. Individuals older than 75 should speak with their health care provider about continuing to screen for colorectal cancer.

Individuals at an increased risk of colorectal cancer should talk to their doctor, prior to age 45, about when to start screening. People may be at increased risk if they have the following: inflammatory bowel disease such as Crohn's disease or ulcerative colitis; a personal or family history of colorectal cancer or colorectal polyps; or a genetic syndrome such as familial adenomatous polyposis (FAP) or hereditary non-polyposis colorectal cancer (Lynch syndrome).

FIGURE 10.
Adults aged 45-75 years who reported being up-to-date with colorectal cancer screening, Wisconsin (2024).[10]

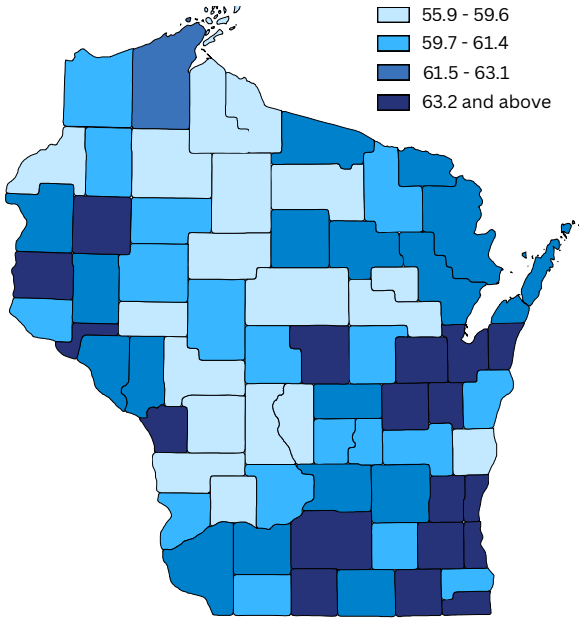


TABLE 1.
Screening types for colorectal cancer.

CATEGORY	SCREENING METHOD	FREQUENCY	DESCRIPTION
Stool Test	Guaiac-based Fecal Occult Blood Test (gFOBT)	Annually	Receive a test kit from your health care provider. Complete kit at home and return. Samples are checked for the presence of blood
	Fecal Immunochemical Test (FIT)	Annually	Stool samples are tested for the presence of blood using antibodies
	FIT-DNA Test (stool DNA test)	Every 3 years	Stool samples are tested for abnormal DNA and blood in the stool
Direct Visualization Test	Flexible Sigmoidoscopy	Every 5 years, or every 10 years with a FIT every year	Lower part of the colon is visualized endoscopically
	Colonoscopy	Every 10 years	The entire colon is visualized endoscopically, and polyps are removed
	CT Colonography	Every 5 years	X-ray and CT combined imaging produce a 3D image of the colon and rectum

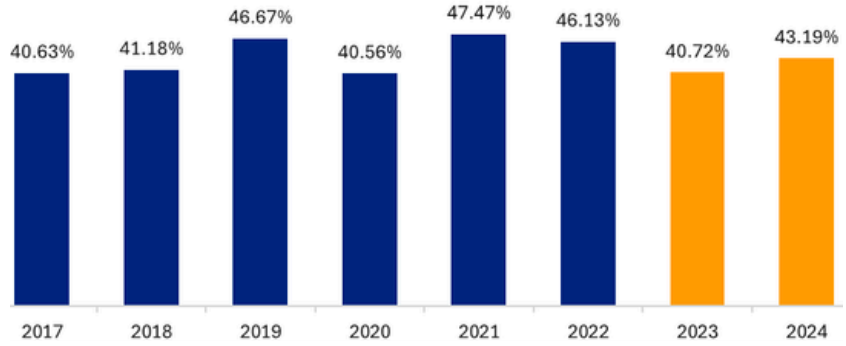
The average colorectal cancer screening rate for individuals seeking care through Wisconsin Community Health Centers was 43.32% from 2017-2024 (Figure 11).[12] Community Health Centers are non-profit, patient-governed clinics that provide primary, preventive, dental, and mental health care to underserved communities, regardless of a patient's ability to pay. Community Health Centers often provide care for medically underserved populations which may encounter unique barriers to care. These barriers could include geographic distance, limited access to services, financial barriers, transportation challenges, and translation needs.

