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New York City Department of Health and Mental Hygiene

SCREENING FOR COLORECTAL CANCER

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SUMMARY OF RECOMMENDATIONS

Timely screening and follow-up for colorectal cancer (CRC) can reduce incidence and mortality and improve inequities in outcomes.

Ask early about CRC risk, follow up promptly on any positive screening tests, and support access to affordable care.

- **Identify people at increased risk who need to start screening before age 45 years.**
  - Begin an ongoing conversation about personal and family health history with patients as early as their 20s to determine the need for earlier screening.
  - For people at high risk due to certain family or personal history, recommend colonoscopy as their primary screening test. For many people at increased risk, screening should start at age 40 years or even earlier.
- **Recommend screening for people at average risk beginning at age 45 years.**
  - For people at average risk, offer a choice of screening tests; explain benefits and limitations of each.
- **Recognize potential CRC symptoms, such as rectal bleeding, and refer for diagnostic colonoscopy.** Do not wait until the person is due for screening.
- **Ensure that positive tests receive prompt follow-up.**
  - Refer immediately for colonoscopy if a non-invasive test, such as a stool-based test, is positive and encourage prompt follow-up. Avoid waits for colonoscopy longer than 6 months.
- **Establish practice workflows to help patients stay on track with screening.**
  - Use a tracking and reminder system to ensure timely screening and appropriate follow-up tests.
- **For people who are uninsured or underinsured, provide information on low-cost or no-cost screening options.**

Colorectal cancer (CRC) screening has contributed to a major decline in overall incidence and mortality from CRC.[1] However, in recent years, these declines primarily reflect trends for people aged older than 65 years.[1] Current recommendations to initiate screening in average-risk individuals at age 45 years, instead of the previous age of 50 years, reflect increasing incidence and mortality among younger adults.[1] Overall, CRC continues to be one of the leading causes of cancer death in NYC.[2]

In this issue of *City Health Information,* we discuss best practices for CRC screening, including identifying people at increased risk, assisting those at average risk and increased risk in choosing a screening test, and ensuring prompt follow-up when needed. We also provide information about low- and no-cost screening options for people who are uninsured or underinsured.

SCREENING, INCIDENCE, AND MORTALITY

In 2022, approximately 67% of New Yorkers aged 45 to 75 years were up to date with CRC screening, but only 36% of those aged 45 to 49 years were up to date.[3]

NYC has substantial inequities in who is most affected by CRC. Successes in screening, including through the efforts of the Citywide CRC Control Coalition (**Resources**), and advances in treatment have contributed to declines in CRC mortality among NYC residents overall and among Asian/Pacific Islander, Black, Latino, and white New Yorkers.[4] However, CRC mortality rates are often higher among Black New Yorkers.[5] Black New Yorkers also have a higher proportion of diagnoses at a late stage, even though screening rates among this population are similar to or higher than those among other groups.[5] It is important to note that racial and ethnic groups are socially determined categories, and that social determinants of health, including the impact of racism on opportunities for good health and access to care, influence both cancer incidence and outcomes.

TALK ABOUT SCREENING EARLY

Assess CRC risk by taking a detailed personal and family health history (**Box 1**[6-10]) for all

BOX 1. IDENTIFYING PEOPLE AT INCREASED RISK FOR COLORECTAL CANCER[6-10]

Take a personal and family history (including at least first- and second-degree relatives) that includes

- Colorectal cancer (CRC) and age at onset
- Other cancer(s) and age at onset
- Colon or rectal polyps (number, size, type) and age at diagnosis
- Genetic syndromes that increase CRC risk, including Lynch syndrome and familial adenomatous polyposis
  - A prediction calculator for Lynch Syndrome is available from the Dana-Farber Cancer Institute at premm.dfci.harvard.edu.

