

Cancer Burden and Inequities in New York City

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Background

Cancer is the leading cause of premature mortality in New York City (NYC). An estimated 40 out of 100 men and 39 out of 100 women¹ in the United States (U.S.) will be diagnosed with cancer at some point in their lives. Over 42,000² New Yorkers are diagnosed with cancer each year, and there are over 10,000³ cancer-related deaths annually. The cancer types addressed in this report are colorectal, lung, breast, cervical, and prostate cancer, sometimes referred to as the “screenable” cancers because they have population-level screening recommendations. The [HealthyNYC](#) initiative has set the target of reducing screenable cancer mortality by 20% by 2030.

This cancer burden is not evenly distributed among white, Black, Latino, and Asian/Pacific Islander (API) New Yorkers, highlighting the underlying issues of social justice, health inequity, and the impacts of racism.⁴ While patterns for individual cancer types vary, Black New Yorkers experience the highest cancer mortality rate among these groups in NYC, as well as nationwide.

Screening and prompt follow-up can help reduce cancer deaths and their inequities. This report will focus on the cancers with recommendations from the U. S. Preventive Services Task Force regarding routine, evidence-based screening tests. People at increased risk from certain other cancer types may also benefit from screening, on an individualized basis, due to risk factors associated with those cancer types.

Key Points:

- Despite progress in lowering cancer incidence and mortality in NYC in recent years, the burden remains high.
- Premature loss of life persists even among the cancers with readily available screening options.
- Using incidence, mortality, and screening data (when available) this report lays out the current cancer landscape and trends within the city and investigates how the burden of cancer differs among racial and ethnic groups and among those living in neighborhoods of differing poverty levels in NYC.
- Black New Yorkers have consistently high cancer mortality rates in both overall and premature mortality. Having the highest incidence does not always correlate with having the highest mortality rate.
- Incidence rate alone cannot tell the whole story; differences in the stage at which people are diagnosed can dramatically change the outlook on their health.

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¹ American Cancer Society. Cancer Facts and Figures 2025. Atlanta: American Cancer Society, 2025.

<https://www.cancer.org/content/dam/cancer-org/research/cancer-facts-and-statistics/annual-cancer-facts-and-figures/2025/2025-cancer-facts-and-figures-acf.pdf>. Accessed December 9, 2025.

² Cancer Incidence - Public Use Data from 1995 to 2022 by Race/Ethnicity (White, Black, Other/Non-Hispanics, Hispanics), New York State Cancer Registry, New York State Department of Health, data as of November 2025.

³ 2022: Li W, Castro A, Gurung S, Maduro G, Sun Y, Seil K, and Van Wye G. Summary of Vital Statistics, 2022. New York, NY: Bureau of Vital Statistics, New York City Department of Health and Mental Hygiene.

⁴ Race and ethnicity are socially constructed systems that categorize humans based on observable physical features such as skin color or ancestry or characteristics such as a shared sense of group membership, values, or language. In this report, we present data by race and ethnicity based on how data were collected or cited in the study referenced. However, this comes with a recognition that there is no biological basis for the health inequities observed between these socially constructed racial categories.

However, screening alone does not eliminate inequities. Other social, economic, and environmental factors, as well as access to preventive services and high-quality medical care, influence who develops cancer and who has the best chance to survive it. Looking at rates of cancer screening, incidence, and mortality together can help identify where more work is needed to ensure that all New Yorkers have the same chance for cancer prevention, early diagnosis, and high-quality treatment.

Breast, prostate, lung, and colorectal cancer are the most diagnosed cancers in NYC.⁵ Lung, colorectal, pancreatic, breast, liver, and prostate cancer are the top causes of cancer-related death in NYC.^{6,7} Screening for colorectal, breast, and cervical cancer, as well as for lung cancer in people with a history of extensive tobacco smoking, are strongly recommended for those who meet the screening criteria. People who have a prostate gland, generally people assigned male at birth, should have the opportunity to discuss screening with a provider and decide if they want to be screened.

About cancer screening

Cancer is a disease in which some cells in a person's body start to grow uncontrollably. If not caught in time, these cells can damage or destroy the part of the body where they started. They can also spread and damage or destroy other parts of the body.

The goal of cancer screening is to help find cancer before it causes any serious damage and before the cells start to spread. Treatment is usually easier at this early stage, and there is a better chance that the cancer can be cured.

About the data

This report includes information not only about the number of cancer cases and deaths, but about the number of people diagnosed with cancer at a distant stage, meaning after the cancer has already spread. Data for this report comes from three sources, except where otherwise noted: Mortality data from NYC Vital Statistics from 2000 to 2022, incidence and stage of diagnosis data from the New York State Cancer Registry from 2000 to

Definitions:

Screenable cancers: Cancers that have a widely accepted screening test which can help detect cancer or, for some cancers, precancerous cells prior to the occurrence of symptoms.

Local stage: Cancer which has not yet moved into surrounding tissue, the lymph nodes, or any locations away from the initial tumor.

Regional stage: Tumor cells have spread into neighboring tissues or nearby lymph nodes but not distant tissue or organs.

Distant stage: Cancer that has spread further from the initial site, including into lymph nodes and organs far from the site of origin.

Neighborhood poverty: Neighborhood poverty is defined as the percentage of the population living below the Federal Poverty Line (FPL) based on the American Community Survey. Neighborhoods are categorized into four groups as follows: "Low poverty" neighborhoods are those with <10% of the population living below the FPL; "Medium poverty" neighborhoods have 10-<20% of the population below FPL; "High Poverty" neighborhoods have 20-<30% of the population living below the FPL; "Very high poverty" neighborhoods have ≥30% of the population living below the FPL.

Racial and ethnic groups: For the purpose of this publication, Vital Statistics data for Latino people include people of Hispanic origin based on ancestry reported on the death certificate, regardless of reported race; Latino excludes reported ancestry from non-Spanish speaking Central/South American countries, and non-Spanish speaking Caribbean islands. Community Health Survey data for Latino include people of Hispanic or Latino origin, as identified by the survey question "Are you Hispanic or Latino?" regardless of specified race. Black, white, Asian, and Other race categories do not include people of Latino origin. For New York State Cancer Registry data, race and ethnicity are included with reported medical information; information may be self-reported or reported by another, depending on the data collection practices at the clinical site.

Sex and Gender: For this publication sex is defined by that which is reported on the health records, death certificates, or survey responses used in the data collection process which may not always match the gender of the individual.

Neighborhoods: Public Use Microdata Areas (PUMA) are 55 geographic areas in NYC with a minimum population of 100,000 people, defined by the Census Bureau. Because of the population minimums, multiple neighborhoods may be combined to define one PUMA.

⁵ Cancer Incidence - Public Use Data from 1995 to 2022 by Race/Ethnicity (White, Black, Other/Non-Hispanics, Hispanics), New York State Cancer Registry, New York State Department of Health, data as of November 2025.

⁶ 2022: Li W, Castro A, Gurung S, Maduro G, Sun Y, Seil K, and Van Wye G. Summary of Vital Statistics, 2022. New York, NY: Bureau of Vital Statistics, New York City Department of Health and Mental Hygiene.

⁷ Screening for pancreatic cancer or liver cancer is used only in certain high-risk cases, and therefore, is beyond the scope of this report.

2022, and screening prevalence data from the NYC Community Health Survey (CHS) from 2023 and 2024 (except where Behavioral Risk Factor Surveillance System is noted as the source). There is a lag time between when a year concludes and when the data becomes available, which varies among these data sets. Multiple years have been combined to allow more reliable subgroup analysis (for example by race and ethnicity or by borough). Trends using single years of data are also presented to understand changes and fluctuations over time. Prevalence estimates and incidence and mortality rates have been age-adjusted to the U.S. 2000 standard population to allow comparison across different groups.

During 2020, the COVID-19 pandemic disrupted access to screening and medical care, and COVID-19 was one of the leading causes of both overall mortality and premature mortality. Cancer data from 2020 should be interpreted with caution. Apparent declines in incidence or

mortality may not represent actual improvements in cancer prevention or care.

Data Analysis: Screening estimates by race and ethnicity and by borough of residence were analyzed using SUDAAN pairwise testing; estimates with a p-value of less than 0.05 compared with the reference value are considered statistically different. Incidence and mortality rates were calculated using NYC Health Department population estimates, 2000 to 2021, updated September 2022. Incidence and mortality rates among different population groups (race and ethnicity groups, neighborhood poverty levels, borough of residence, and neighborhood of residence as defined by PUMA geography) were compared using 95% confidence intervals. A confidence interval is a range of values in which we are 95% sure the true value lies. If the confidence intervals of two measures did not overlap, a significant difference was inferred. This is a conservative measure of statistical difference. Proportion of cases diagnosed

were analyzed using analysis of variance (ANOVA) tests to check whether statistically significant differences exist between race and ethnicity groups, and Tukey post-hoc test was used to make pairwise comparisons. Trends in cancer incidence and mortality between 2000 and 2022 were analyzed using JoinPoint (National Cancer Institute). This technique compares the average annual percent change of cancer incidence or mortality in a specified group (for example, each racial or ethnic group) to determine if there were statistically significant changes during the period. The JoinPoint software can identify “segments” or specific periods of decrease or increase during the whole period 2000 to 2022. The trend sees a consistent dip in the 2020 incidence rate due to the COVID-19 pandemic resulting in many people not having their regular screenings and avoiding hospitals for more minor symptoms. Incidence rates returned to their pre-pandemic trend in the subsequent years.

Lung Cancer

About lung cancer screening:

Lung cancer screening is recommended for people ages 50 to 80 with a history of at least 20 pack-years of smoking.^{8,9} “Pack-years” is the number of packs per day multiplied by the number of years of smoking. Experts differ on how long to continue screening after a

person stops smoking, but the U.S. Preventive Services Task Force recommends continuing for at least 15 years. People with other types of lung cancer risk, such as exposure to chemicals in the workplace, should talk with their doctors about what is best for them.

The test used for lung cancer screening is a low dose CT scan. It is a brief scan that is done once a year. If the scan finds something that could be cancer, the person may need additional tests.

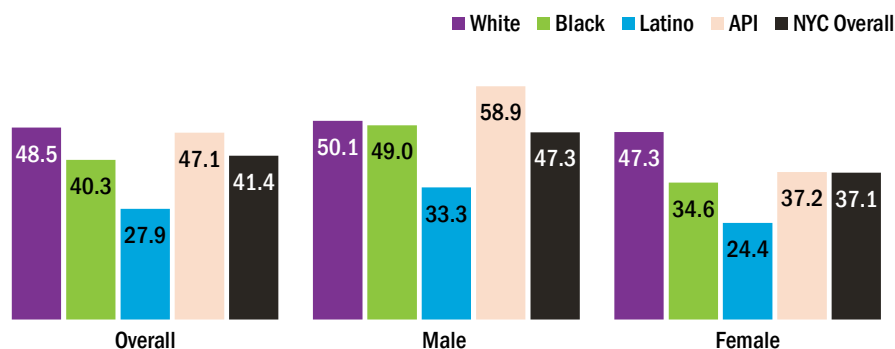
- In New York State in 2024, about 28% of people eligible for lung cancer screening had been screened in the past year, according to the national Behavioral Risk Factor Surveillance System (BRFSS).¹⁰

- In 2018-2022, in NYC, white and API New Yorkers had the highest incidence of lung cancer (48.5 and 47.1 cases per 100,000, respectively), compared with Black and Latino New Yorkers. Incidence in Black New Yorkers (40.3 cases per 100,000) was higher than that among Latino New Yorkers (27.9 cases per 100,000).

- Among male New Yorkers, in 2018-2024 the incidence of lung cancer was highest among API males (58.9 cases per 100,000), compared with white, Black, and Latino males. Rates among white and Black males (50.1 and 49.0 cases per 100,000, respectively) were higher than the rate among Latino males (33.3 cases per 100,000).

- Among female New Yorkers, in 2018-2022 the incidence of lung cancer was highest among white females (47.3 cases per 100,000), followed by API and Black females (37.2 and 34.6 cases per 100,000, respectively) and then Latina females (24.4 cases per 100,000).

Lung cancer incidence rates by race and ethnicity, and sex, New York City, 2018–2022
Age-adjusted rates per 100,000 people



Rates restricted to NYC residents. White, Black, Asian and Pacific Islander (API) race categories exclude Latino ethnicity. Latino includes Hispanic or Latino of any race.

Source: New York State Cancer Registry, NYS Department of Health, 2018-2022 public use data as of November 2024

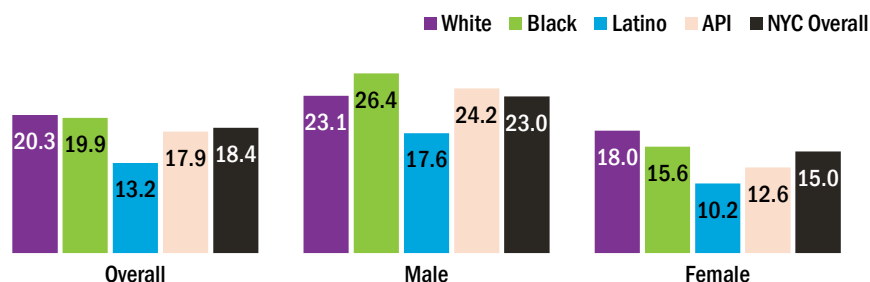
⁸ Wolf AMD, Oeffinger KC, Shih TY, et al. Screening for lung cancer: 2023 guideline update from the American Cancer Society. *CA Cancer J Clin.* 2024 Jan-Feb;74(1):50-81.

⁹ U.S. Preventive Services Task Force. Final recommendation statement. Lung cancer: screening. March 9, 2021. Accessed February 18, 2026 at <https://www.uspreventiveservicestaskforce.org/uspstf/recommendation/lung-cancer-screening>

¹⁰ Topic: Had CAT/CT Chest Scan, New York, 2024. In: Centers for Disease Control and Prevention, BRFSS Prevalence & Trends Data [database online]. <https://www.cdc.gov/brfss/brfssprevalence>. Accessed October 23, 2025.