The average colorectal cancer screening rate for individuals seeking care through health systems that are a part of the Wisconsin Collaborative for Healthcare Quality was 77.76% from 2017-2024 (Figure 12).[13] Individuals receiving care through WCHQ-participating health systems often have greater availability of onsite screening and diagnostic services and access to comprehensive care coordination.

The nearly 35 percentage point gap between colorectal cancer screening rates in Community Health Centers and WCHQ-participating health system members highlights the role healthcare access and resources play in influencing preventive care outcomes.[12,13] Addressing these disparities is essential to ensuring access to life-saving screening across all populations in Wisconsin.

FIGURE 11.

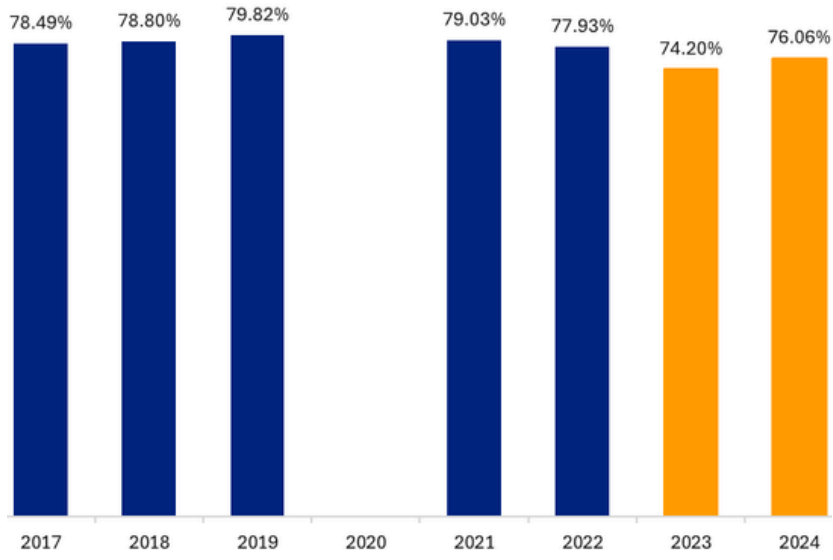
Colorectal cancer screening rate of Wisconsin Community Health Centers (2017-2024).[12]



Note: Blue bars indicate CRC screening for adults 50-75 years; orange bars indicate CRC screening for adults 45-75 years

FIGURE 12.

Colorectal cancer screening rate of Wisconsin Collaborative for Healthcare Quality health systems (2017-2024).[13]



Note: Blue bars indicate colorectal cancer screening for adults 50-75 years; orange bars indicate colorectal cancer screening for adults 45-75 years. Data unavailable in 2020.

RISK REDUCTION

More than half of all colorectal cancers are linked to risk factors that can be changed. The leading modifiable risk factors contributing to colorectal cancer include: excess body weight, certain types of diets, alcohol use, type 2 diabetes, and smoking.[14]

EXCESS BODY WEIGHT

Individuals with excess body weight (overweight or obesity) could be at increased risk for developing CRC.

DIET

A diet high in red meats (such as beef, pork, lamb, or liver) and processed meats (such as hot dogs and some lunch meats) could raise an individual's risk for developing colorectal cancer. Healthier diet options may include plenty of fruits, vegetables, and whole grains.

ALCOHOL USE

Moderate and heavy alcohol use has been linked to an increased risk of colorectal cancer. If people drink alcohol, they should have no more than two drinks a day for men and on drink a day for women.

TYPE 2 DIABETES MELLITUS

Individuals with type 2 diabetes may be more likely than individuals who do not have the disease to develop colorectal cancer. Even though type 2 diabetes and colorectal cancer can share some of the same risk factors, after taking those factors into consideration, individuals with type 2 diabetes still have an increased risk.

SMOKING

Long term use of smoked tobacco can increase an individual's risk of developing and dying from colorectal cancer. Smoking tobacco also increases the risk for individuals to develop colon polyps.