Personal history should also include

- Inflammatory bowel disease
- Cystic fibrosis
- Any previous cancer treatment

If the history raises concern for an undiagnosed genetic mutation or syndrome that increases CRC risk, refer for specialist evaluation (eg, gastroenterology or genetics). Patterns to watch for include

- CRC before age 50 years, in the person or a first- or second-degree relative
- Other tumors associated with Lynch syndrome (LS) in the person or first- or second-degree relative(s), especially if one of the following
  - Occurred before age 50 years
  - Multiple family members
  - Multiple cancers in the same person
- Many polyps, eg, 10 or more cumulative adenomas, or 5 or more serrated polyps (proximal to the rectum), or 2 or more hamartomatous polyps in the individual or a first-degree relative

Tumors related to Lynch Syndrome, also known as hereditary nonpolyposis colorectal cancer, include endometrial, gastric, ovarian, pancreatic, urothelial, brain, biliary tract, or small intestine cancer; or sebaceous carcinoma, sebaceous adenoma, or keratoacanthoma.

***See Risk Assessment and Screening Toolkit to Detect Familial, Hereditary and Early Onset Colorectal Cancer*.**

individuals beginning at age 20 years and update this information annually if possible.[11]

Waiting until age 45 years to discuss screening misses many opportunities to catch or prevent early cancers among people at increased risk. Taking a careful personal and family health history will help identify people who need early screening.

Approximately 5% of US adults are aware of a first-degree relative with CRC.[12] In a study of family history among people diagnosed with CRC between age 40 and 49 years, approximately 1 in 4 cases could have been either prevented or diagnosed earlier if recommendations for early screening were followed.[13]

For people at average risk, early conversations about screening allow time for them to become comfortable with the idea of screening and think about the method they prefer.

If a person presents with possible CRC symptoms, do not wait until they are due for screening; consider colonoscopy in addition to other workup (**Box 2**[11]).

WHEN TO BEGIN SCREENING

For people at average risk

Most cases of CRC are sporadic (ie, no obvious risk factors), so screening is important for everyone.[14] For people at average risk, both the US Preventive Services Task Force (USPSTF) and the American Cancer Society (ACS) recommend[15,16]

- Begin screening at age 45 years.
- Individualize screening recommendations for ages 76 to 85 years.
- Stop screening after age 85 years, due to limited benefit.

People at average risk have multiple screening options. Offering an informed choice of tests can increase screening uptake by accommodating each individual's preferences.

For people at increased risk

According to most current US-based guidelines, colonoscopy is the recommended screening test for many people at increased risk of CRC.

For people with a **personal history of CRC or advanced polyps**, follow recommendations for surveillance from their gastroenterologist or oncologist, or refer for specialist evaluation if needed. Guidelines that address these situations are available from professional organizations and groups such as the National Comprehensive Cancer Network (NCCN) and the US Multi-Society Task Force on Colorectal Cancer.[7,17,18]

For people with a **family history of CRC or advanced polyps** (**Box 3**[7,19]) in one or more first-degree relatives, begin screening at age 40 years or 10 years younger than the earliest diagnosis, whichever is earlier.

- For people with multiple first-degree relatives affected, or with a single first-degree relative diagnosed before age 60 years, recommend colonoscopy as the

BOX 2. POTENTIAL COLORECTAL CANCER SYMPTOMS[11]

- Diarrhea or constipation that is a change from the patient's normal pattern
- Narrowing or flattening of the stool that does not resolve within a few days
- Feeling that the bowel does not empty completely
- Rectal bleeding (bright red blood) or maroon or black stools
- Abdominal pain or cramping that is new
- Fatigue
- Weight loss
- Anemia

BOX 3. ADVANCED POLYPS[7,19]

Advanced polyps are

- Any adenoma 1 cm or larger OR with villous or tubulovillous features OR with high-grade dysplasia
- Any sessile serrated polyp/lesion (may also be called sessile serrated adenoma) 1 cm or larger OR any serrated lesion with dysplasia
- Any traditional serrated adenoma

screening test. If the screening is negative, continue with colonoscopy at 5-year intervals.
- For people with only a single first-degree relative diagnosed at age 60 years or older, a choice of test options, with the same intervals as for someone at average risk, may be appropriate.

These recommendations combine guidance from several different expert groups (**Table 1**[7-9]). For people with only second- or third-degree relatives with CRC, see **Table 1** for options.