- In 2018-2022, in NYC, lung cancer mortality was highest among white and Black New Yorkers (20.3 and 19.9 deaths per 100,000, respectively), followed by API (17.9 deaths per 100,000) and then Latino (13.2 deaths per 100,000) New Yorkers.
- Among male New Yorkers, in 2018-2022 the lung cancer mortality rates were higher among Black, API, and white males (26.4, 24.2 and 23.1 deaths per 100,000, respectively) than the rate among Latino males (17.6 deaths per 100,000).
- Among female New Yorkers, in 2018-2022 the lung cancer mortality rate was highest among white females (18.0 deaths per 100,000), followed by Black (15.6 deaths per 100,000), API (12.6 deaths per 100,000), and then Latina (10.2 deaths per 100,000) females.
- In 2018-2022, a higher proportion of lung cancer cases were diagnosed at the distant stage among Black and Latino New Yorkers (49% and 48%, respectively) compared with white and API New Yorkers (39% and 44%, respectively).
- A higher proportion of lung cancer cases were diagnosed at the distant stage among males (47%) than among females (40%) in NYC.

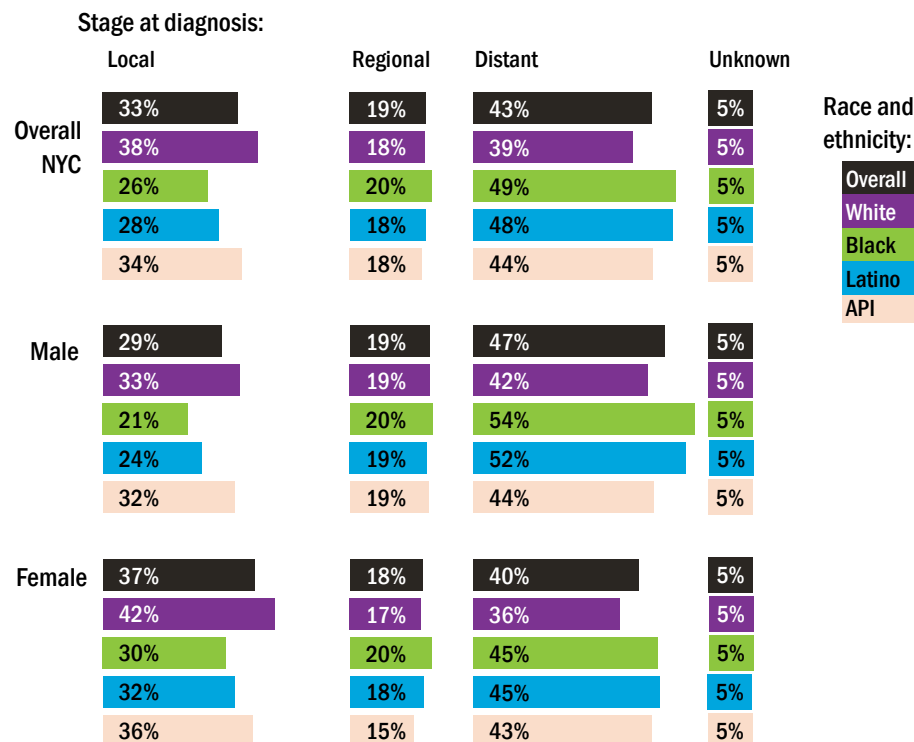
Lung cancer mortality rates by race and ethnicity, and sex, New York City, 2018-2022
Age-adjusted rates per 100,000 people



Rates restricted to NYC residents. White, Black, Asian and Pacific Islander (API) race categories exclude Latino ethnicity. Latino includes Hispanic or Latino of any race.

Source: NYC Department of Health and Mental Hygiene Bureau of Vital Statistics, 2018-2022

Percentage of lung cancer diagnoses at each stage, among New York City cases overall and among males and females, by race and ethnicity, 2018-2022



Rows may not sum to 100% due to rounding. Cases restricted to NYC residents. White, Black, Asian and Pacific Islander (API) race categories exclude Latino ethnicity. Latino includes Hispanic or Latino of any race.

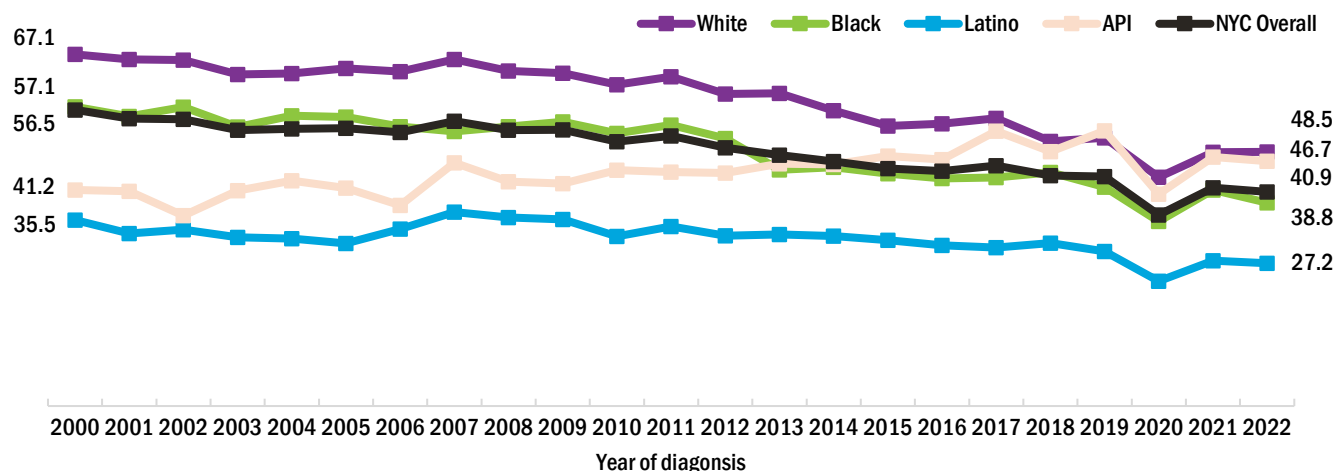
Source: New York State Cancer Registry, NYS Department of Health, 2018-2022 public use data as of November 2024

- A higher proportion of lung cancer cases were diagnosed at the local stage among white and API New Yorkers (38% and 34%, respectively) compared with Black and Latino New Yorkers (26% and 28%, respectively).

- Lung cancer incidence declined from 2000 to 2022 overall and among Black, white, and Latino New Yorkers but increased among API New Yorkers. In detail, incidence fluctuated among Latino New Yorkers, declining from 2009 to 2022 after being stable from 2000 to 2009; among white New Yorkers, incidence rates were stable from 2000 to 2010 and then declined from 2010 to 2022.
- Lung cancer mortality rates declined among NYC residents overall and among Black and white New Yorkers from 2000 to 2022. In that same period, Latino New Yorkers had a stable mortality rate from 2000 to 2009 and a decreasing mortality rate from 2009 to 2022. Mortality rates among API New Yorkers were stable from 2000 to 2013 and then decreased from 2013 to 2022.

Lung cancer incidence rates by race and ethnicity, New York City, 2000 to 2022

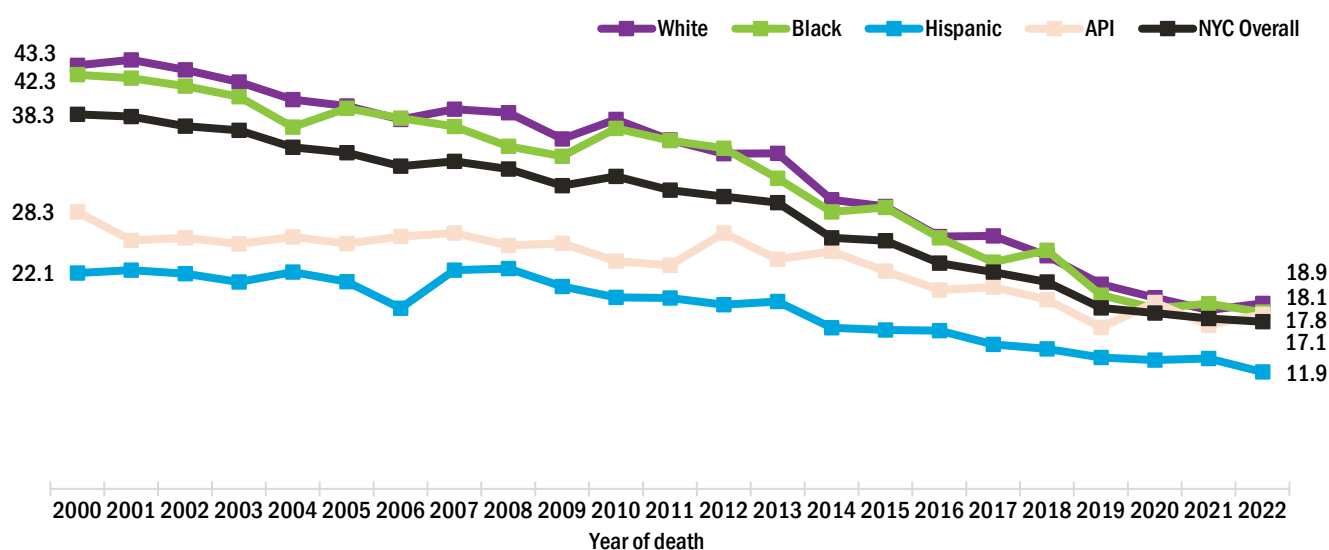
Age-adjusted rates per 100,000 people



Rates restricted to NYC residents. White, Black, Asian and Pacific Islander (API) race categories exclude Latino ethnicity. Latino includes Hispanic or Latino of any race. Source: New York State Cancer Registry, New York State Department of Health, 2000-2022 data as of November 2023. Rates in 2020 and 2021 were affected by COVID-19-related disruptions to care.

Lung cancer mortality rates by race and ethnicity, New York City, 2000 to 2022

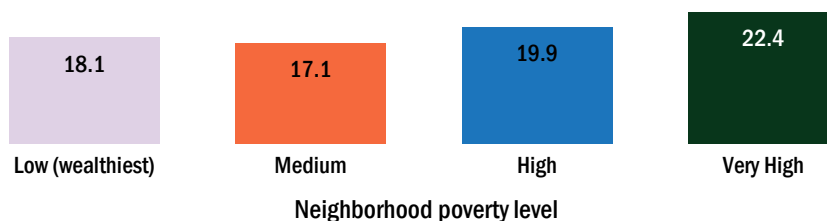
Age-adjusted rates per 100,000 people



Rates restricted to NYC residents. White, Black, Asian and Pacific Islander (API) race categories exclude Latino ethnicity. Latino includes Hispanic or Latino of any race. Source: NYC Department of Health and Mental Hygiene Bureau of Vital Statistics, 2000-2022. Rates in 2020 and 2021 were affected by COVID-19-related disruptions to care.

- In NYC overall in 2018–2022, residents in neighborhoods with very high and high poverty had the highest lung cancer mortality rates (22.4 and 19.9 deaths per 100,000 respectively), followed by residents in neighborhoods with low and medium poverty rates (18.1 and 17.1 deaths per 100,000 respectively).
- Residents of Staten Island had the highest rates of lung cancer incidence (60.5 cases per 100,000) compared with residents of other boroughs.
- Lung cancer incidence rates were similar among residents of the Bronx, Manhattan, Brooklyn, and Queens (41.3, 40.6, 39.8 and 39.2 cases per 100,000, respectively).
- Lung cancer mortality rates were highest among residents of Staten Island (29.5 deaths per 100,000) followed by the Bronx (21.0 deaths per 100,000) then Brooklyn (18.5 per 100,000), Manhattan (17.1 deaths per 100,000), and Queens (15.5 deaths per 100,000).

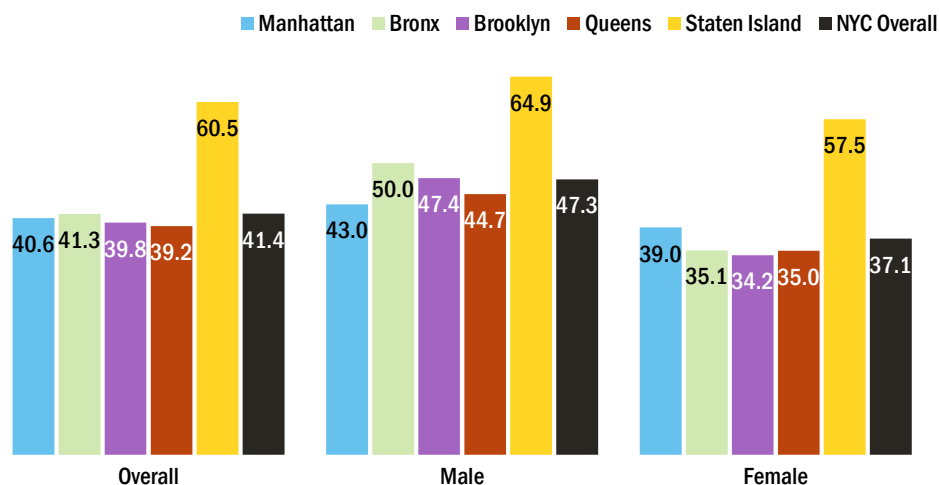
Lung cancer mortality rate by neighborhood poverty, New York City, 2018–2022
Age-adjusted rates per 100,000 people



Rates restricted to NYC residents. Neighborhood poverty (based on ZIP code) is defined as the percentage of the population living below the Federal Poverty Line (FPL) based on the American Community Survey 2018–2022, categorized in four groups: “Low poverty,” <10% below FPL; “Medium poverty,” 10–<20% below FPL; “High Poverty,” 20–<30% below the FPL; “Very high poverty,” ≥30% below FPL.

Source: NYC Department of Health and Mental Hygiene Bureau of Vital Statistics, 2018–2022

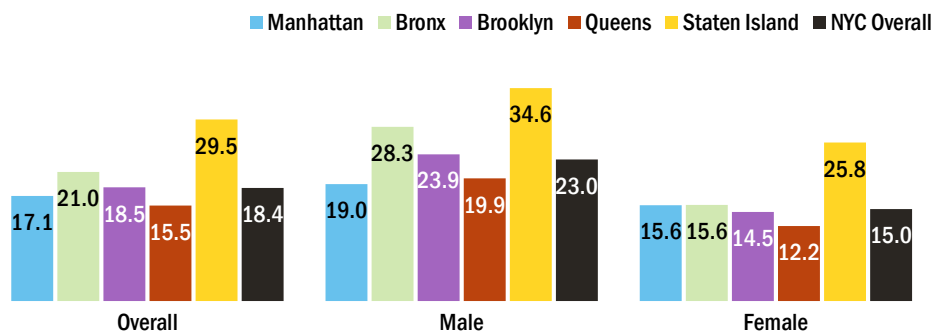
Lung cancer incidence rates by borough of residence and sex, New York City, 2018–2022
Age-adjusted rates per 100,000 people



Rates restricted to NYC residents.