TREATMENT

Treatment options for colorectal cancer vary based on the stage of disease at diagnosis, the location of the tumor, and the overall health of the individual. Despite the availability of treatment options, some Wisconsin residents do not receive the recommended care after a colorectal cancer diagnosis. Similar to national trends, individuals may decline treatment due to underlying health concerns or personal preference. More commonly, however, treatment gaps reflect structural barriers that limit timely access to care. In Wisconsin, these barriers may include: geographical access challenges, financial barriers, transportation difficulties, limited provider availability, stigma, fear or fatalism, and lack of awareness of treatment guidelines.

Public health strategies to address these barriers in Wisconsin include enhancing patient navigation, expanding telehealth oncology services, strengthening transportation assistance programs, increasing provider education on evidence-based colorectal cancer treatment, and improving insurance coverage and financial assistance for cancer care. Ensuring equitable access to timely, evidence-based care is essential to improving colorectal cancer survival and reducing cancer disparities across Wisconsin communities.

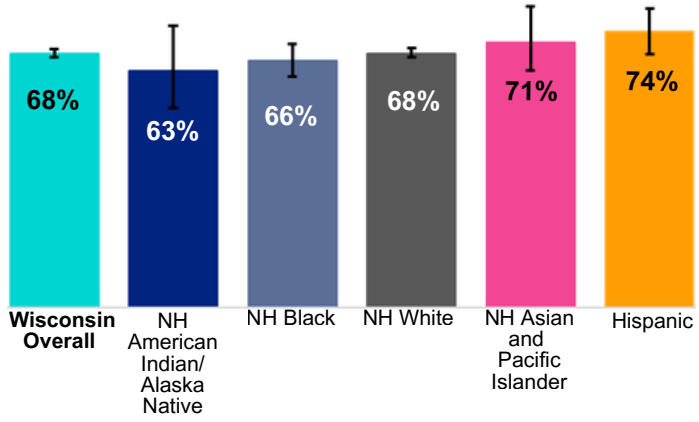
FIVE-YEAR SURVIVIAL

Five-year relative survival statistics measure the proportion of people who will be alive five years after diagnosis, given that they did not die from something else during that time.

The overall five-year relative survival rate for colorectal cancer in Wisconsin is 68% with a U.S. five-year relative survival rate of 65%.[15]

Hispanic populations had the highest five-year survival rate at 74%. NH American Indian/Alaskan Native (AI/AN) populations in Wisconsin have the lowest five-year survival rates at 63% (Figure 13). The NH AI/AN and NH Black five-year relative survival rates are lower than the overall state of Wisconsin survival rate of 68%.[15]

FIGURE 13.
Five-year relative survival (%) for colorectal cancer by race/ethnicity, Wisconsin (2015-2021).[15]



STAGE AT DIAGNOSIS

The stage at which the cancer was detected can impact the survival rates for colorectal cancer. Detecting colorectal cancer at the earliest stage can improve the relative five-year survival ratios.

In Wisconsin from 2015-2021, the five-year relative survival of individuals diagnosed with colorectal cancer at a distant stage was 19% compared to 91% for cases diagnosed at a localized stage (the cancer had not spread outside the colon or rectum) (Table 2).[15]

TABLE 2.
Five-year relative survival, by stage, for colorectal cancer cases, Wisconsin (2015-2021).[15]

Wisconsin overall five-year survival 68%		
Localized	***Regional***	***Distant***
91%	76%	19%

TABLE 3.
Five-year relative survival (%) by stage at diagnosis and race/ethnicity for colorectal cancer, Wisconsin (2015-2021).[15]

	Localized	**Regional**	**Distant**
Wisconsin	91%	76%	19%
NH White	92%	76%	19%
NH American Indian/Alaska Native	90%	65%	18%
NH Black	92%	71%	10%
NH Asian or Pacific Islander	88%	86%	21%
Hispanic	95%	74%	33%

In addition to the five-year survival, stage distribution provides insight into how many cancers are being diagnosed at the localized stage (no spread) compared to late stage (regional and distant stages).