Family history of CRC in one or more first-degree relatives is associated with approximately a two-fold increase in risk.[20] Relative risk increases with increasing numbers of affected first-degree relatives and appears to be highest in young relatives of people with early-onset CRC.[21-23] A more modest increase is associated with CRC in a second-degree relative or a

TABLE 1. EXAMPLES OF COLORECTAL CANCER SCREENING GUIDELINES THAT ADDRESS POSITIVE FAMILY HISTORY[a,7-9]

<table>
<tr><th></th><th>American College of Gastroenterology (2021)</th><th>US Multi-Society Task Force (2017)[b]</th><th>National Comprehensive Cancer Network (2026)</th></tr>
<tr><td>First-degree relative(s) with colorectal cancer (CRC)</td><td colspan="3">Age 40 years or 10 years before youngest diagnosis, if earlier
Colonoscopy every 5 years</td></tr>
<tr><td>Only 1 first-degree relative with CRC, onset aged 60 years or older</td><td colspan="2">Age 40 years
Any recommended test, same intervals as average risk</td><td>Age 40 years or 10 years before youngest diagnosis, if earlier
Colonoscopy every 5 years</td></tr>
<tr><td>First-degree relative(s) with advanced polyps[c]</td><td colspan="2">Age 40 years or 10 years before youngest diagnosis, if earlier
Colonoscopy every 5 years</td><td rowspan="2">Age 40 years or age of youngest diagnosis, if earlier
Colonoscopy every 5-10 years</td></tr>
<tr><td>Only 1 first-degree relative with advanced polyps, onset aged 60 years or older[c]</td><td colspan="2">Age 40 years
Any recommended test, same intervals as average risk</td></tr>
<tr><td>Second- or third-degree relative(s) with CRC</td><td rowspan="2">If only one second-degree relative with colorectal cancer or advanced polyps:
Age 45 years,
follow average-risk guidance</td><td rowspan="2">——</td><td>Age 45 years
Colonoscopy every 10 years</td></tr>
<tr><td>Second- or third-degree relative(s) with advanced polyps[c]</td><td>——</td></tr>
</table>

[a] Intervals only apply if the test result is normal; if colonoscopy is positive, follow up as needed and adapt schedule according to findings.

[b] Represents the American College of Gastroenterology, American Gastroenterological Association, and American Society for Gastrointestinal Endoscopy.

[c] For family history of polyps: American College of Gastroenterology specifies advanced polyp(s); US Multi-Society Task Force and National Comprehensive Cancer Network specify confirmed/documented advanced adenomas.

first cousin.[21,24] A family history of advanced adenomas is also associated with an increased risk of CRC.[25]

Health conditions associated with increased CRC risk

The following is general information on when to begin screening for people with these conditions, so that you can alert individuals who may not be keeping up with specialist care. However, the appropriate starting age and screening intervals can vary based on individual risk factors. Refer to gastroenterology for guidance on the best starting age, methods, and screening intervals. Screening should begin by age 45 years at the latest.

- **Genetic syndrome**, such as Lynch Syndrome or familial adenomatous polyposis: Screening schedule depends on the variant; in some cases, screening starts in childhood or young adulthood.[6,10]
- **Inflammatory bowel disease**, such as ulcerative colitis or Crohn's colitis: Begin screening 8 years after initial symptoms.[7,26,27] Begin immediately if there is primary sclerosing cholangitis.[26,27] Patients with only ulcerative proctitis or proctosigmoiditis (limited disease) may be able to follow average-risk screening recommendations, under guidance from their gastroenterologist.[7]
- **Cystic fibrosis**: Begin screening at age 40 years; if there is a history of solid organ transplant, begin at age 30 years or within 2 years from date of transplant if it occurs after that age.[7,28]
- **Cancer before age 40 years**: Recommendations will depend on what treatment was given and when; for example, someone who had abdominopelvic radiation may be advised to begin screening with colonoscopy at age 30 years or 5 years after treatment, whichever is later.[7,29]