Source: New York State Cancer Registry, New York State Department of Health, 2018–2022 data as of November 2024

Lung cancer mortality rates by borough of residence and sex, New York City, 2018–2022
Age-adjusted rates per 100,000 people



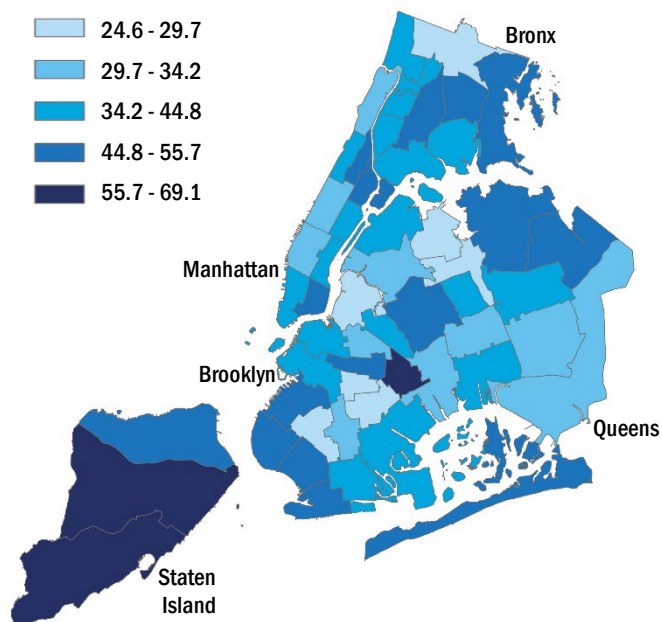
Rates restricted to NYC residents.

Source: NYC Department of Health and Mental Hygiene Bureau of Vital Statistics, 2018–2022

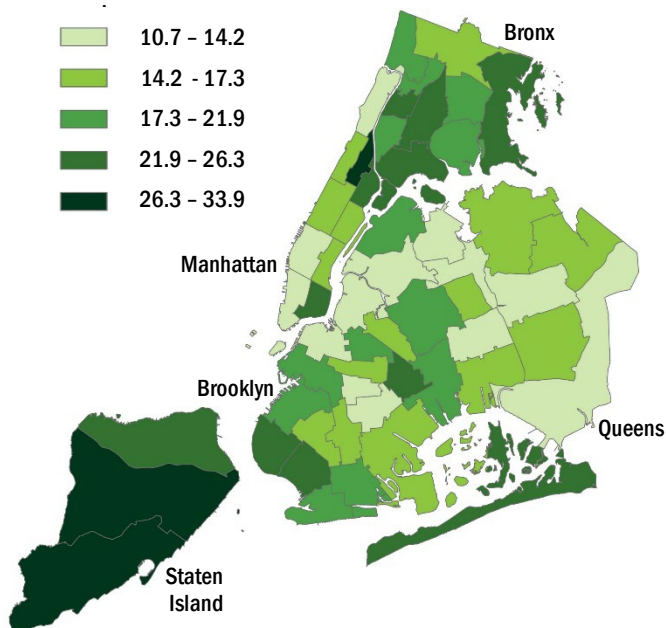
- At the neighborhood level,
 - In 2018-2022, lung cancer incidence rates by neighborhood ranged from 24.6 to 69.1 per 100,000 residents.
 - In 2018-2022, lung cancer mortality rates by neighborhood ranged from 10.7 to 33.9 per 100,000 residents.

Lung cancer incidence and mortality rates, New York City neighborhoods, 2018-2022

Age-adjusted lung cancer incidence rate per 100,000 people



Age-adjusted lung cancer mortality rate per 100,000



Rates restricted to NYC residents.

Neighborhoods: Public Use Microdata Areas (PUMA) are 55 geographic areas in NYC with a minimum population of 100,000 people, defined by the Census Bureau. Because of the population minimums, multiple neighborhoods may be combined to define one PUMA.

Sources: Incidence: New York State Cancer Registry, New York State Department of Health, 2018-2022 data as of November 2024

Mortality: NYC Department of Health and Mental Hygiene Bureau of Vital Statistics, 2018-2022

Colorectal Cancer

About colorectal cancer

screening: All adults should talk with their health care providers about their colorectal cancer risk to find out how early they should begin screening. People with no specific risk factors should start screening at age 45 and continue at least through age 75. People at higher risk may need to begin screening at a younger age or have more frequent screening.

The most recommended screening tests are:

Colonoscopy: A flexible tube with a camera is inserted into the rectum and moved through the colon to look for cancer or pre-cancerous polyps.

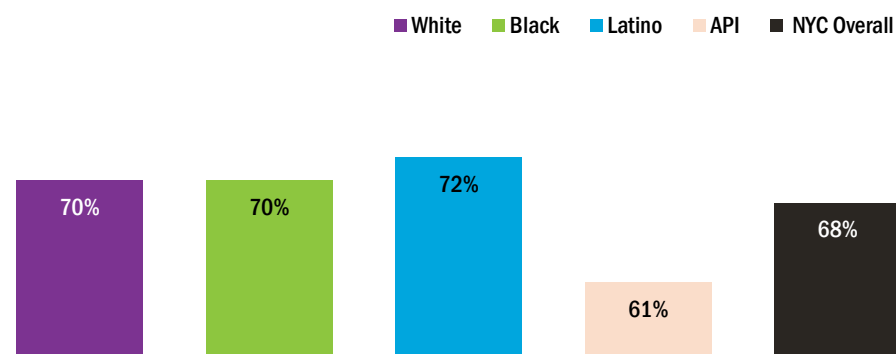
Removing pre-cancerous polyps can help prevent colorectal cancer. Colonoscopy is widely considered the gold-standard for colorectal cancer screening.

Stool-Based Testing: A stool sample is tested for potential signs of colorectal cancer. Stool-based tests can sometimes help find pre-cancerous polyps. Any positive stool-based test must be followed up with a colonoscopy.

Other, less common screening options include CT colonography (a type of CT scan) and flexible sigmoidoscopy (similar to colonoscopy but can only look at part of the colon). There is also a new blood test available.

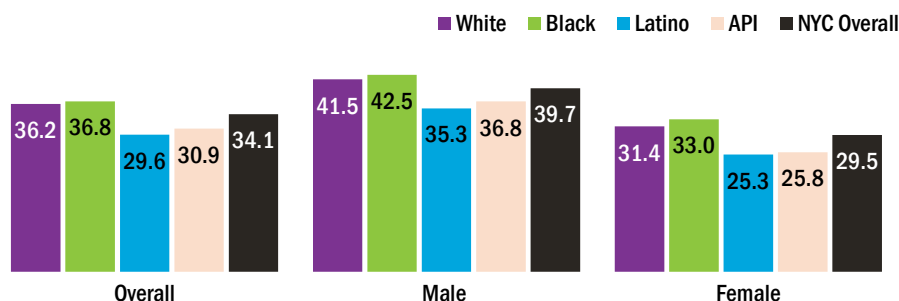
- Colorectal cancer screening prevalence was determined by self-report of either a colonoscopy in the past 10 years or a stool-based test in the past year. This does not represent every screening option but provides an approximation of those who are up to date with screening. Using this definition, in 2023, 68% of New Yorkers ages 45 to 75 were up to date with colorectal cancer screening. Latino (72%), Black (70%), and white New Yorkers (70%) had a similar prevalence to each other, however API New Yorkers (61%) were less likely than white adults to be up to date on colorectal cancer screening.
- In 2018-2022, Black and white New Yorkers had the highest incidence rate of colorectal cancer (36.8 and 36.2 cases per 100,000, respectively), followed by API (30.9 cases per 100,000) and then Latino (29.6 cases per 100,000) New Yorkers.

Colorectal cancer screening prevalence by race and ethnicity, New York City, 2023
Percentage of adults ages 45 to 75 years



Colorectal cancer screening is colonoscopy in the past 10 years or stool-based test in the past year. White, Black, Asian and Pacific Islander (API) race categories exclude Latino ethnicity. Latino includes Hispanic or Latino of any race.
Source: New York City Community Health Survey, 2023.

Colorectal cancer incidence rates by race and ethnicity, and sex, New York City, 2018-2022
Age-adjusted rates per 100,000 people

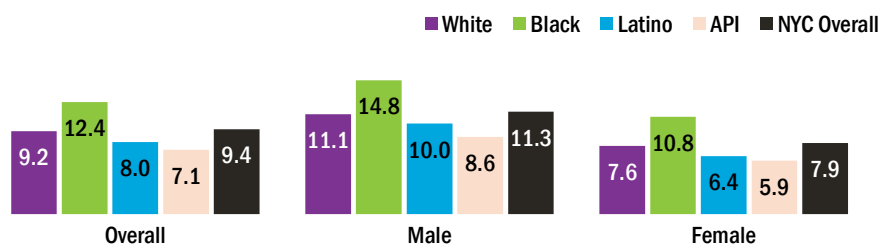


Rates restricted to NYC residents. White, Black, Asian and Pacific Islander (API) race categories exclude Latino ethnicity. Latino includes Hispanic or Latino of any race.

Source: New York State Cancer Registry, NYS Department of Health, 2018-2022 data as of November 2024

- In 2018-2022, the colorectal cancer mortality rate among Black New Yorkers was 35% higher than the rate among white New Yorkers (12.4 and 9.2 deaths per 100,000, respectively).
- Among male New Yorkers, in 2018-2022 Black males had the highest colorectal cancer mortality rate (14.8 deaths per 100,000) compared with white, Latino, and API males (11.1, 10.0, and 8.6 deaths per 100,000, respectively).
- Among female New Yorkers, in 2018-2022 Black females had the highest colorectal cancer mortality rate (10.8 deaths per 100,000) followed by white, Latino, and API females (7.6, 6.4, and 5.9 deaths per 100,000, respectively).
- In 2018-2022, Black New Yorkers had the highest proportion of cases of colorectal cancer diagnosed at the distant stage (29%).
- The proportion of colorectal cancer cases diagnosed at the local stage was similar among white (34%), Black (30%), Latino (32%), and API (33%) New Yorkers.

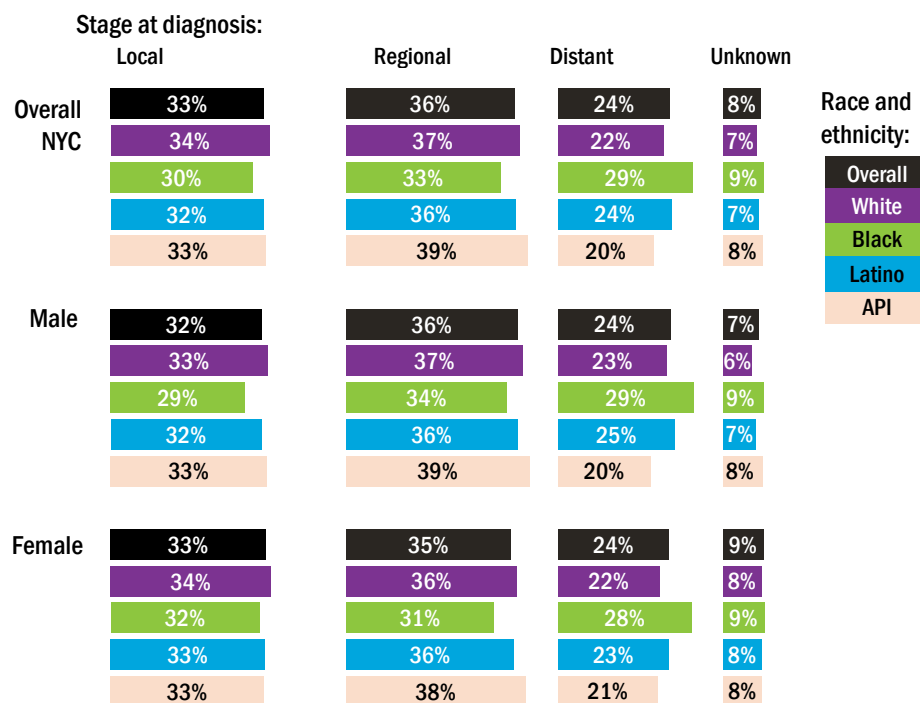
Colorectal cancer mortality rate by race and ethnicity and sex, New York City, 2018–2022
Age-adjusted rates per 100,000 people



Rates restricted to NYC residents.

Source: NYC Department of Health and Mental Hygiene Bureau of Vital Statistics, 2018-2022

Percentage of colorectal cancer diagnoses at each stage, among New York City cases overall and among males and females, by race and ethnicity, 2018-2022



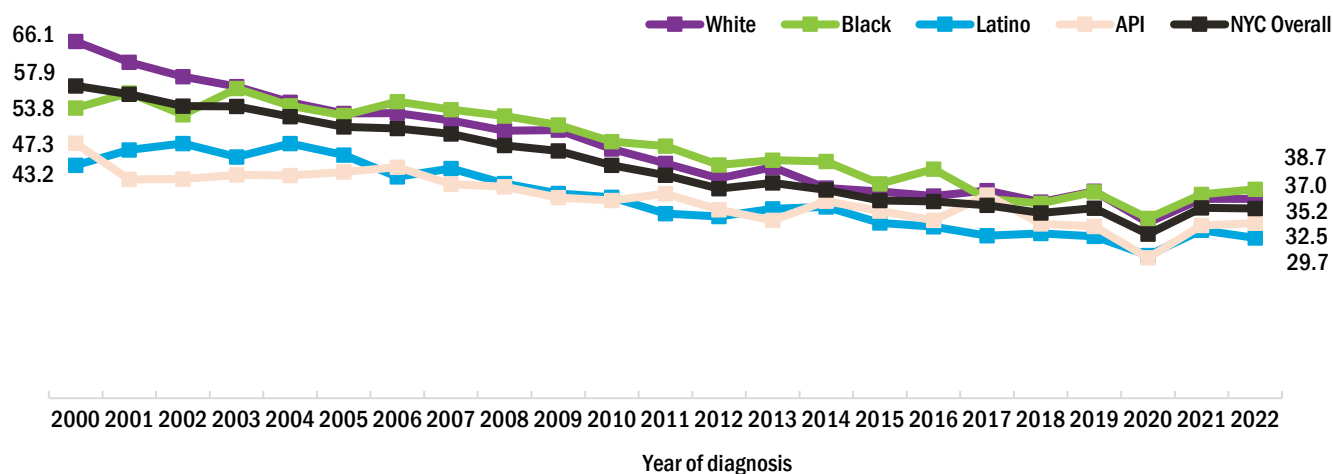
Rows may not sum to 100% due to rounding. Cases restricted to NYC residents. White, Black, Asian and Pacific Islander (API) race categories exclude Latino ethnicity. Latino includes Hispanic or Latino of any race.

