



Department of Health

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Dear Colleagues:

New York State's public health response to COVID-19 has naturally focused on the most immediate threats—currently, the heightened risk of viral transmission within newly reopened schools and colleges and the approaching flu season. But COVID-19 poses a significant secondary threat: the delay in routine screening for major diseases such as cancer. A national [Prevent Cancer Foundation survey](#) released in August found that 35% of American adults had a cancer screening scheduled during the pandemic and missed it, and 22% who had routine medical appointments or screenings scheduled in the upcoming three months planned to postpone or cancel.

In late August, many Americans mourned the death of 43-year-old actor Chadwick Boseman, who succumbed to colorectal cancer (CRC) after a four-year battle. The loss of this beloved figure reminded the public that CRC can afflict people younger than 50: Mr. Boseman was 39 when diagnosed. This month, I want to address the importance of remaining vigilant with CRC screening as well as cancer screening generally. I will also discuss another important public health concern that is being exacerbated by the pressures and social isolation of COVID-19: greater statewide opioid use and risk for overdose.

Ensuring That No CRC Diagnosis Is Missed. As one of the most preventable types of cancer, CRC affects all genders, ages, races, and ethnicities. Despite improvements in CRC screening rates and treatment outcomes over the past two decades, every year we still diagnose nearly 9,000 New Yorkers with CRC and lose over 3,000. Although most people diagnosed with CRC are age 50 or older, of the 9,000 CRC cases diagnosed annually in the State, nearly 11% occur in people younger than age 50. Roughly 6% of the over 3,000 CRC deaths occurred in this age group.

As clinicians, we must be aware of existing disparities and work within our practices and communities to address their potential causes. New York State sadly mirrors national trends in the increasing incidence of CRC among those younger than 50, with diagnoses going up by 1.8% each year. And, among all ages, New York's CRC rate among men (45 per 100,000) is much higher than that among women (34 per 100,000). While nearly 70% of CRC diagnoses in the State are among non-Hispanic Whites, according to an [American Cancer Society report](#), rates of colorectal cancer are higher among Black people. From 2012 to 2016, the rate of new cases in non-Hispanic Black people was 45.7 per 100,000, about 20% higher than the rate among non-Hispanic white people and 50% higher than the rate among Asian Americans and Pacific Islanders. Alaska Natives had the highest rate: 89 per 100,000.

Clinically, we must consider a three-pronged defense against this preventable cancer:

1. *Symptom surveillance at any age with appropriate workup.* CRC should be considered a possible diagnosis in ANY patient (regardless of age) presenting with blood in their bowel movements, changes in bowel habits,

abdominal pain, weight loss, or unexplained anemia. In such patients, the U.S. Preventive Services Task Force and the American Cancer Society recommend a colonoscopy.

2. *Risk assessment with colonoscopy for anyone at high risk for CRC.* Adults of all ages should be asked about their risk for CRC. Screening colonoscopy should be completed at appropriate intervals for anyone with a family history of adenomas, cancer, or inflammatory bowel disease or with a genetic syndrome (e.g., Lynch syndrome) that elevates their risk.
3. *Cancer screening with immediate follow-up of abnormal results.* Several safe and effective tests are available to screen average-risk adults for CRC, including take-home stool tests and tests providing a structural exam of the colon and rectum (colonoscopy, sigmoidoscopy, and CT colonography). Abnormal results on a stool test or CT colonography must be immediately followed up with a colonoscopy. Talk to all of your adult patients about their risk of CRC and be sure to start average-risk screening *no later than* age 50.

Getting Screenings, Treatment, and Survivor Care “Back on the Books.” However long the pandemic lasts, we must simultaneously remind patients about the importance of staying up to date with any indicated [breast, cervical, lung, or colorectal cancer screening](#) while ensuring them that their visit to the screening site will be safe. Primary care and health system specialists should work closely with community groups to accomplish this critical preventive health goal and target efforts toward populations least likely to be accessing care. The American Cancer Society outlines [guidance on screening being done safely](#), and the National Colorectal Cancer Roundtable provides a [new playbook for reigniting CRC screening](#).

For the more than 1 million adult cancer survivors in our state who are currently undergoing or have completed treatment, the pandemic’s impact may have only exacerbated the physical and psychosocial health effects of cancer and its long-term outcomes. These effects can negatively impact cancer survivors’ quality of life, resulting in decreased survival and poor cancer-related outcomes. Given the toll that COVID-19 has taken on cancer survivors, it is worth remembering that many cancer survivors need tailored, patient-centered care. I would like to share with you and your networks [The George Washington University’s Cancer Survivorship E-Learning Series for Primary Care Providers](#). This free, self-paced, online training is designed to better prepare clinicians to attend to the needs of those diagnosed with cancer and/or those in posttreatment.

COVID-19 and Opioid Overdose. Overdose deaths from heroin, illicitly produced fentanyl, and prescribed opioid analgesics continue to ravage all parts of New York State. Deaths involving any opioid increased among New Yorkers from 1,074 in 2010 to 3,224 in 2017, with a 7% increase from 2016 to 2017. In 2018, however, the number of deaths declined 7% compared to the previous year, from 3,224 to 2,991, marking the first decrease since 2010. Unfortunately COVID-19-associated pressures and social isolation are likely fueling greater opioid use and risk for overdose. Anecdotal reports from the State’s syringe exchange programs have confirmed this suspicion, as have reports of opioid overdoses for individuals who believed they were using only cocaine.

In its 2016 guidelines for prescribing opioids for chronic pain, the Centers for Disease Control and Prevention (CDC) [recommends co-prescribing naloxone](#) with opioid medications when patients may be at risk of overdose. A July 2020 Drug Safety Communication from the

Federal Drug Administration (FDA) [encourages healthcare professionals](#) to discuss naloxone with *all* patients who are prescribed opioid pain relievers or are taking medications used for treating opioid use disorder (MOUD) and recommends that naloxone be considered for all persons at risk for an opioid overdose, including those whose risk does not entail opioid analgesic or MOUD prescriptions.

Consistent with CDC, FDA, and other guidelines, the New York State Department of Health strongly recommends prescribing naloxone to:

1. Patients who are prescribed opioids at a dose greater than 50 MME.
2. Patients whose use of opioids—prescribed or otherwise—is accompanied by benzodiazepine, alcohol, or stimulant use.
3. Patients in substance use disorder (SUD) treatment, whether or not that treatment includes MOUD. (Although methadone and buprenorphine treatment dramatically reduce the risk of overdose, patients may still be at risk for overdose if there is a return to other opioid use.)
4. Patients with a history of SUD, whether they are in treatment for SUD or not.
5. Patients who have had an opioid overdose. (It is important to consider that some patients will describe an overdose as a “bad reaction” rather than use or respond to the term “overdose.”)

Additionally, in August Governor Cuomo [signed legislation](#) that expands the list of entities authorized to possess and administer an opioid overdose reversal medication to include restaurants, bars, malls, beauty parlors, theaters, hotels, and retail establishments.

I am very aware of the greater responsibilities that this pandemic continues to place on the shoulders of our clinicians and providers—and I am eternally grateful for everything you do for your patients and for New York State. “New York Tough” begins with you. Thank you again. Stay well.

Sincerely,



Howard A. Zucker, M.D., J.D.