In Wisconsin, 65.1% of colorectal cancers are diagnosed at a late-stage (Figure 14).[3]

Higher percentages of late-stage diagnoses suggest these cancers are not detected early and may require more advanced and complex treatments which come at higher costs and reduced survival.

Cancer control professionals can leverage local data to identify and implement evidence-based interventions that have demonstrated success at increasing colorectal cancer screening and early detection, while ultimately reducing late-stage diagnoses and mortality.

When looking at stage distribution by race and ethnicity, NH AI/AN and Hispanic populations have higher proportions of cases diagnosed at distant stages (28%) and NH Asian or Pacific Islander had the lowest proportion of cases diagnosed at distant stages (21%) (Figure 15).[3]

FIGURE 14.

Percentage of late-stage* colorectal cancer diagnosis by Wisconsin county (2018-2022).[3]

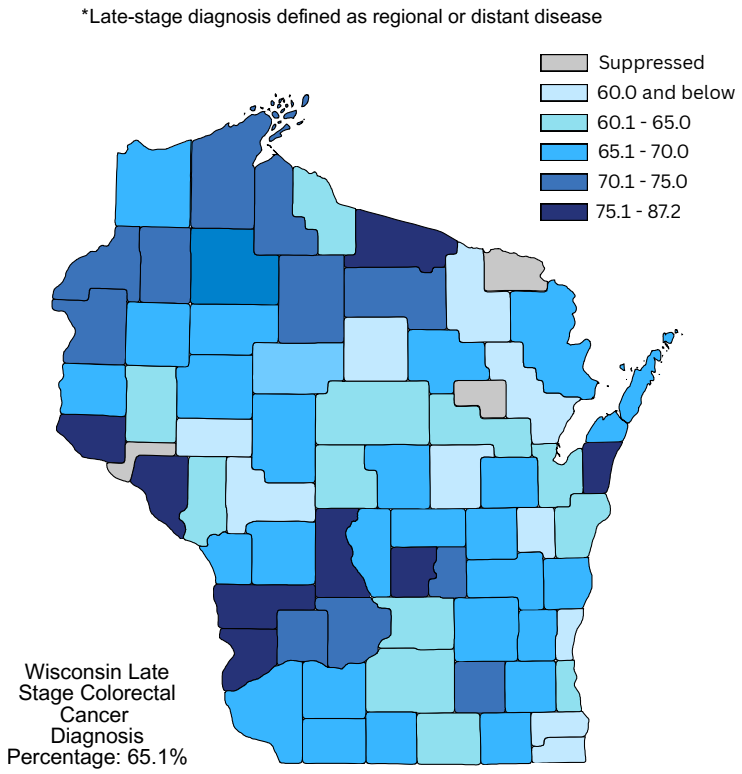
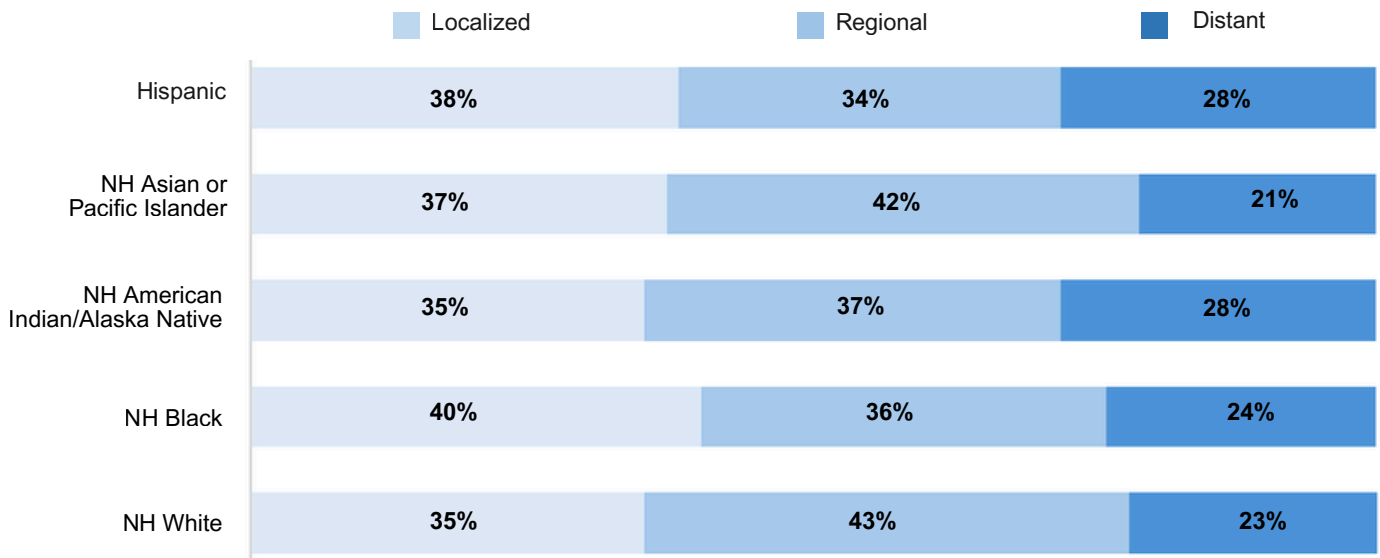