Source: New York State Cancer Registry, New York S Department of Health, 2018-2022 data as of November 2024

- Colorectal cancer incidence declined from 2000 to 2022 among NYC residents overall and among white, Black, Latino, and API New Yorkers. The colorectal cancer incidence rate among Black New Yorkers was stable from 2000 to 2007, decreased from 2007 to 2020, and was stable from 2020 to 2022. Among white New Yorkers, the incidence rate decreased from 2000 to 2015 and was stable from 2015 to 2022.
- Colorectal cancer mortality rates declined among NYC residents overall and among API, Black, Latino, and white New Yorkers from 2000 to 2022. However, the rate among Black New Yorkers did not decline enough to eliminate the inequity in colorectal cancer mortality between Black New Yorkers and white, API, and Latino New Yorkers.

Colorectal cancer incidence rates by race and ethnicity, New York City, 2000 to 2022

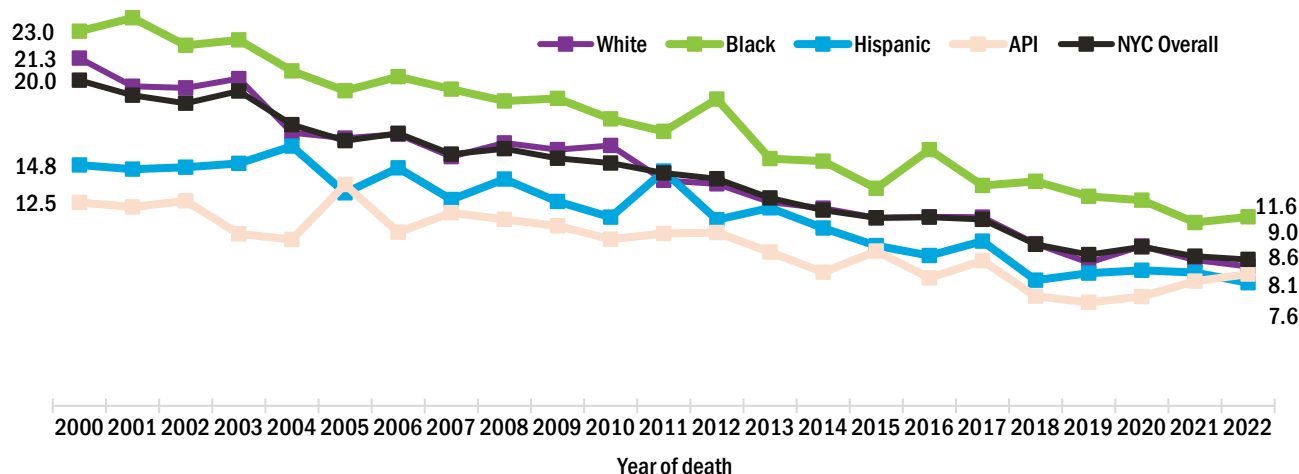
Age-adjusted rates per 100,000 people



Rates restricted to NYC residents. White, Black, Asian and Pacific Islander (API) race categories exclude Latino ethnicity. Latino includes Hispanic or Latino of any race. Source: New York State Cancer Registry, New York State Department of Health, 2000-2022 data as of November 2023. Rates in 2020 and 2021 were affected by COVID-19-related disruptions to care.

Colorectal cancer mortality rates by race and ethnicity, New York City, 2000 to 2022

Age-adjusted rates per 100,000 people



Rates restricted to NYC residents. White, Black, Asian and Pacific Islander (API) race categories exclude Latino ethnicity. Latino includes Hispanic or Latino of any race. Source: NYC Department of Health and Mental Hygiene Bureau of Vital Statistics, 2000-2022. Rates in 2020 and 2021 were affected by COVID-19-related disruptions to care.

- In 2018-2022, living in neighborhoods with low poverty was associated with lower rates of colorectal cancer mortality overall (8.3 per 100,000) compared with living in neighborhoods with the highest poverty levels (high and very high poverty both 10.2 per 100,000).
- In 2018-2022, residents of Staten Island had the highest colorectal cancer incidence rate (40.7 cases per 100,000) followed by those of Brooklyn, Queens, and the Bronx (35.4, 34.2, and 34.3 cases per 100,000, respectively) and then Manhattan (29.7 cases per 100,000).
- In 2018-2022 in NYC, residents of Manhattan and Queens had the lowest colorectal cancer mortality rates (8.2 and 8.4 per 100,000, respectively) compared with rates among residents of the Bronx and Brooklyn (10.1 and 10.3 per 100,000, respectively) and Staten Island, with the highest rate (12.2 per 100,000).

Colorectal cancer mortality rate by neighborhood poverty, New York City, 2018–2022

Age-adjusted rates per 100,000 people

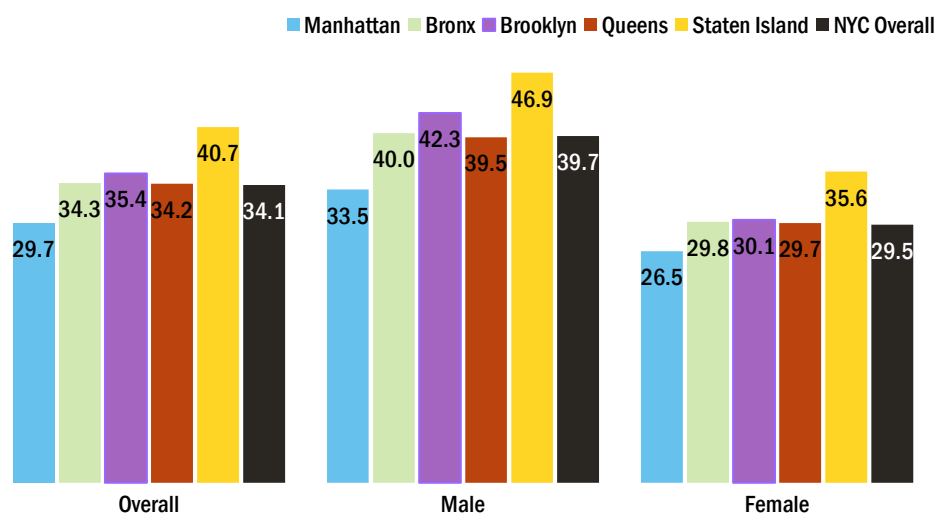


Rates restricted to NYC residents. Neighborhood poverty (based on ZIP code) is defined as the percentage of the population living below the Federal Poverty Line (FPL) based on the American Community Survey 2018-2022, categorized in four groups: "Low poverty," <10% below FPL; "Medium poverty," 10-20% below FPL; "High Poverty," 20-30% below the FPL; "Very high poverty," ≥30% below FPL.

Source: NYC Department of Health and Mental Hygiene Bureau of Vital Statistics, 2018-2022

Colorectal cancer incidence rates by borough of residence and sex, New York City, 2018–2022

Age-adjusted rates per 100,000 people

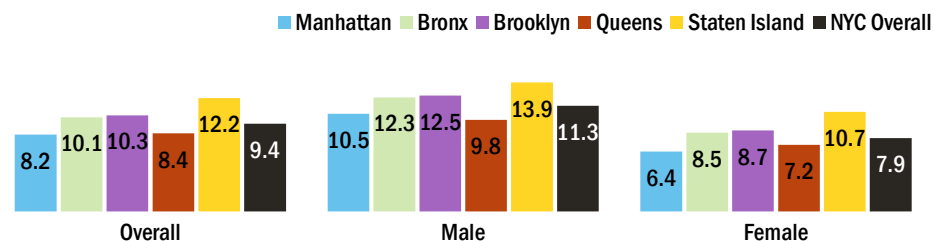


Rates restricted to NYC residents.

Source: New York State Cancer Registry, NYS Department of Health, 2018-2022 data as of November 2024

Colorectal cancer mortality rate by borough of residence and sex, New York City, 2018–2022

Age-adjusted rates per 100,000 people



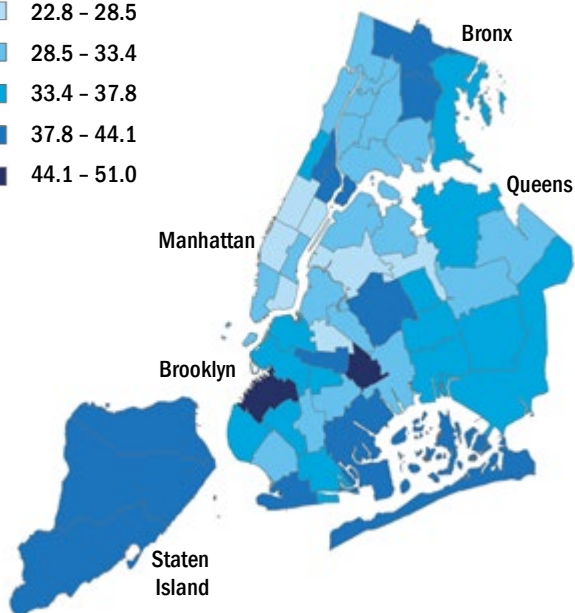
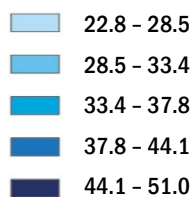
Rates restricted to NYC residents.

Source: NYC Department of Health and Mental Hygiene Bureau of Vital Statistics, 2018-2022

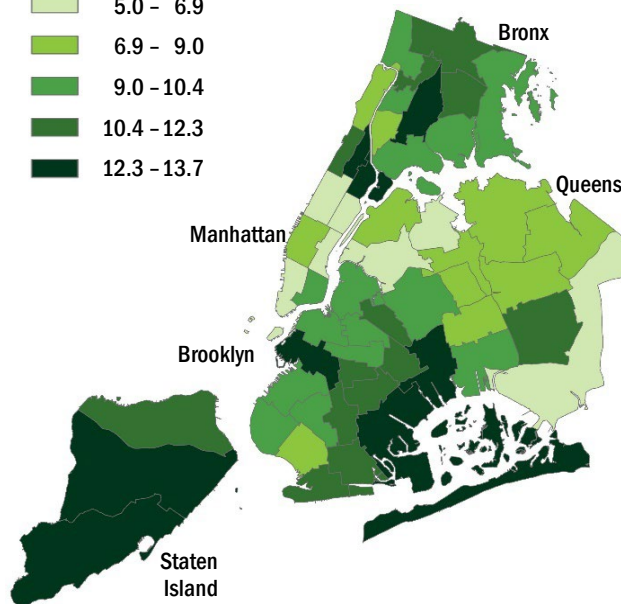
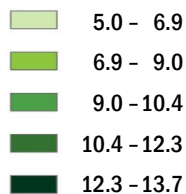
- At the neighborhood level:
 - In 2018-2022, colorectal cancer incidence rates by neighborhood ranged from 22.8 to 51.0 per 100,000 residents.
 - In 2018-2022, colorectal cancer mortality rates by neighborhood ranged from 5.0 to 13.7 per 100,000 residents.

Colorectal cancer incidence and mortality in New York City neighborhoods, 2018–2022

Age-adjusted colorectal cancer incidence rate per 100,000 people



Age-adjusted colorectal cancer mortality rate per 100,000 people



Notes: Rates restricted to NYC residents.

Neighborhoods: Public Use Microdata Areas (PUMA) are 55 geographic areas in NYC with a minimum population of 100,000 people, defined by the Census Bureau. Because of the population minimums, multiple neighborhoods may be combined to define one PUMA.

Sources: Incidence: New York State Cancer Registry, NYS Department of Health, 2018-2022 data as of November 2024.

Mortality: NYC Department of Health and Mental Hygiene Bureau of Vital Statistics, 2018-2022

Prostate Cancer

About prostate cancer screening: Recommendations for prostate cancer screening vary, but in general all people with prostates should have the opportunity to discuss screening with their health care provider and decide if they want to be screened. Prostate cancer often develops slowly, and some cases may not cause any issues over the course of someone’s life. Diagnosis and treatment can be invasive and therefore, screening will not be right for everyone.

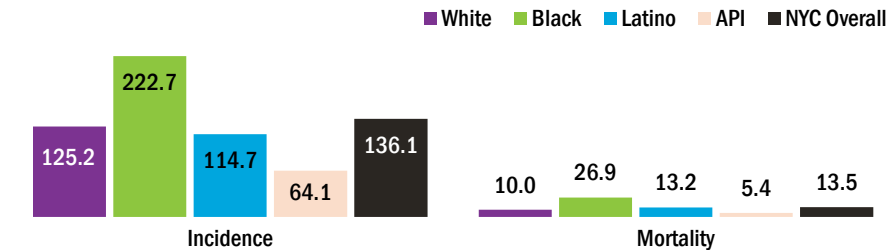
The American Cancer Society¹¹ recommends having the conversation about screening at different ages, depending on each person’s risk:

- Age 40 for those with more than one close family member who had prostate cancer before age 65.
- Age 45 for those who are Black¹² or have one close family member who had prostate cancer before age 65.
- Age 50 for those who do not have specific risk factors.

The test used for prostate cancer screening is a blood test for a protein called prostate-specific antigen (PSA). Depending on the test result, a provider may recommend additional tests.

- In 2024, about 37% of males in NYC between the ages of 45 and 75 had a PSA test in the previous two years. White (46%) and Latino (39%) New Yorkers had a similar prostate cancer screening prevalence. Black (34%) as well as API male New Yorkers (21%) were less likely than white males to have been tested. Prostate cancer screening rates are difficult to interpret because there is not a strong national recommendation to screen.
- In 2018-2022, prostate cancer incidence was highest among Black Male New Yorkers (222.7 cases per 100,000), followed by white (125.2 cases per 100,000), then Latino (114.7 cases per 100,000) and API New Yorkers (64.1 cases per 100,000).