COMPARISON OF SCREENING OPTIONS

People at average risk can choose the screening test that best matches their risk tolerance and comfort level (**Box 4**[15,16,30]). Trials directly comparing the long-term outcomes of CRC screening options are limited. However, a population-based study in Spain found that invitation to fecal immunochemical test (FIT) on a biennial schedule had outcomes similar to invitation to colonoscopy for both detecting CRC and reducing CRC mortality at 10 years.[31]

BOX 4. COMMON SCREENING OPTIONS: PATIENT EXPERIENCE[15,16,30]

Colonoscopy	Stool-based Tests

• Invasive
• Requires bowel preparation using a laxative to clean out the colon
• Generally involves sedation
• Requires a companion to accompany the person home after the test
• Polyps and small cancers can be removed at the time of screening
	• Noninvasive
	  ○ Requires colonoscopy if positive
	• Can be done at home (if the test kit is mailed, ensure the patient has a secure and convenient way to receive the package so it is not delayed or stolen)
	• No preparation needed in advance, except for HSgFOBT, which has some dietary and medication restrictions
	• Requires the person to collect their own stool sample
	  ○ HSgFOBT, FIT, and FIT-DNA require using a brush or spatula to take a sample from the surface of the stool
	  ○ HSgFOBT must be repeated with multiple bowel movements

FIT, fecal immunochemical test; FIT-DNA, multi-target stool DNA test; FIT-RNA, multi-target stool RNA test; HSgFOBT, high-sensitivity guaiac-based fecal occult blood test

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A secondary analysis found that people who received screening with either colonoscopy or FIT had a reduced risk of death from CRC, compared with people who did not participate in screening.[31] There was a nonsignificant trend toward greater reductions in both incidence and mortality with colonoscopy. A US-based study is currently in progress, with completion expected in 2028.[32]

Colonoscopy

Colonoscopy has long been considered the "gold standard" for CRC screening, and it is preferred for people at high risk. It allows for both CRC detection and CRC prevention through removal of precancerous polyps.[15,16] Colonoscopy involves direct visualization of the colon and rectum, using a tube inserted via the anus with a small video camera at one end. It requires bowel preparation using a laxative to clear stool from the colon, generally includes sedation, and involves inserting an instrument inside the body, but only needs to be repeated once every 10 years if normal in average-risk individuals.

Stool-based tests

Stool-based tests may be a preferred choice for people who want to avoid the inconvenience of a colonoscopy or want a test with no immediate risks (**Box 4**). Be sure to inform people who choose a stool-based test that if it is positive, they will need a colonoscopy.

Stool-based tests detect occult blood from CRC, and to a lesser degree, precancerous polyps; some add detection of either DNA or RNA signals suggestive of neoplasia. The addition of DNA or RNA testing increases sensitivity for both CRC and advanced adenomas, at the expense of reduced specificity (**Table 2**[15,33-36]). However, since these tests are typically recommended once every 3 years versus annually for options that

TABLE 2. NONINVASIVE TEST SENSITIVITY AND SPECIFICITY[15,33,34-38]

Test	Brand	Frequency	Sensitivity (%)		Specificity (%)	
			CRC	AA	CRC	AA
HSgFOBT	Various	Annual	50-75	6-17	96-98	96-99
FIT	Various[a]	Annual	74	23	94	96
FIT-DNA	Cologuard	1-3 years[b]	92	42	87[c]	
	Cologuard Plus	1-3 years[d]	94	43	91[c]	
FIT-RNA (original instructions)[f]	Colosense	3 years[e]	94	46	86[c]	
cfDNA blood test	Shield	3 years[e]	83	13	90[c]	

NOTE: These numbers come from different studies and are not directly comparable. They are offered to give a sense of how each type of test performs for CRC and AA detection.