FIGURE 15.

Stage distribution* (%) of new colorectal cancer cases by race/ethnicity, Wisconsin (2018-2022).[3]



Unstaged or unknown cancers cases are not included

CONCLUSION

The Wisconsin Cancer Plan 2020-2030[16] is a blueprint for action and underscores several priorities relevant to improving colorectal cancer outcomes for everyone living in Wisconsin. Steps can be taken to stregthen risk reduction strategies that support colorectal cancer prevention, enhance our approaches to colorectal cancer screening to detect cancer early, and pursue better treatment outcomes and improved survivorship opportunities.

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APPENDIX 1: Colorectal cancer cases (2010-2022) and deaths (2010-2023) and age-adjusted incidence and mortality rates per 100,000, U.S. and Wisconsin.[3,6,17]

	Incidence				Mortality			
	Wisconsin		U.S.		Wisconsin		U.S.	
Diagnosis year	Cases	Rate (95% CI)	Cases	Rate (95% CI)	Deaths	Rate (95% CI)	Deaths	Rate (95% CI)
2010	2,591	40.1 (38.6, 41.7)	149,691	42.4 (42.2, 42.7)	939	14.4 (13.5, 15.3)	52,045	15.6 (15.4, 15.7)
2011	2,641	40.3 (38.8, 41.9)	150,028	41.8 (41.6, 42)	992	14.9 (14, 15.9)	51,783	15.2 (15.1, 15.3)
2012	2,559	38.4 (36.9, 40)	149,330	40.8 (40.5, 41)	931	13.7 (12.9, 14.7)	51,516	14.8 (14.7, 14.9)
2013	2,553	37.9 (36.5, 39.5)	150,085	40.4 (40.2, 40.6)	975	14.2 (13.3, 15.1)	51,813	14.6 (14.5, 14.7)
2014	2,596	38 (36.6, 39.6)	154,054	40.4 (40.2, 40.6)	945	13.6 (12.7, 14.5)	51,651	14.3 (14.2, 14.4)
2015	2,559	37.2 (35.8, 38.7)	155,177	40 (39.8, 40.2)	910	12.8 (12, 13.7)	52,396	14.2 (14.1, 14.3)
2016	2,671	38.1 (36.6, 39.6)	155,660	39.5 (39.3, 39.7)	934	13.3 (12.4, 14.2)	52,286	13.9 (13.8, 14)
2017	2,550	36.3 (34.8, 37.7)	154,050	38.6 (38.4, 38.8)	889	12.5 (11.7, 13.4)	52,547	13.7 (13.6, 13.8)
2018	2,554	35.9 (34.5, 37.4)	156,825	38.5 (38.3, 38.7)	933	12.7 (11.9, 13.6)	52,163	13.4 (13.3, 13.5)
2019	2,642	36.7 (35.3, 38.2)	158,481	38.3 (38.1, 38.5)	896	12.1 (11.3, 12.9)	51,896	13.1 (13, 13.2)
2020	2,273	31.1 (29.8, 32.5)	141,029	34.1 (34, 34.3)	851	11.3 (10.5, 12.1)	51,896	12.9 (12.8, 13)
2021	2,580	35.4 (34, 36.8)	154,676	37.4 (37.2, 37.6)	873	11.6 (10.9, 12.5)	52,729	12.9 (12.8, 13)
2022	2,609	35.9 (34.5, 37.4)	151,448	37 (36.8, 37.2)	883	11.7 (10.9, 12.5)	52,967	12.8 (12.7, 12.9)
2023	NA	NA	NA	NA	900	11.7 (10.9, 12.5)	53,779	12.7 (12.6, 12.8)