Prostate cancer incidence and mortality rate by race and ethnicity, New York City, 2018-2022
Age-adjusted rates per 100,000 males



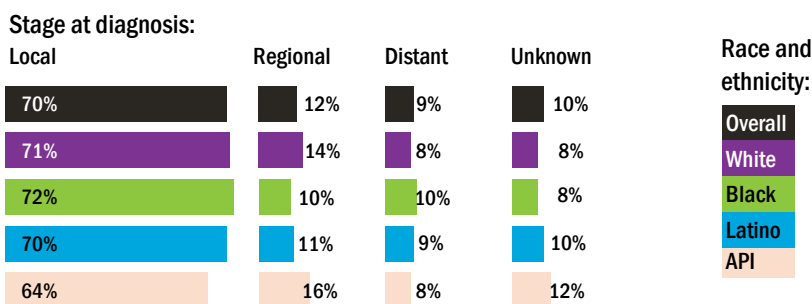
Rates restricted to NYC residents. White, Black, Asian and Pacific Islander (API) race categories exclude Latino ethnicity. Latino includes Hispanic or Latino of any race.
Sources: Incidence: New York State Cancer Registry, NYS Department of Health, 2018-2022 data as of November 2023. Mortality: NYC Department of Health and Mental Hygiene Bureau of Vital Statistics, 2018-2022

- In 2018-2022, prostate cancer mortality rates were highest among Black New Yorkers (26.9 deaths per 100,000), followed by Latino (13.2 deaths per 100,000), white (10.0 deaths per 100,000), and API New Yorkers (5.4 deaths per 100,000).
- The prostate cancer mortality rate among Black males was more than double that of white or Latino males and nearly five times that of API males.

¹¹ Wolf AMD, Wender RC, Etzioni RB, et al. American Cancer Society Guideline for the early detection of prostate cancer: update 2010. CA: Cancer J Clin 2010;60:70–98.
¹² Black men are included here because of elevated prostate cancer risk in this broadly defined group. However, because “race” is a socially constructed category, individuals within this group can have varying levels of risk.

- White (8%), Black (10%), Latino (9%), and API (8%) male New Yorkers had a similar proportion of cases of prostate cancer diagnosed at the distant stage. API males had the lowest proportion of cases of prostate cancer diagnosed at the local stage (64%), compared with white (71%), Black (72%), and Latino (70%) males.
- Prostate cancer incidence was stable from 2000 to 2022 overall, although among API male New Yorkers it declined. Prostate cancer incidence among Black male New Yorkers declined from 2000 to 2020 and was stable from 2020 to 2022. Incidence among Latino male New Yorkers was stable from 2000 to 2011, declined from 2011 to 2016, and was stable between 2016 to 2022. Incidence among white male New Yorkers decreased from 2000 to 2004, was stable from 2004 to 2007, and then decreased thereafter to 2022.

Percentage of prostate cancer diagnoses in each stage, among New York City cases, by race and ethnicity, 2018-2022



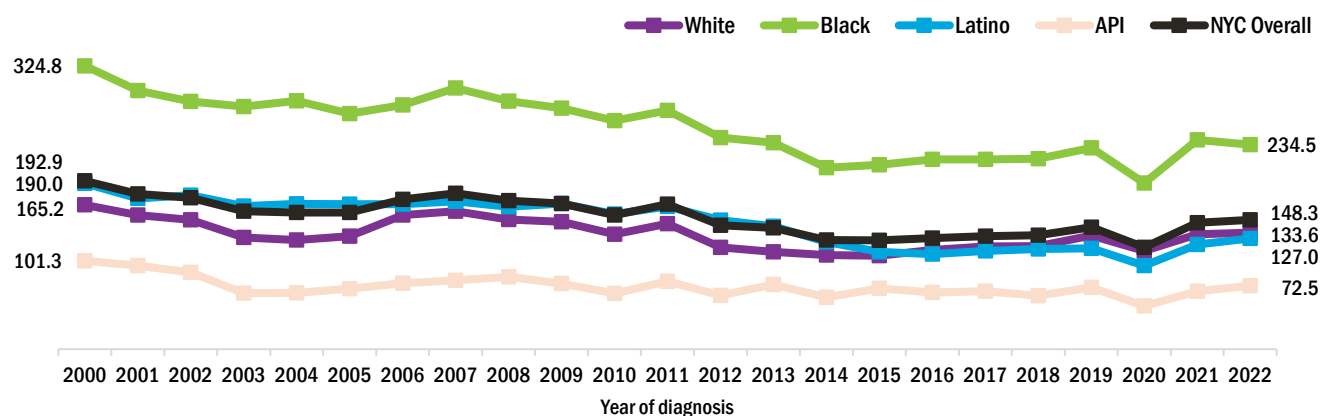
Within each race/ethnicity group, percentages may not sum to 100% due to rounding. Cases restricted to NYC residents. White, Black, Asian and Pacific Islander (API) race categories exclude Latino ethnicity. Latino includes Hispanic or Latino of any race.

Source: New York State Cancer Registry, NYS Department of Health, 2018-2022. data as of November 2024.

For the past two decades, Black male New Yorkers have consistently had the highest incidence of and mortality from prostate cancer.

Prostate cancer incidence rates by race and ethnicity, New York City, 2000 to 2022

Age-adjusted rates per 100,000 males

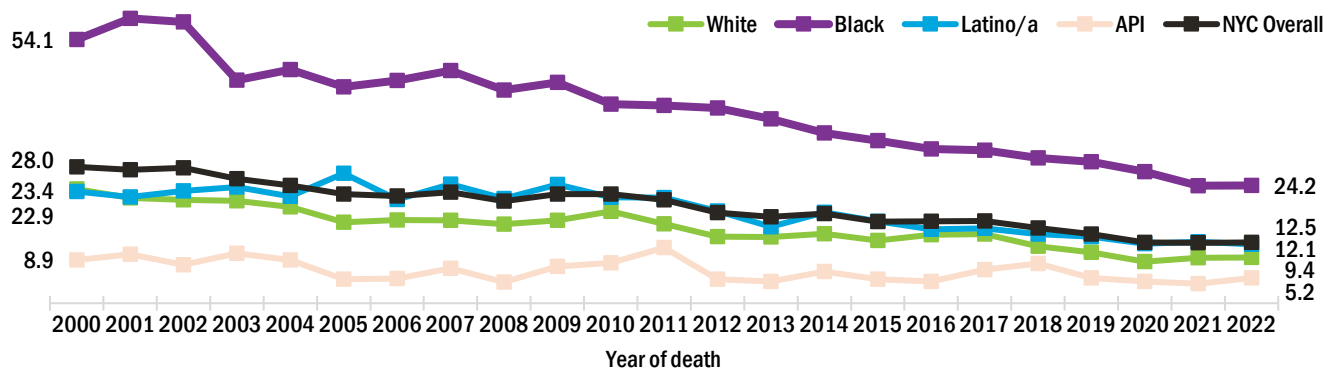


Rates restricted to NYC residents. White, Black, Asian and Pacific Islander (API) race categories exclude Latino ethnicity. Latino includes Hispanic or Latino of any race. Source: New York State Cancer Registry, NYS Department of Health, 2000-2022 data as of November 2023. Rates in 2020 and 2021 were affected by COVID-19-related disruptions to care.

- Prostate cancer mortality declined among NYC males overall and among Black, API, and white males from 2000 to 2022. Prostate cancer mortality rates among Latino male New Yorkers were stable from 2000 to 2007, and decreased from 2007 to 2022.
- Despite these declines over time, for the past two decades, Black male New Yorkers have consistently had the highest incidence of and mortality from prostate cancer, and the rate is nearly twice that of the citywide population.

Prostate cancer mortality rates by race and ethnicity, New York City, 2000 to 2022

Age-adjusted rates per 100,000 males



Rates restricted to NYC residents. White, Black, Asian and Pacific Islander (API) race categories exclude Latino ethnicity. Latino includes Hispanic or Latino of any race.

Source: NYC Department of Health and Mental Hygiene Bureau of Vital Statistics, 2000-2022. Rates in 2020 and 2021 were affected by COVID-19-related disruptions to care.

- In 2018-2022, male New Yorkers living in neighborhoods with very high poverty had a higher mortality rate of 17.1 per 100,000 from prostate cancer, compared with the rates found among males living in neighborhoods with medium or low poverty rates of 13.3 and 11.7 per 100,000 respectively.
- In 2018-2022, prostate cancer incidence was highest among residents of the Bronx (158.0 cases per 100,000) and lowest among Queens residents (119.9 cases per 100,000). Prostate cancer mortality was highest among Bronx residents (18.4 deaths per 100,000) compared with other boroughs.

Prostate cancer mortality rate by neighborhood poverty, New York City, 2018-2022

Age-adjusted rates per 100,000 people

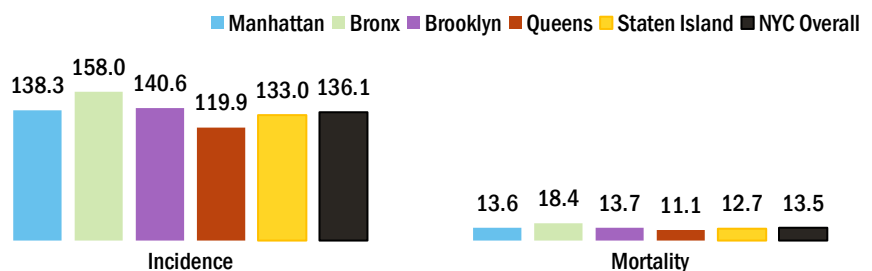


Rates restricted to NYC residents only. Neighborhood poverty (based on ZIP code) is defined as the percentage of the population living below the Federal Poverty Line (FPL) based on the American Community Survey 2018-2022, categorized in four groups: "Low poverty," <10% below FPL; "Medium poverty," 10-20% below FPL; "High Poverty," 20-30% below the FPL; "Very high poverty," ≥30% below FPL.

Source: NYC Department of Health and Mental Hygiene Bureau of Vital Statistics, 2018-2022

Prostate cancer incidence and mortality rate by borough of residence, New York City 2018-2022

Age-adjusted incidence and mortality rates per 100,000 males



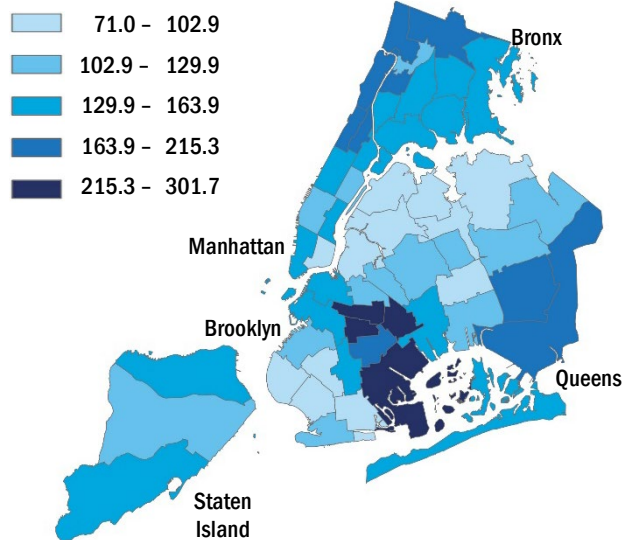
Rates restricted to NYC residents.

Sources: Incidence: New York State Cancer Registry, NYS Department of Health, 2018-2022 data as of November 2024. Mortality: NYC Department of Health and Mental Hygiene Bureau of Vital Statistics, 2018-2022.

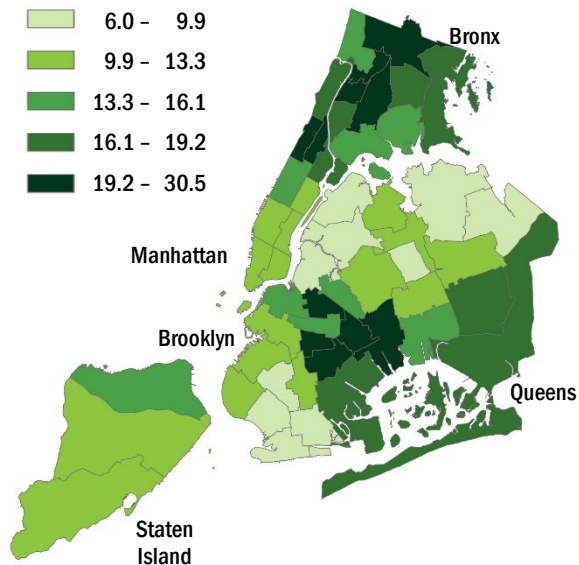
- At the neighborhood level,
 - In 2018-2022, prostate cancer incidence rates by neighborhood ranged from 71.0 to 301.7 per 100,000 residents.
 - In 2018-2022, prostate cancer mortality rates by neighborhood ranged from 6.0 to 30.5 per 100,000 residents.

Prostate cancer incidence and mortality rates, New York City neighborhoods, 2018-2022

Age-adjusted prostate cancer incidence
rate per 100,000 males



Age-adjusted prostate cancer mortality
rate per 100,000 males



Rates restricted to NYC residents.

Neighborhoods: Public Use Microdata Areas (PUMA) are 55 geographic areas in NYC with a minimum population of 100,000 people, defined by the Census Bureau. Because of the population minimums, multiple neighborhoods may be combined to define one PUMA.

Sources: Incidence: New York State Cancer Registry, New York State Department of Health, 2018-2022 data as of November 2024

Mortality: NYC Department of Health and Mental Hygiene Bureau of Vital Statistics, 2018-2022

Breast Cancer

About breast cancer screening:

By age 25, all adults assigned female at birth should talk with their health care providers about their breast cancer risk and when they should begin screening. People without increased risk who were assigned female at birth, regardless of their gender identity, should begin screening at age 40

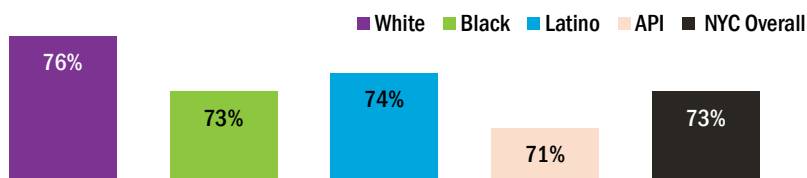
and continue at least through age 74.¹³ People at high risk may need to begin earlier. Trans women who are taking or have taken hormones should also talk with their health care providers about screening.¹⁴

For people at average risk, the test used for breast cancer screening is a mammogram, which is a kind of

X-ray. Depending on personal history as well as whether a patient has dense breast tissue, a health care provider may recommend additional tests. In New York State, anyone who has dense breasts identified is required by law to receive notice by mail.