AA, advanced adenoma; cfDNA, cell-free DNA; CRC, colorectal cancer; FIT, fecal immunochemical test; FIT-DNA, multi-target stool DNA test; FIT-RNA, multi-target stool RNA test; HSgFOBT, high-sensitivity guaiac-based fecal occult blood test

[a] Based on pooled studies for the OC-Sensor family of FITs

[b] Per United States Preventive Services Task Force (USPSTF); National Comprehensive Cancer Network and American Cancer Society (ACS) suggest 3-year interval

[c] Specificity for combined CRC and advanced precancerous lesions; precise definitions vary across studies

[d] Based on USPSTF guidance for Cologuard

[e] Per National Comprehensive Cancer Network screening guidelines; not yet reviewed for USPSTF guidelines, as of the time of this publication. Recommendations may evolve with additional studies and real-world experience with these new tests.

[f] Instructions have been simplified since the original study.

only detect occult blood, specificity over time may be comparable.[9]

Screening guidelines and expert recommendations generally include FIT and FIT-DNA as options.[7,15,16,37-39] At the time of this publication, FIT-RNA is too new to have been considered for some published guidelines; it does appear as an option in the 2026 guidance from the NCCN and from the ACS.[7,16] Some include the high-sensitivity guaiac-based test; however, this option requires taking samples from 3 successive bowel movements, while the others each require samples from only one bowel movement.[15,16,39,40]

If a stool-based test is negative, repeat the test on a regular schedule, such as every year for FIT or every 3 years for FIT-DNA or FIT-RNA.[16]

Other options

Many organizations' guidelines include computed tomography (CT) colonography and/or flexible sigmoidoscopy (with or without periodic FIT) as additional options.[7,15,16,38,40] Since these are not widely used in NYC, they are not discussed further here.

At the time of publication, the NCCN guidelines, ACS guidelines, and expert commentary from the American Gastroenterological Association (AGA) include one type of blood test as an option for CRC screening, but only for people who decline other forms of screening.[7,16,41] This test detects genomic changes and abnormal methylation status in cell-free DNA released into the bloodstream. It has a low sensitivity for precancerous polyps compared with FIT, FIT-DNA, and FIT-RNA, which is likely because precancerous polyps are not highly vascular and do not reliably release DNA into the bloodstream.[33,42]

The FDA approved the first blood test of this type for CRC screening in 2024, and another option may be available later in 2026.[42] Blood tests for cancer screening are an evolving technology; as new blood tests become available, be sure to review related research and check for updates to screening guidelines to understand their best use.

AFTER A POSITIVE NONINVASIVE TEST

If a noninvasive screening test is positive, screening is not complete until the individual has had a colonoscopy. There is no reason to repeat the noninvasive test. Refer to colonoscopy promptly.

Be sure to specify on the referral that this is a follow-up for a positive test; otherwise, the person may be placed on a waiting list with people who are due for a routine colonoscopy.

The follow-up colonoscopy should be completed as soon as possible. Encourage follow-up within 2 months to emphasize the importance and reduce delays during which a cancer could progress. While the evidence base for a definitive time frame is limited, waiting longer than 6 months should be avoided due to increasing risk for CRC with lengthy delays.[43-46] For example, one large, US-based study found a trend toward higher rates of both any CRC and advanced-stage CRC after 6 months, reaching statistical significance after 9 months.[44]

WORKFLOWS AND REMINDERS

Consider reviewing your electronic health record (EHR) system and office workflows to support on-time screening. For example,

- Work with your EHR provider to set up a flexible reminder system that allows for variations in starting age, screening tests, and intervals.
- Create and send reminders to patients, using a method with which your patient population is comfortable (eg, mail, text, phone call, patient portal).
- Designate a staff member to follow up on test results, including
  - Informing individuals of positive test results and helping them schedule colonoscopy or other follow-up if needed;
  - Making sure colonoscopy reports are received and entered into the EHR; and
  - Updating the reminder system to reflect screening status.
- Employ a patient navigator who can maintain a list of patients who are due for

screening, encourage them to be screened, assist with scheduling follow-ups, and track results.

See CRC Screening and Follow-up: A Practice Guide for additional information.

AFFORDABILITY AND ACCESS

Insurance coverage in New York State

Most insurance plans in New York State (NYS), including Medicare and NY Medicaid, cover CRC screening, often at no cost to the patient.[47] This includes the follow-up colonoscopy after a positive stool-based test. However, coverage can vary, so people who are not sure of their coverage should check with their insurance providers to determine which screening tests are covered.