APPENDIX 2: Colorectal cancer counts and age-adjusted incidence rates per 100,000 by sex and age at diagnosis, Wisconsin (2018-2022).[3]

	Males		Females		Total	
Age at Diagnosis	Cases	Rate (95% CI)	Cases	Rate (95% CI)	Cases	Rate (95% CI)
35-44	310	16.8 (15.0, 18.8)	306	17.1 (15.3, 19.2)	616	17 (15.7, 18.4)
45-54 years	1,093	58.6 (55.1, 62.2)	758	41.9 (38.9, 45.0)	1,851	50.4 (48.1, 52.7)
55-64 years	1,542	73.6 (69.9, 77.4)	1,062	50.7 (47.6, 53.8)	2,604	62.1 (59.7, 64.4)
65-74 years	1,741	115.9 (110.5, 121.5)	1,335	85.5 (80.9, 90.2)	3,076	100.4 (96.9, 104.0)
75+ years	1,894	221.4 (211.5, 231.6)	2,323	189.8 (182.1, 197.8)	4,217	203.1 (197.0, 209.4)
Total	**6,580**	**74.5 (72.6, 76.4)**	**5,784**	**58.6 (57,60.2)**	**12,364**	**66.2 (65, 67.5)**

APPENDIX 3: Colorectal cancer deaths and age-adjusted mortality rates per 100,000 by sex and age at diagnosis, Wisconsin (2019-2023).[6]

	Males		Females		Total	
Age at Death	Deaths	Rate (95% CI)	Deaths	Rate (95% CI)	Deaths	Rate (95% CI)
35-44 years	58	1.5 (1.2, 1.9)	60	1.5 (1.2, 1.9)	118	8.7 (8.1, 9.3)
45-54 years	214	11.5 (10.0, 13.2)	151	8.3 (7.1, 9.8)	365	10.0 (9.0, 11.1)
55-64 years	473	22.7 (20.7, 24.9)	283	13.5 (12.0, 15.2)	765	18.1 (16.8, 19.5)
65-74 years	579	37.4 (34.4, 40.6)	413	25.6 (23.1, 28.2)	992	31.3 (29.4, 33.4)
75+ years	997	115.6 (108.5, 123.1)	2,1241,138	87.8 (82.6, 93.0)	2,135	99.2 (95.1, 103.6)
Total	**2,321**	**26.4 (25.3, 27.5)**	**2,045**	**19.2 (18.4, 20.1)**	**4,366**	**22.5 (21.8, 23.2)**

APPENDIX 4: Colorectal cancer cases (total and % late stage) and age adjusted incidence rates (2018-2022), and deaths and age-adjusted mortality rates (2019-2023) by Wisconsin county.[3,6]