- In 2023, nearly three in four NYC females ages 40 to 74 reported having a mammogram in the past two years (73%).
- In 2018-2022, breast cancer incidence was highest among white female New Yorkers (148.9 cases per 100,000), followed by Black (128.7 cases per 100,000), API (115.0 cases per 100,000) and then Latina (96.3 cases per 100,000) females.
- In 2018-2022, breast cancer mortality rates were highest among Black female New Yorkers (21.3 deaths per 100,000), followed by white (15.7 deaths per 100,000), Latina (11.4 deaths per 100,000), and then API (8.4 deaths per 100,000) females.

Prevalence of receiving a mammogram in the past two years among females ages 40 to 74, by race and ethnicity, New York City, 2023

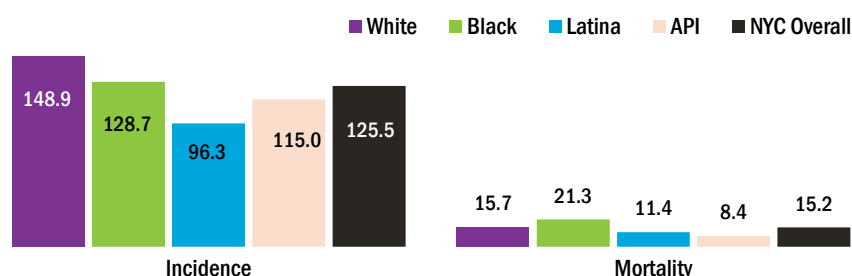


White, Black, Asian and Pacific Islander (API) race categories exclude Latina ethnicity. Latina includes Hispanic or Latino of any race.

Source: Community Health Survey, 2023

Female breast cancer incidence and mortality rates by race and ethnicity, New York City, 2018-2022

Age-adjusted rates per 100,000 females



Rates restricted to NYC residents. White, Black, Asian and Pacific Islander (API) race categories exclude Latina ethnicity. Latina includes Hispanic or Latina of any race.

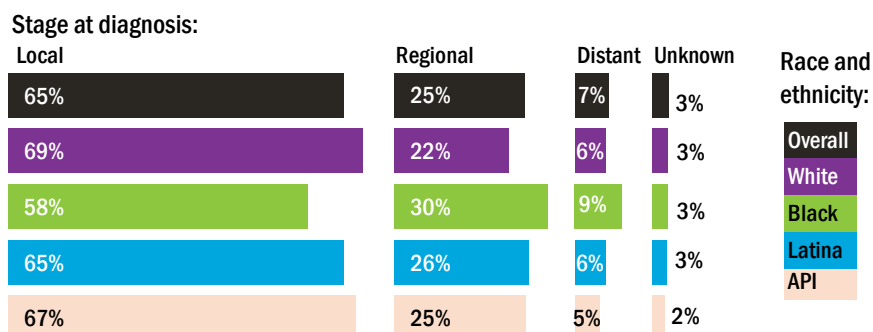
Sources: Incidence: New York State Cancer Registry, NYS Department of Health, 2018-2022 data as of November 2023. Mortality: NYC Department of Health and Mental Hygiene Bureau of Vital Statistics, 2018-2022.

¹³ U.S. Preventive Services Task Force. Final recommendation statement. Breast cancer: screening. April 30, 2024. Accessed February 18, 2026 at <https://www.uspreventiveservicestaskforce.org/uspstf/recommendation/breast-cancer-screening>

¹⁴ Expert Panel on Breast Imaging, Brown A, Lourenco AP, et al. ACR Appropriateness Criteria® Transgender Breast Cancer Screening. *J Am Coll Radiol*. 2021;18(11S):S502-S515. doi:10.1016/j.jacr.2021.09.005

- In 2018-2022, Black female New Yorkers had the lowest proportion of cases diagnosed at the local stage (58%) and the highest proportion of cases diagnosed at the distant stage (9%), compared with white (69%, 6%), Latina (65%, 6%), and API (67%, 5%) females. API females had the lowest proportion of cases diagnosed at the distant stage.
- Breast cancer incidence increased among all female New Yorkers and across all race and ethnicity groups from 2000 to 2022. During that same time period, breast cancer incidence increased the most among API New Yorkers, followed by Black, Latino, and white New Yorkers in that order.

Percentage of female breast cancer diagnoses in each stage among New York City cases, by race and ethnicity, 2018-2022



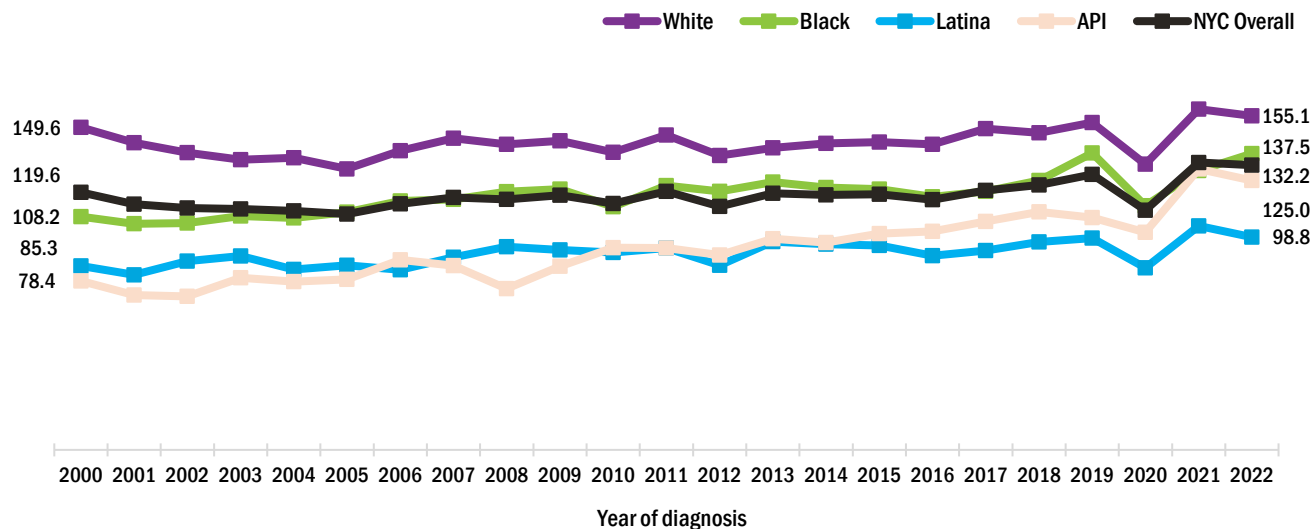
Within each race/ethnicity group, percentages may not sum to 100% due to rounding. Cases restricted to NYC residents. White, Black, Asian and Pacific Islander (API) race categories exclude Latina ethnicity. Latina includes Hispanic or Latina of any race.

Source: New York State Cancer Registry, NYS Department of Health, 2018-2022 data as of November 2024

Over the past two decades, white females have consistently had higher breast cancer incidence rates compared with Black women, while mortality rates among Black women have been similar or higher.

Female breast cancer incidence rates by race and ethnicity, New York City, 2000 to 2022

Age-adjusted rates per 100,000 females



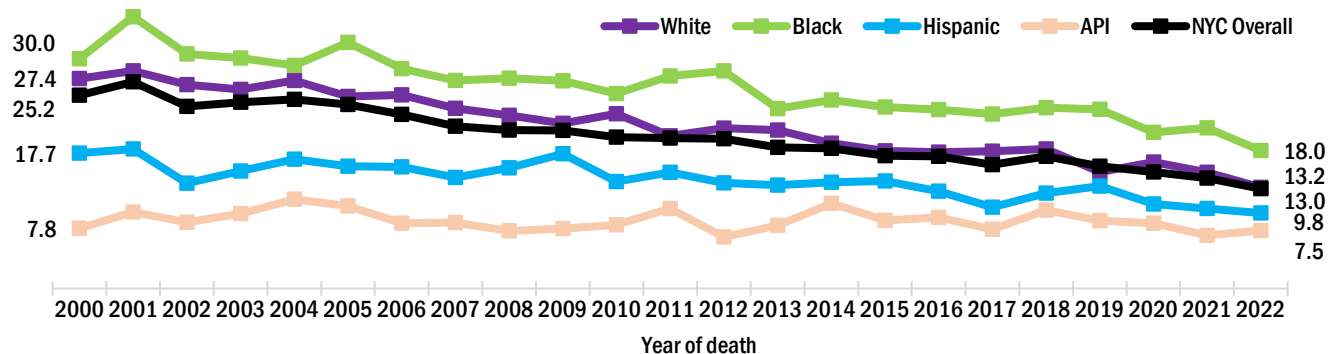
Rates restricted to NYC residents. White, Black, Asian and Pacific Islander (API) race categories exclude Latino ethnicity. Latina includes Hispanic or Latina of any race.

Source: New York State Cancer Registry, NYS Department of Health, 2000-2022, data as of November 2023. Rates in 2020 and 2021 were affected by COVID-19-related disruptions to care.

- Breast cancer mortality declined among females in NYC overall and among Black, Latina, and white females from 2000 to 2022. Mortality rates among API females were stable during the same period.
- Over the past two decades, white females have consistently had higher breast cancer incidence rates compared with Black women, while mortality rates among Black women have been similar or higher.

Female breast cancer mortality rates by race and ethnicity, New York City, 2000 to 2022

Age-adjusted rates per 100,000 females



Rates restricted to NYC residents. White, Black, Asian and Pacific Islander (API) race categories exclude Latina ethnicity. Latina includes Hispanic or Latina of any race.

Source: NYC Department of Health and Mental Hygiene Bureau of Vital Statistics, 2000-2022. Rates in 2020 and 2021 were affected by COVID-19-related disruptions to care.

- In 2018-2022 in NYC overall, the breast cancer mortality rate was higher in neighborhoods with very high poverty compared with neighborhoods with low poverty (18.0 vs. 14.2 deaths per 100,000).

Female breast cancer mortality rate by neighborhood poverty, New York City 2018-2022



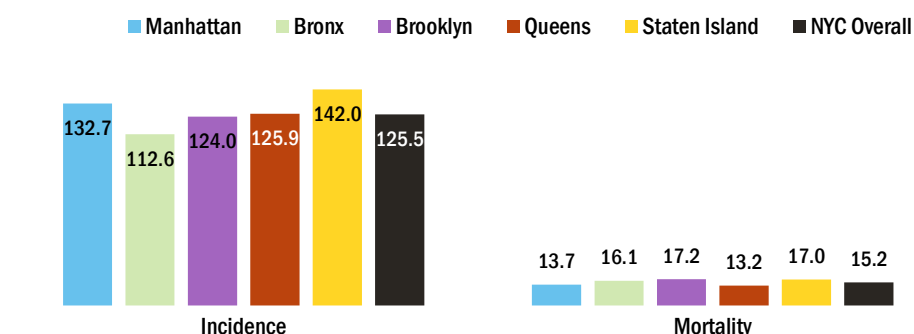
Rates restricted to NYC residents. Neighborhood poverty (based on ZIP code) is defined as the percentage of the population living below the Federal Poverty Line (FPL) based on the American Community Survey 2018-2022, categorized in four groups: "Low poverty," <10% below FPL; "Medium poverty," 10-20% below FPL; "High Poverty," 20-30% below the FPL; "Very high poverty," ≥30% below FPL.

Source: NYC Department of Health and Mental Hygiene Bureau of Vital Statistics, 2018-2022

- In 2018-2022, female residents of Staten Island and Manhattan had the highest breast cancer incidence rate (142.0 and 132.7 cases per 100,000, respectively), followed by female residents of Queens and Brooklyn (125.9 and 124.0 cases per 100,000, respectively), and then the Bronx (112.6 cases per 100,000).
- The breast cancer mortality rate in 2018-2022 was highest among female residents of Brooklyn, Staten Island, and the Bronx (17.2, 17.0 and 16.1 per 100,000, respectively), followed by female residents of Manhattan and Queens (13.7 and 13.2 deaths per 100,000, respectively).

Female breast cancer incidence and mortality rates by borough of residence, New York City, 2018-2022

Age-adjusted rates per 100,000 females



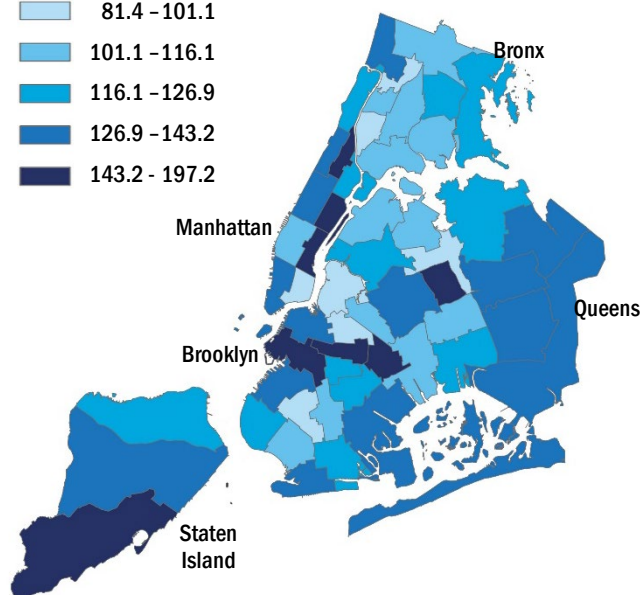
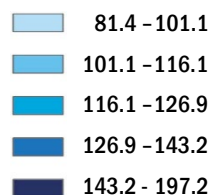
Rates restricted to NYC residents.

