groups, for each sex and calendar years of study period. Counted crude, age-standardised rates per 100,000. The classification scheme used by ICD-10.
Results: Age-standardised (ASR) annual total cancer incidence was in males 201.2 and females 137.9 (total 169.55 per 100,000). The most frequent diagnostic groups in males were tumours of the stomach (44.65), lung (41.0), skin (27.8); in females – skin (23.5), breast (19.1), stomach (16.2). There were 301 registered with leukaemia (84 – acute myeloid, 66 – chronic myeloid, 48 – non differentiated, 42 – chronic lymphoid, 23 – acute lymphoid, 10 – erythraemia, 15 – other myeloid leukaemia, and 13 with myeloid dysplastic syndrome. Both acute and chronic leukaemia ASR in the Kyrgyz republic was 1.22 per 100,000.
Leukaemia incidence was slightly higher in urban (1.62) than rural (1.18) regions. High incidence rate in leukaemia was registered in North area; Bishkek (2.99) and Chuy (2.22). Lower incidence was registered in South region (Osh, Batken, Djalal-Abad) with ASR from 0.2 to 0.3 per 100 000.
Leukaemia incidence was significantly higher in the Slavic ethnic groups (Russians, with an ASR of 3.21 cases per 100,000, Ukrainians 3.03) compared with 1.09 for Kyrgyzs, 0.54 for Kazakhs and 0.27 for Uzbeks people.
Conclusion: Leukaemia incidence in Kyrgyzstan is low and similar to those reported from some Asian developing countries. The data could be use for a wide range of epidemiological and other studies. These include analyses of geographical variations in incidence, trends in survival, health of long-term survivors.

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Ethnic disparities in cancer incidence, mortality, stage at diagnosis and survival, in Aotearoa/New Zealand

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Background: The recently established New Zealand Cancer Control Strategy aims to reduce inequalities throughout the cancer care continuum – yet little information is available on baseline ethnic disparities in cancer outcomes. This study examined disparities in cancer incidence, mortality, stage at diagnosis and survival between Maori, (the indigenous people of Aotearoa/New Zealand), and the colonial settler population.
Methods: New cancer registrations from the New Zealand Cancer Registry during 1996 to 2001were linked to national mortality data. For 25 cancers, age-standardised incidence and mortality rates and ratios were calculated. Poisson regression was used to calculate Maori: non-Maori odds ratios for stage at diagnosis, adjusted for age and sex at diagnosis. Cox's regression was used to estimate relative risks of cancer-specific death after diagnosis (hazard ratios), adjusted for sex, age and stage at diagnosis, and within each stage-group (localised, regional, distant, unknown). Survival curves were calculated using Kaplan-Meier estimates.
Results: Leading cancer types differed for Maori and non-Maori. Incidence was higher among Maori for lung, stomach, cervix, testis, liver, and higher among non-Maori for colorectal, melanoma, prostate, bladder, brain cancers.
Maori were 18% more likely to be diagnosed with cancer than non-Maori (RR 1.18; 95%CI: 1.15–1.21) but nearly twice as likely to die from cancer (RR 1.93; 95%CI: 1.87–1.99). Mortality/incidence ratios were higher among Mäori than non-Mäori for most cancers. Maori had lower survival than non-Maori for cancers of the breast, cervix, prostate, colorectum, lung, uterus, kidney, leukaemia, NHL.
Unknown stage at diagnosis was more common among Maori than non-Maori for most common cancers. Maori were more likely than non-Maori to be diagnosed at a later stage with cancers of the breast, lung, colon and rectum, cervix, prostate, testis, kidney, oral cancers, and melanoma. Stage at diagnosis accounted for only part of the survival disparity between Maori and non-Maori for lung (18%), breast (30%), cervix (20%), colorectal (49%), prostate (47%) cancers.
Conclusions: These findings indicate the existence of disparities between Maori and non-Maori in timely access to definitive diagnostic procedures, staging procedures, and optimal treatment or management of cancer. Ethnic disparities in pathways through care must be investigated and addressed.

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Diagnostic and therapeutic delay after mammography screening in the Hungarian nation wide organized breast cancer screening programme

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Background and Aim: After the evaluation of pilot projects, the Hungarian nation wide breast cancer programme was launched in January 2002. Women between the age of 45–65 are invited by a personal letter for mammography screening and a 2 years screening interval is applied. The aim of the study is to analyse diagnostic and therapeutic delay after mammography screening in the Hungarian organized breast cancer screening programme.
Methods: The data derive from the database of the National Health Insurance Fund Administration containing routinely collected financial data. The study includes all the patients having mammography screening in the year of 2002. The starting point (T_0) was defined as the time of the mammography screening. T_1 denotes the time of the first diagnostic procedure after the mammography screening. T_2 denotes the time of the first therapeutic procedure after mammography screening and diagnosis. We calculated the average delay between the time of mammography screening (time = T_0), further diagnostic (time = T_1) and therapeutic (time = T_2) procedures. For the calculation of the average period spent from the time of mammography screening we used the median value instead of arithmetic mean.
Results: Altogether N = 314.395 women were included into the study. The average diagnostic delay between T_0 and T_1 time was 20 days measured by the time of ultrasound examination in axilla and 26 days measured by the time of ultrasound examination in breast. The average therapeutic (surgical) delay between T_0 and T_2 time was 43–47 days, 50–53 days and 57 days measured by the time of subtotal mastectomy, total mastectomy or breast operations because of non-malignant causes respectively. The average chemo or radio therapeutic delay between T_0 and T_2 time was 83 days and 136 days measured by the time of chemotherapy or radiotherapy respectively. The average delay between the time of diagnosis (T_1) and the first therapeutic event (T_2) was 26 days with a 16 days shortest and 38 days longest delay in the different Hungarian counties.
Conclusion: The diagnostic and therapeutic delay in the Hungarian breast cancer screening programme is similar to the value reported by other national programmes. We realized significant regional differences, which result in large discrepancies in the equity. We can assume that these differences can be reduced by better organization and the more consistent application of professional guidelines.

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The network on rare tumours in Italy

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Background: Rare tumours (RT) pose huge difficulties in terms of quality of care, access to health resources and clinical research. The Network on Rare Tumors (Rete Tumori Rari – RTR) is a collaborative effort in Italy aimed at improving quality of care, making institutions share patients, define clinical practice guidelines on RT and rationalize access to health facilities. It promotes collaborative clinical research by encouraging patient accrual into trials.
Methods: RTR includes 70 institutions across Italy. Internet access is the only requirement to join. Clinical cases are shared and messages exchanged through a secure Web resource, and all data, images and transactions are stored in a data base. Patients may be i) "logically" shared, ie the case is dealt with following clinical practice guidelines previously agreed upon; ii) "virtually" shared, ie the case is discussed over the network; iii) "physically" shared, ie the patient moves from a center to another to receive appropriate care as needed. A network moderator "switches on" the institutions to involve in each case sharing, inasmuch