People at increased risk who need early or more frequent screening or surveillance may still have co-pays and other costs.

In addition, until 2030, Medicare allows for co-insurance for a screening colonoscopy if a polyp is removed.[48] People with Medicare can find details about CRC screening coverage at www.medicare.gov; those who have a Medicare Advantage plan may have additional coverage.

Options for people without insurance

People without insurance may be able to access low-cost or no-cost screening through one of these programs:

RESOURCES FOR PROVIDERS

New York City (NYC) Health Department

- Colorectal Cancer (CRC) Screening and Follow-up: A Practice Guide: https://www.nyc.gov/assets/doh/downloads/pdf/cancer/colorectal-cancer-screening-and-follow-up-guide.pdf
- Risk Assessment and Screening Form: https://www.nyc.gov/assets/doh/downloads/pdf/cancer/colon-cancer-screening-form.pdf
- Talking about CRC Screening With Your Patients: A Plain Language Provider Communication Guide: https://www.nyc.gov/assets/doh/downloads/pdf/cancer/talking-about-colorectal-cancer-screening-with-patients.pdf
- Citywide CRC Control Coalition (C5): https://www.nyc.gov/site/doh/providers/resources/citywide-colon-cancer-control-coalition.page
  Opportunities for education, networking, and collaboration

Clinical Tools

- American Cancer Society (ACS), National CRC Roundtable (NCCRT). A Clinician's Guide to CRC Screening: Dos and Don'ts: https://nccrt.org/wp-content/uploads/2024/10/A-Clinicians-Guide-to-Colorectal-Cancer-Screening_FINAL.pdf
- ACS, NCCRT. Risk Assessment And Screening Toolkit To Detect Familial, Hereditary and Early Onset CRC: https://nccrt.org/resource/risk-assessment-and-screening-toolkit-to-detect-familial-hereditary-and-early-onset-colorectal-cancer
- ACS, NCCRT. Steps for Increasing CRC Screening Rates: A Manual for Primary Care Practices: https://nccrt.org/resource/steps-for-increasing-crc-screening-rates-2022
- ACS, NCCRT. 2023 Lead Time Messaging Guidebook: https://nccrt.org/resource/2023-lead-time-messaging-guidebook
- ACS, NCCRT. Clinician's Reference: Stool-Based Tests for CRC Screening: https://nccrt.org/resource/fobt-clinicians-reference-resource

Guidelines

- United States (US) Preventive Services Task Force. CRC: Screening: https://www.uspreventiveservicestaskforce.org/uspstf/recommendation/colorectal-cancer-screening
- ACS. CRC screening: An update to the ACS guideline, 2026: https://acsjournals.onlinelibrary.wiley.com/doi/full/10.3322/caac.21457
- American College of Gastroenterology (ACG). ACG Clinical Guidelines: CRC Screening 2021: https://journals.lww.com/ajg/Fulltext/2021/03000/ACG_Clinical_Guidelines__Colorectal_Cancer.14.aspx
- US Multi-Society Task Force on CRC. Updates on Age to Start and Stop CRC Screening: https://www.gastrojournal.org/article/S0016-5085(21)03626-X/fulltext
- US Multi-Society Task Force on CRC. CRC Screening: Recommendations for Physicians and Patients: https://www.gastrojournal.org/article/S0016-5085(17)35599-3/fulltext
- National Comprehensive Cancer Network: CRC Screening: https://www.nccn.org/guidelines/guidelines-detail?category=2&id=1429
- American College of Physicians. Screening for CRC in asymptomatic average-risk adults: https://www.acpjournals.org/doi/10.7326/M23-0779

Clinical Practice Updates

- AGA. Risk stratification for CRC screening and post-polypectomy surveillance: https://gastro.org/clinical-guidance/risk-stratification-for-colorectal-cancer-screening-and-surveillance
- AGA. Blood tests for CRC screening: https://gastro.org/clinical-guidance/blood-tests-for-colorectal-cancer-crc-screening

- The New York State Cancer Services Program (866-442-2262) provides no-cost colorectal, breast, and cervical cancer screening and diagnostic follow-up tests for NYS residents without insurance. Uninsured New Yorkers may also be eligible for cancer treatment coverage through the Medicaid Cancer Treatment Program.
- NYC Health + Hospitals (844-NYC-4NYC) offers assistance including NYC Care, a health care access program that provides services on an income-based sliding scale.