Sources: Incidence: Source: New York State Cancer Registry, NYS Department of Health, 2018-2022 data as of November 2023. Mortality: NYC Department of Health and Mental Hygiene Bureau of Vital Statistics, 2018-2022

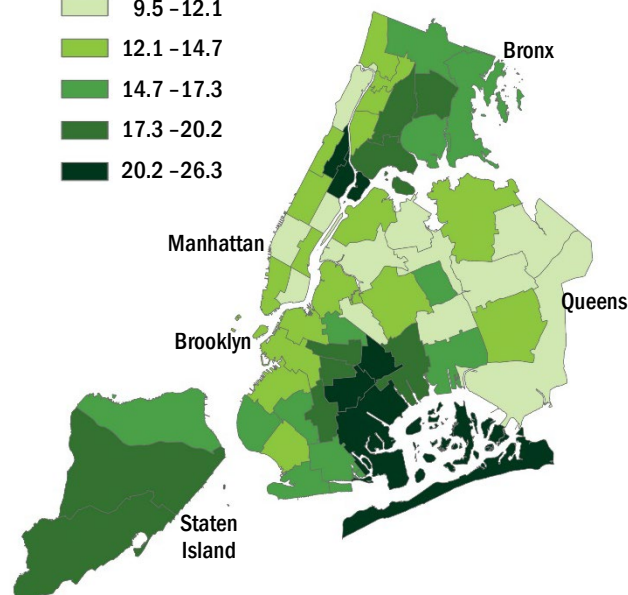
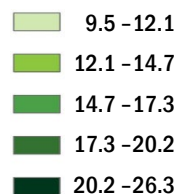
- At the neighborhood level,
 - In 2018-2022, female breast cancer incidence rates by neighborhood ranged from 81.4 to 197.2 per 100,000 people.
 - In 2018-2022, female breast cancer mortality rates by neighborhood ranged from 9.5 to 26.3 per 100,000 people.

Female breast cancer incidence and mortality in New York City neighborhoods, 2018-2022

Age-adjusted breast cancer incidence rate per 100,000 females



Age-adjusted breast cancer mortality rate per 100,000 females



Rates restricted to NYC residents. Neighborhoods: Public Use Microdata Areas (PUMA) are 55 geographic areas in NYC with a minimum population of 100,000 people, defined by the Census Bureau. Because of the population minimums, multiple neighborhoods may be combined to define one PUMA.

Sources: Incidence: New York State Cancer Registry, NYS Department of Health, 2018-2022 data as of November 2024

Mortality: NYC Department of Health and Mental Hygiene Bureau of Vital Statistics, 2018-2022

Cervical Cancer

About cervical cancer screening:

In general, people with a cervix, regardless of gender identity, should start screening in their early to mid-20s and continue at least through age 65. A health care provider may recommend a test for human papillomavirus (HPV), a Pap test, or a combination of the two. Screening is typically

recommended once every three to five years; each person should ask when their next screening is due.^{15,16} People at high risk may need to follow a different screening schedule.

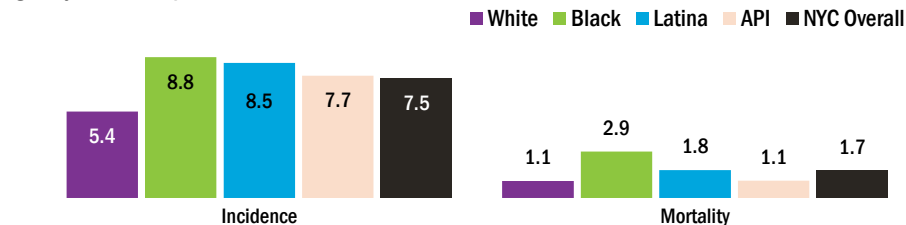
The HPV test is used because HPV infection, which can be sexually transmitted, is a major cause of

cervical cancer. Usually, a person’s immune system will clear the infection, but if not, then the risk for cervical cancer rises. The Pap test looks for cancer and for changes in cells that can lead to cancer. Removing abnormal cells can help prevent cervical cancer.

- In 2024, 59% of female New Yorkers ages 21 to 65 reported they were screened for cervical cancer in the past three years, including 64% of white, 62% of Black, 58% of Latina, and 48% of API females.
- In 2018-2022, cervical cancer incidence in NYC was higher among Black, Latina, and API females (8.8, 8.5, and 7.7 cases per 100,000, respectively) compared with white females (5.4 cases per 100,000).
- In 2018-2022, cervical cancer mortality rates were highest among Black female New Yorkers (2.9 deaths per 100,000), compared with Latina, API, and white females (1.8, 1.1, and 1.1 deaths per 100,000, respectively).

Cervical cancer incidence and mortality rates by race and ethnicity, New York City, 2018-2022

Age-adjusted rates per 100,000 females



Rates restricted to NYC residents. White, Black, Asian and Pacific Islander (API) race categories exclude Latina ethnicity. Latina includes Hispanic or Latina of any race.

Sources: Incidence: New York State Cancer Registry, NYS Department of Health, 2018-2022 data as of November 2024. Mortality: NYC Department of Health and Mental Hygiene Bureau of Vital Statistics, 2018-2022

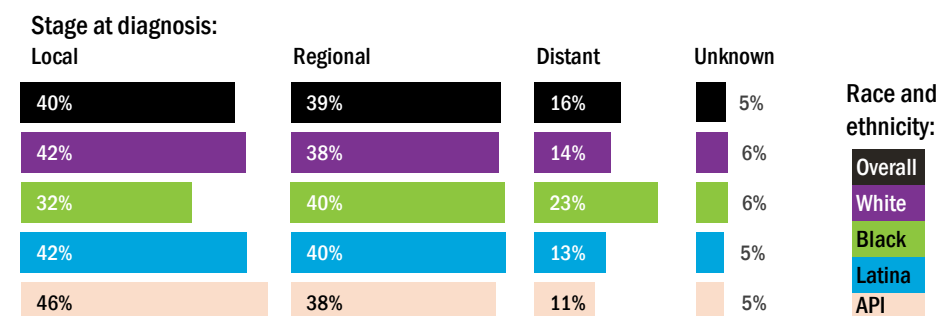
Cervical cancer mortality rates declined for NYC females overall and among API, Black, and Latina females from 2002 to 2022. However, these declines have not eliminated the inequity in cervical cancer mortality among Black females.

¹⁵ U.S. Preventive Services Taskforce. Final Recommendation Statement. Cervical Cancer: Screening Guidelines, August 21, 2018 <https://www.uspreventiveservicestaskforce.org/uspstf/recommendation/cervical-cancer-screening>. Accessed February 19, 2026.

¹⁶ American Cancer Society Cervical Cancer Screening Guidelines, July 30, 2020.

- Black female New Yorkers had the lowest proportion of cases of cervical cancer diagnosed at the local stage (32%) and the highest proportion of cases diagnosed at the distant stage (23%), compared with white (42% local, 14% distant), Latina (42% local, 13% distant), and API (46% local, 11% distant) females.
- The proportion of cases diagnosed at the regional stage was similar across white, Black, Latina, and API females (ranging from 38% to 40%).
- Cervical cancer incidence declined from 2000 to 2022 among NYC females overall and among Black, Latina, and white females. Incidence was stable for API females during the same period.

Percentage of cervical cancer diagnoses in each stage among New York City cases, by race and ethnicity, 2018-2022

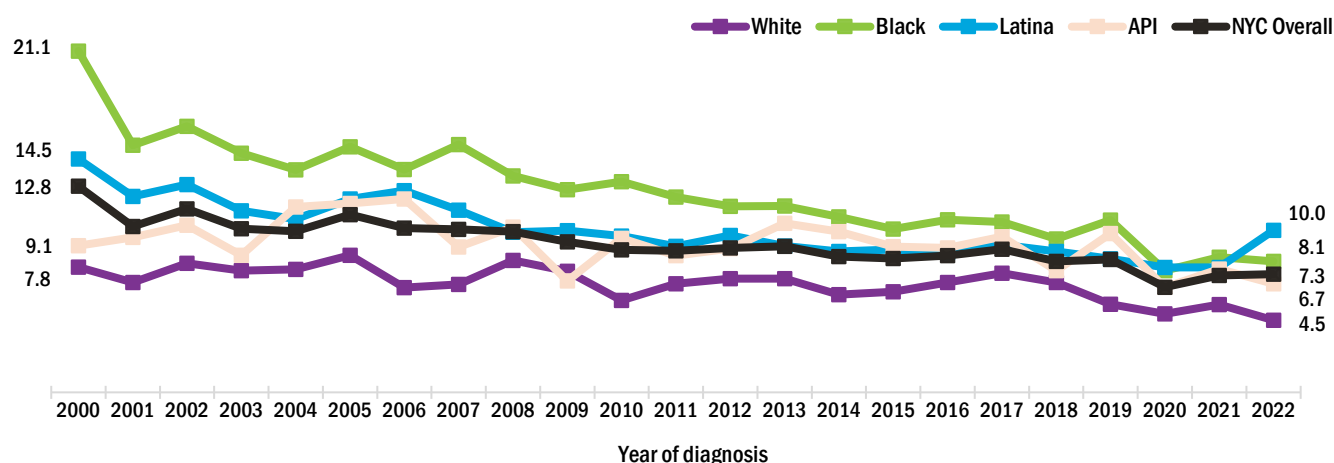


Within each race/ethnicity group, percentages may not sum to 100% due to rounding. Cases restricted to NYC residents. White, Black, Asian and Pacific Islander (API) race categories exclude Latino ethnicity. Latina includes Hispanic or Latina of any race.

Source: New York State Cancer Registry, New York State Department of Health, 2018-2022 data as of November 2023

Cervical cancer incidence rates by race and ethnicity, New York City, 2000 to 2022

Age-adjusted rates per 100,000 females



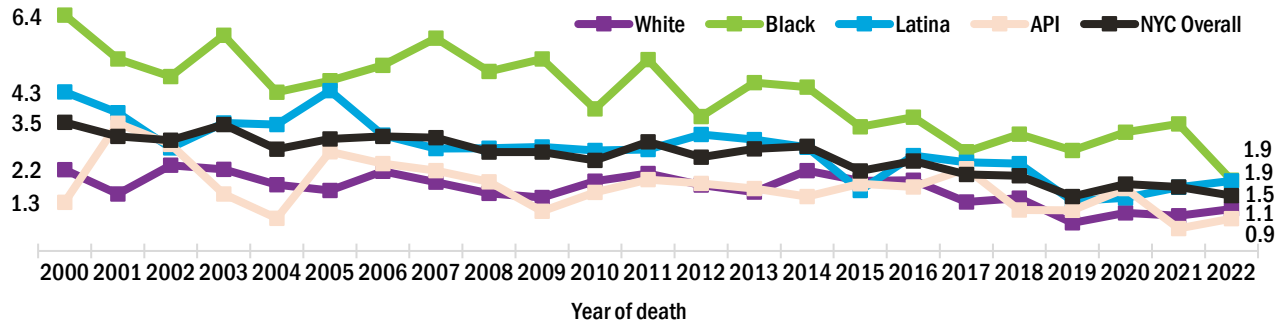
Rates restricted to NYC residents. White, Black, Asian and Pacific Islander (API) race categories exclude Latina ethnicity. Latina includes Hispanic or Latina of any race.

Source: New York State Cancer Registry, New York State Department of Health, 2000-2022, data as of November 2024. Rates in 2020 and 2021 were affected by COVID-19-related disruptions to care.

- Cervical cancer mortality rates declined among NYC females overall and among API, Black, and Latina females from 2002 to 2022. Cervical cancer mortality among white females was stable from 2000 to 2015 and decreased from 2015 to 2022.

Cervical cancer mortality rates by race and ethnicity, New York City, 2000 to 2022

Age-adjusted rates per 100,000 females



Rates restricted to NYC residents. White, Black, Asian and Pacific Islander (API) race categories exclude Latina ethnicity. Latina includes Hispanic or Latina of any race.

Source: NYC Department of Health and Mental Hygiene Bureau of Vital Statistics, 2018-2022. Rates in 2020 and 2021 were affected by COVID-19-related disruptions to care.

- In 2018-2022, females living in neighborhoods with low poverty had a lower rate of cervical cancer mortality (1.1 deaths per 100,000) than those living in neighborhoods with very high poverty (2.7 deaths per 100,000).
- In 2018-2022, female residents of Manhattan had a lower cervical cancer incidence rate (5.6 cases per 100,000) compared with those in the Bronx, Queens, Brooklyn, and Staten Island (9.0, 8.0, 7.6, and 6.8 cases per 100,000, respectively).

Cervical cancer mortality rate by neighborhood poverty, NYC 2018-2022

Age-adjusted rates per 100,000 females

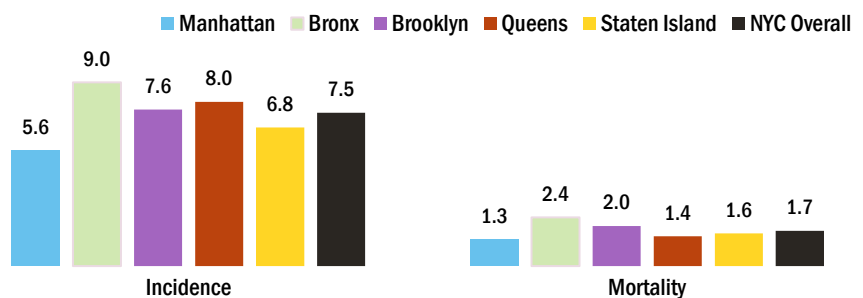


Notes: Rates restricted to NYC residents. Neighborhood poverty (based on ZIP code) is defined as the percentage of the population living below the Federal Poverty Line (FPL) based on the American Community Survey 2018-2022, categorized in four groups: "Low poverty," <10% below FPL; "Medium poverty," 10-20% below FPL; "High poverty," 20-30% below the FPL; "Very high poverty," ≥30% below FPL.