	Incidence		Mortality		Late Stage Diagnosis	
County	Cases	Rate (95% CI)	Deaths	Rate (95% CI)	Cases	Late Stage Cases (%)
Adams	67	37.0 (27.5, 49.4)	26	16.5 (9.8, 26.5)	41	66.1%
Ashland	50	44.6 (32.5, 60.0)	13	11.4 (5.9, 20.5)	34	73.9%
Barron	137	39.2 (32.5, 47.0)	60	16.0 (12.1, 21.0)	90	69.8%
Bayfield	54	39.6 (28.5, 54.3)	23	18.4 (11.0, 29.8)	38	74.5%
Brown	490	32.6 (29.7, 35.7)	164	10.6 (9.0, 12.4)	301	63.4%
Buffalo	36	37.3 (25.5, 53.2)	12	10.7 (5.5, 20.0)	26	76.5%
Burnett	49	32.2 (23.1, 44.7)	22	11.6 (7.2, 19.5)	32	72.7%
Calumet	105	33.9 (27.5, 41.3)	33	10.6 (7.2, 15.1)	61	59.2%
Chippewa	158	34.9 (29.5, 41.1)	53	11.8 (8.7, 15.6)	101	67.3%
Clark	76	35.8 (27.9, 45.3)	29	13.3 (8.7, 19.4)	48	65.8%
Columbia	139	35.9 (30.0, 42.8)	46	11.5 (8.3, 15.7)	81	62.8%
Crawford	43	36.7 (25.7, 51.1)	18	15.1 (8.5, 25.4)	34	87.2%
Dane	834	29.3 (27.3, 31.4)	270	9.0 (7.9, 10.1)	504	62.8%
Dodge	211	36.3 (31.4, 41.9)	81	13.7 (10.8, 17.1)	130	66.3%
Door	72	25.7 (19.4, 33.9)	28	8.7 (5.6, 13.7)	43	67.2%
Douglas	93	32.8 (26.2, 40.7)	35	11.2 (7.7, 16.0)	61	67.8%
Dunn	70	27.3 (21.1, 34.9)	21	7.7 (4.7, 12.1)	41	63.1%
Eau Claire	193	32.9 (28.2, 38.1)	62	9.4 (7.2, 12.2)	109	59.2%
Florence	12	32.7 (15.4, 65.1)	^	^	^	^
Fond du Lac	254	38.1 (33.4, 43.4)	76	10.8 (8.5, 13.7)	168	68.0%
Forest	32	37.8 (25.7, 55.3)	16	17.3 (9.8, 30.6)	18	58.1%
Grant	123	39.5 (32.5, 47.7)	55	16.8 (12.4, 22.2)	74	66.1%
Green	78	31.1 (24.3, 39.3)	24	9.7 (6.1, 14.7)	46	65.7%
Green Lake	50	36.5 (26.5, 49.4)	10	6.6 (3.2, 13.0)	33	70.2%
Iowa	58	36.4 (27.3, 47.9)	24	15.1 (9.5, 23.0)	39	69.6%
Iron	19	30.6 (16.5, 55.2)	^	^	11	64.7%

APPENDIX 4 Continued

	Incidence		Mortality		Late Stage Diagnosis	
County	Cases	Rate (95% CI)	Deaths	Rate (95% CI)	Cases	Late Stage Cases (%)
Jackson	68	46.5 (35.9, 59.6)	21	13.4 (8.3, 21.1)	36	58.1%
Jefferson	192	36.6 (31.5, 42.5)	59	10.9 (8.2, 14.2)	135	73.8%
Juneau	77	39.2 (30.7, 49.8)	32	16.2 (10.9, 23.5)	55	77.5%
Kenosha	351	36.5 (32.6, 40.6)	113	11.5 (9.4, 13.9)	201	59.6%
Kewaunee	48	30.3 (22.1, 40.9)	17	10.7 (6.2, 17.9)	36	76.6%
La Crosse	211	30.9 (26.7, 35.6)	80	11.2 (8.8, 14.1)	135	67.2%
Lafayette	54	51.2 (37.5, 68.4)	19	14.0 (8.3, 22.7)	35	70.0%
Langlade	68	44.9 (34.0, 58.5)	34	21.8 (14.6, 31.9)	45	68.2%
Lincoln	97	43.8 (35.1, 54.4)	31	13.4 (8.9, 19.8)	53	55.8%
Manitowoc	208	36.4 (31.4, 42.1)	67	11.0 (8.4, 14.2)	121	62.4%
Marathon	291	33.5 (29.7, 37.8)	99	10.5 (8.5, 12.9)	175	61.8%
Marinette	124	37.1 (30.4, 45.1)	37	10.5 (7.3, 14.9)	79	65.8%
Marquette	38	31.5 (21.4, 45.3)	24	19.2 (11.7, 30.4)	28	77.8%
Menominee	6	24.0 (8.2, 55.9)	^	^	^	^
Milwaukee	1,928	39.2 (37.4, 41.1)	676	13.5 (12.5, 14.6)	1,142	62.6%
Monroe	74	25.5 (19.8, 32.4)	31	10.7 (7.2, 15.4)	49	70.0%
Oconto	115	39.4 (32.1, 48.1)	35	11.6 (8.0, 16.6)	62	54.9%
Oneida	126	39.6 (32.4, 48.3)	48	15.4 (11.1, 21.1)	84	71.8%
Outagamie	388	35.1 (31.6, 38.8)	129	11.6 (9.6, 13.8)	249	68.2%
Ozaukee	216	34.7 (30.0, 40.0)	67	9.6 (7.4, 12.4)	117	56.8%
Pepin	17	35.7 (19.7, 60)	^	^	^	^
Pierce	78	33.9 (26.6, 42.7)	41	17.2 (12.2, 23.6)	50	75.8%
Polk	108	32.5 (26.4, 39.8)	41	11.0 (7.8, 15.3)	76	74.5%
Portage	153	37.4 (31.5, 44.1)	60	14.8 (11.2, 19.2)	92	65.2%
Price	36	30.4 (20.4, 44. 6)	14	11.6 (6.1, 21.4)	23	71.9%
Racine	412	33.6 (30.3, 37.2)	151	12.2 (10.3, 14.4)	225	58.0%