The NYC Health Department offers assistance with signing up for an insurance plan. Call 311 or visit the Health Insurance webpage.

SUMMARY

Support for on-time screening and prompt follow-up for any positive findings can help drive down both CRC incidence and mortality, and has the potential to reduce the impact of rising rates of CRC in adults aged less than 50 years. Take a careful personal and family health history, starting with young adults in their 20s, and update it regularly; make a strong recommendation for screening when appropriate and help patients understand their options; make use of reminder systems and workflows to help patients stay on track; and provide uninsured or underinsured patients with information on affordable screening options. With your help, NYC can continue to see improvements in the burden of CRC.

RESOURCES FOR PATIENTS

New York City (NYC) Health Department

- Colon Cancer Screening Action Kit: https://www.nyc.gov/site/doh/providers/resources/public-health-action-kits-colon-cancer.page
  - Why You Should Get Screened for Colon Cancer (Brochure): https://www.nyc.gov/assets/doh/downloads/pdf/cancer/why-you-should-get-screened-for-colon-cancer.pdf
  - When to Get Screened for Colon Cancer (Palm Card): https://www.nyc.gov/assets/doh/downloads/pdf/cancer/when-to-get-screened-for-colon-cancer.pdf
  - Which Colon Cancer Screening is Right For Me? (Fact Sheet): https://www.nyc.gov/assets/doh/downloads/pdf/cancer/which-colon-cancer-screening-is-right.pdf
  - Talking About Colon Cancer Can Save Your Life: A Conversation Guide (Booklet): https://www.nyc.gov/assets/doh/downloads/pdf/cancer/colon-cancer-conversation-guide.pdf
  - How to Get Free or Low-Cost Colon Cancer Screening (Palm Card): https://www.nyc.gov/assets/doh/downloads/pdf/cancer/how-to-get-free-or-low-cost-colon-cancer-screening.pdf
  - Ten Ways to Lower Your Cancer Risk (Fact Sheet): https://www.nyc.gov/assets/doh/downloads/pdf/cancer/lower-your-cancer-risk.pdf

  Available in multiple languages; visit nyc.gov/health and search for "colon cancer"
- Graphic novellas about screening
  - Preparing for a Colonoscopy: Sandra's Story: https://www.nyc.gov/assets/doh/downloads/pdf/cancer/colonoscopy-novella.pdf
  - Choosing a Colon Cancer Screening Test: Mark's Decision: https://www.nyc.gov/assets/doh/downloads/pdf/cancer/colon-cancer-screening-test-novella.pdf
  - How to Do an At-Home Colon Cancer Test: https://www.nyc.gov/assets/doh/downloads/pdf/cancer/at-home-colon-cancer-test-novella.pdf

  Available in multiple languages; visit nyc.gov/health and search for "colon cancer"
- Colonoscopy Prep: What to Expect (video): https://www.youtube.com/watch?v=np7g1Xn4lPg

Educational Materials

- American Cancer Society (ACS). About Colorectal Cancer: https://www.cancer.org/cancer/types/colon-rectal-cancer/about.html
- ACS. Cancer Screening and Early Detection brochures: https://education.cancer.org/collections/cancer-screening-and-early-detection
- ACS. Education Materials for Your Patients: https://www.cancer.org/health-care-professionals/patient-education-materials-for-professionals.html

Mental Health

- 988 Suicide and Crisis Lifeline (24/7):
  - Call 988
  - Visit https://nyc988.cityofnewyork.us/en

  A 24/7 call, text, and chat line for people seeking crisis counseling. Services include suicide prevention; substance use services; peer support; short-term counseling; assistance scheduling appointments or accessing other mental health services; and follow-ups to ensure connection to care. Interpreters available in more than 200 languages.

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