APPENDIX 4 Continued

	Incidence		Mortality		Late Stage Diagnosis	
County	Cases	Rate (95% CI)	Deaths	Rate (95% CI)	Cases	Late Stage Cases (%)
Richland	53	43.8 (31.8, 59.0)	20	13.1 (7.9, 21.2)	37	74.0%
Rock	367	37.2 (33.4, 41.3)	100	9.8 (7.9, 12.0)	219	62.8%
Rusk	38	33.4 (23.0, 47.7)	15	11.7 (6.5, 20.7)	24	66.7%
St. Croix	194	35.9 (30.9, 41.5)	66	13.3 (10.1, 17.2)	133	72.7%
Sauk	163	37.1 (31.4, 43.5)	62	10.0 (5.9, 17.3)	94	60.3%
Sawyer	40	30.8 (21.2, 43.7)	18	13.9 (9.9, 19.1)	24	63.2%
Shawano	107	36.9 (29.9, 45.3)	42	11.4 (9.1, 14.1)	70	68.6%
Sheboygan	270	36.7 (32.3, 41.6)	91	12.6 (9.6, 16.1)	175	66.0%
Taylor	48	33.3 (24.3, 45.1)	19	14.5 (8.4, 23.4)	30	63.8%
Trempealeau	55	28.4 (21.1, 37.5)	17	8.1 (4.6, 13.4)	29	61.7%
Vernon	87	40.1 31.8, 50.1)	35	15.9 (10.8, 22.7)	66	80.5%
Vilas	82	37.5 (28.7, 48.7)	33	13.5 (9.1, 20.3)	60	78.9%
Walworth	266	39.0 (34,2, 44.3)	81	11.1 (8.8, 14.0)	178	69.0%
Washburn	57	41.7 (30.4, 56.4)	31	22.4 (14.5, 33.9)	38	74.5%
Washington	299	33.3 (29.5, 37.5)	103	11.6 (9.4, 14.1)	190	65.3%
Waukesha	827	30.6 (28.5, 32.9)	280	9.7 (8.6, 11.0)	526	66.5%
Waupaca	132	35,7 (29.6, 42.8)	42	10.5 (7.5, 14.4)	73	59.3%
Waushara	72	38.9 (29.8, 50.3)	30	14.4 (9.4, 21.6)	47	68.1%
Winnebago	331	33.0 (29.4, 36.9)	98	9.5 (7.6, 11.6)	208	65.8%
Wood	178	33.4 (28.4, 39.0)	77	13.9 (10.9, 17.7)	109	64.5%
Wisconsin	12,653	34.9 (34.3, 35.6)	4,403	11.6 (11.3, 12.0)	7,818	65.1%