Source: NYC Department of Health and Mental Hygiene Bureau of Vital Statistics, 2018-2022

Cervical cancer incidence and mortality rate by borough of residence, New York City, 2018-2022

Age-adjusted rates per 100,000 females

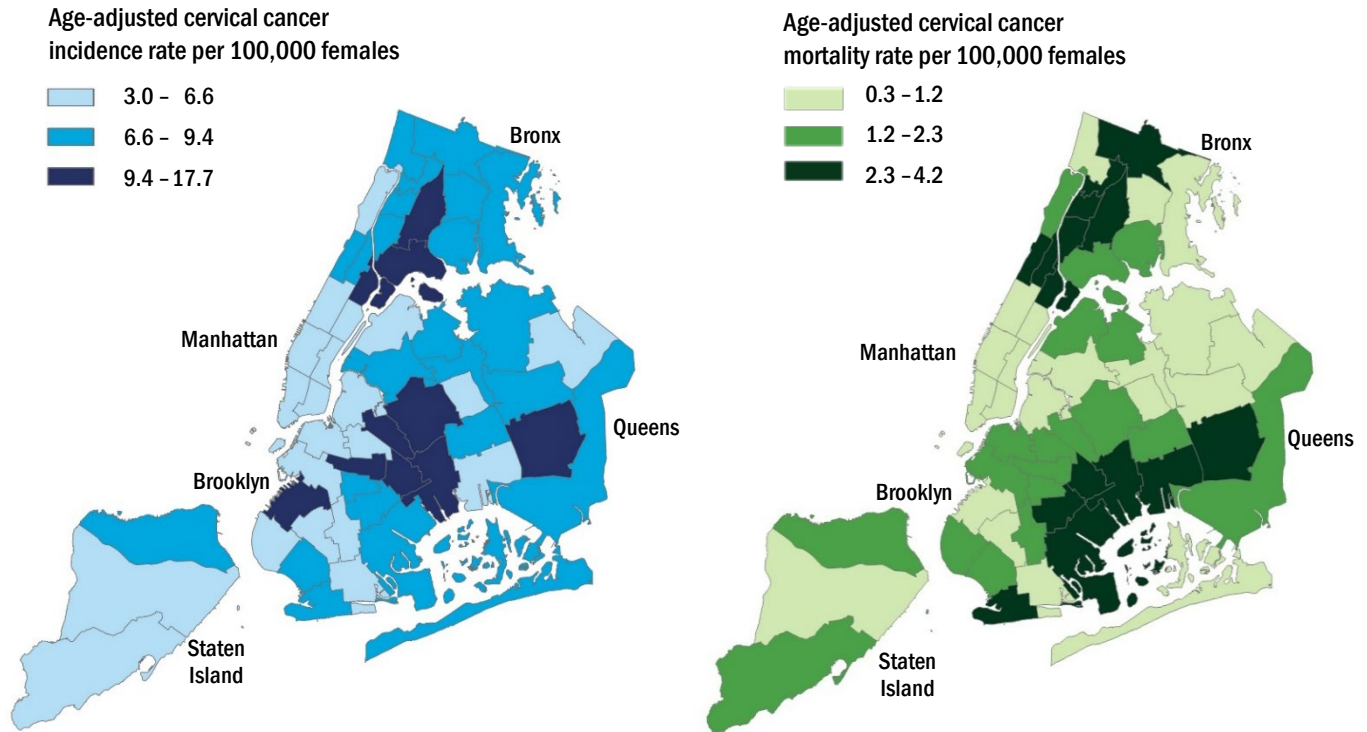


Rates restricted to NYC residents.

Sources: Incidence: New York State Cancer Registry, New York State Department of Health, 2017-2021 data as of November 2023. Mortality: NYC Department of Health and Mental Hygiene Bureau of Vital Statistics, 2018-2022

- At the neighborhood level,
 - In 2018-2022, cervical cancer incidence rates by neighborhood ranged from 3.0 to 17.7 per 100,000 people.
 - In 2018-2022, cervical cancer mortality rates by neighborhood ranged from 0.3 to 4.2 per 100,000 people.

Cervical cancer incidence and mortality rates in New York City neighborhoods, 2018-2022



Rates restricted to NYC residents.

Neighborhoods: Public Use Microdata Areas (PUMA) are 55 geographic areas in NYC with a minimum population of 100,000 people, defined by the Census Bureau. Because of the population minimums, multiple neighborhoods may be combined to define one PUMA.

Sources: Incidence: New York State Cancer Registry, New York State Department of Health, 2018-2022 data as of November 2023

Mortality: NYC Department of Health and Mental Hygiene Bureau of Vital Statistics, 2018-2022

Premature Mortality Due to Screenable Cancers

Lung cancer

- In 2018-2022, the overall premature mortality rate due to lung cancer was higher among males (6.9 premature deaths per 100,000) than among females (4.7 premature deaths per 100,000). Latina females had the lowest premature mortality.
- Among males in 2018-2022, Black males had the highest rate of premature mortality due to lung cancer (10.2 premature deaths per 100,000) followed by API and white males (7.1 and 6.2, respectively). Latino males had the lowest premature mortality rate due to lung cancer (4.5 premature deaths per 100,000).

Lung cancer premature mortality rates by race and ethnicity, and sex, New York City, 2018–2022

Age-adjusted rates per 100,000 people ages 0-64 years



Rates restricted to NYC residents only. Premature mortality is death before age 65.

White, Black, Asian and Pacific Islander (API) race categories exclude Latino ethnicity. Latino includes Hispanic or Latino of any race.

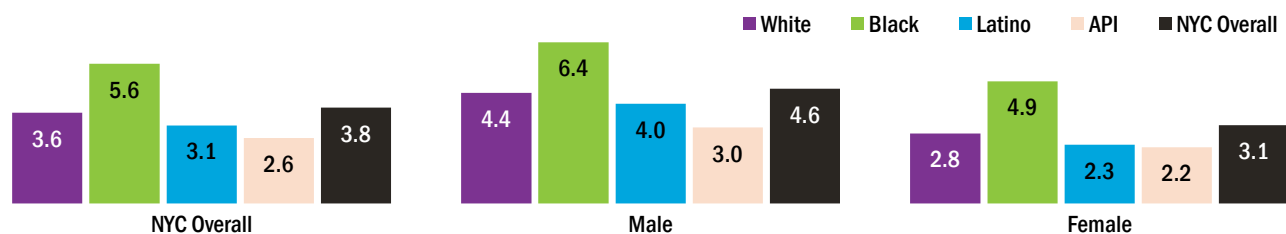
Source: NYC Department of Health and Mental Hygiene Bureau of Vital Statistics, 2018-2022

Colorectal cancer

- In 2018-2022, the overall rate of premature mortality (death before age 65) due to colorectal cancer was higher among males (4.6 deaths per 100,000) than among females (3.1 deaths per 100,000).
- Among both males and females, Black New Yorkers had the highest rates of premature mortality due to colorectal cancer (6.4 premature deaths per 100,000 for males and 4.9 premature deaths per 100,000 for females) compared with white, Latino, and API males and females.

Colorectal cancer premature mortality rates by race and ethnicity, and sex, New York City, 2018–2022

Age-adjusted rates per 100,000 people ages 0-64 years



Rates restricted to NYC residents only. Premature mortality is death before age 65.

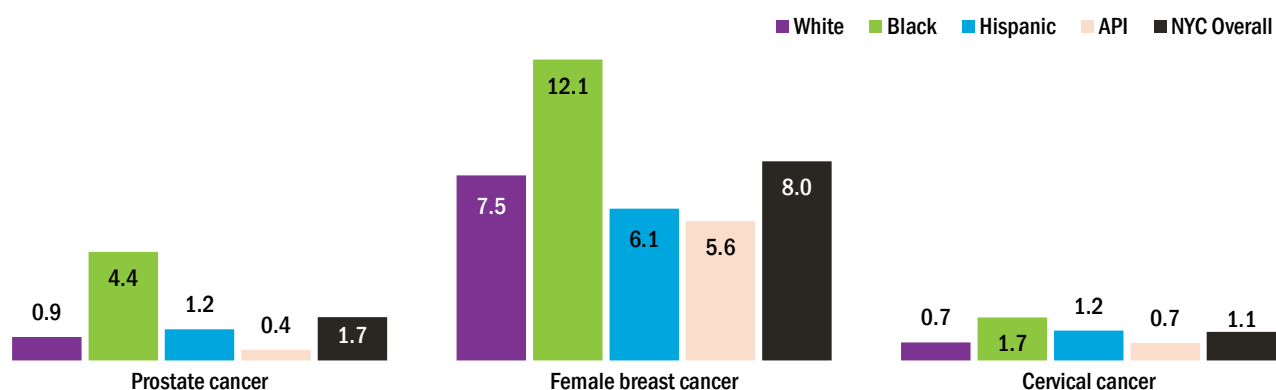
White, Black, Asian and Pacific Islander (API) race categories exclude Latino ethnicity. Latino includes Hispanic or Latino of any race.

Source: NYC Department of Health and Mental Hygiene Bureau of Vital Statistics, 2018-2022

Prostate, breast, and cervical cancer

- In 2018-2022, Black New Yorkers had higher rates of premature mortality due to both prostate and breast cancer compared with white, Latino, and API New Yorkers.
- The rate of premature mortality due to breast cancer among Black females was about 61% higher than among white females and nearly twice that of Latina or API females.
- The rate of premature mortality due to prostate cancer among Black males was over four times higher than among white males, about three times higher than that of Latino males, and more than ten times higher than among API males.

Prostate, female breast, and cervical cancer premature mortality rates by race and ethnicity, New York City, 2018–2022
Age-adjusted rates per 100,000 people ages 0–64 years



Rates restricted to NYC residents only. Premature mortality is death before age 65.

White, Black, Asian and Pacific Islander (API) race categories exclude Latino ethnicity. Latino includes Hispanic or Latino of any race.

Source: NYC Department of Health and Mental Hygiene Bureau of Vital Statistics, 2018-2022

Implications

The analysis of cancer data presented in this report reveals a mixed picture. Over the past two decades, mortality rates due to the five “screenable cancers” (lung, breast, colorectal, prostate, and cervical cancers) have been declining in NYC. Nevertheless, cancer continues to pose a substantial public health burden, and it remains one of the leading causes of both death and premature death in NYC. Together, the five cancers discussed in this report make up approximately 42% of cancer deaths in NYC. Despite improvements in overall mortality rates, this report also shows persistent and significant inequities in who dies from the screenable cancers in NYC. Mortality due to breast, colorectal, prostate, and cervical cancers is highest among Black New Yorkers compared with white, Latino, and API New Yorkers. Premature mortality is highest among Black New Yorkers for breast, colorectal, and prostate cancer. Black New Yorkers have the highest proportion of distant-stage diagnosis for colorectal, breast, and cervical cancers and Black and Latino New Yorkers have the highest proportion for lung cancer.

Although screening is a proven way to reduce cancer mortality, data

suggest that solely increasing screening will not eliminate these inequities. For example, in breast cancer, Black New Yorkers consistently report receiving mammograms at rates similar to or higher than the citywide average, yet the inequities described above persist.

Differences in cancer mortality across racial and ethnic groups cannot be assumed to be due to innate physical differences. The racial and ethnic categories of Black, API, Latino, and white are used here because they are common socially defined categories in the United States, not because these groups are biologically or genetically unique. While an individual’s ancestry can influence cancer risk, reducing population-level inequities in cancer deaths will require identifying and addressing the social structures that contribute to the patterns identified here.

Research has demonstrated how differences in quality of care for people of different racial and ethnic groups can contribute to differences in outcomes. Examples include inequities in treatment delays, genetic counseling and testing for cancer risk, tumor biomarker testing,

and overall receipt of care that is consistent with expert guidelines.^{17,18,19}

Other social, economic, and environmental determinants of health also can impact cancer incidence and outcomes. Lack of paid medical leave, lack of health insurance, and transportation challenges can all make it difficult to obtain timely, high-quality care for cancer.²⁰ Even for people with insurance, out-of-pocket costs can lead to financial hardship which impacts options for treatment and self-care.²¹ As shown in this analysis, mortality rates for the screenable cancers tend to track with neighborhood poverty in NYC. Many high-poverty neighborhoods in NYC have experienced longstanding disinvestment, with a disproportionate impact of both historical and current structural racism on the health of people living there. A closer look at the interactions among cancer mortality, geography, social determinants of health, and individuals’ race and ethnicity in NYC could help to direct where and how work on cancer inequities could have the most impact.

¹⁷ Islami F, Bispo JB, Lee H. American Cancer Society’s report on the status of cancer disparities in the United States, 2023. *CA Cancer J Clin.* 2024;74(2):136-166. doi: 10.3322/caac.21812.

¹⁸ Mitchell E, Alese OB, Yates C, et al. Cancer healthcare disparities among African Americans in the United States. *J Natl Med Assoc.* 2022;114(3):236-250. doi: 10.1016/j.jnma.2022.01.004.

¹⁹ Saka AH, Giaquinto AN, McCullough LE. Cancer statistics for African American and Black people, 2025. *CA J Cancer Clin.* 2025 Feb 20;75(2):111-140. doi: 10.3322/caac.21874.

²⁰ Alcaraz KI, Wiedt TL, Daniels EC, Yabroff KR, Guerra CE, Wender RC. Understanding and addressing social determinants to advance cancer health equity in the United States: A blueprint for practice, research, and policy. *CA Cancer J Clin.* 2020 Jan;70(1):31-46. doi: 10.3322/caac.21586.

²¹ Islami F, Bispo JB, Lee H. American Cancer Society’s report on the status of cancer disparities in the United States, 2023. *CA Cancer J Clin.* 2024;74(2):136-166. doi: 10.3322/caac.21812.

Overall, the patterns of cancer incidence, late stage at diagnosis, and mortality highlight the need to consider implications of how social and structural inequities contribute to these unequal health outcomes.

The following are some approaches that can support not only high-quality care for all, but also more equitable opportunities for health:

At healthcare sites, quality improvement efforts can identify and address gaps or inequities in care, including ensuring high quality screening, prompt diagnosis and treatment, receipt of guideline-consistent care, access to clinical trials, attention to quality of life during and after treatment, and access to financial assistance when needed. Providing patient navigation services, which guide and support people through our complex health care system, can increase completion rates for screening and reduce barriers to high-quality cancer treatment.

Community organizations can promote screening and help their communities understand that cancer is treatable and can be survivable, especially if it is caught early. They can encourage people to talk to their health care providers about their family history and cancer risk; in some cases, people at high risk need early,

more frequent, or more intensive screening.

Policy reforms can address non-medical barriers to diagnosis and treatment such as mandated time off work, expanded transportation, and subsidized childcare to allow for medical visits or hospitalizations. Increasing access to healthy foods and support to reduce tobacco and alcohol use can mitigate cancer risk. Increased investment in historically neglected neighborhoods could include increased access to green space and reductions in traffic volume which could reduce exposure to cancer causing elements, such as air pollution, and increase opportunities for physical activity such as safe and pleasant parks and playgrounds.

In addition, more research is needed to ensure that screening has the maximum possible impact. For example, current screening recommendations for lung cancer only include people who meet criteria for a certain level of smoking during their lifetime. However, these criteria do not predict risk equally well across different demographic groups. More work is needed to see if recommendations should be expanded or tailored to different types of risk.²² Most of the major breast cancer screening trials involved predominantly white women and several were based in

countries other than the United States.^{23,24} This does not address observed variations among U.S. populations, differences in risk among people of different genetic ancestry, or the impact of structural racism, which likely contributes to elevated rates among Black women of aggressive, poor-prognosis tumors that are less readily found through screening.²⁵ Increasing diversity in clinical trials offers a clear way of improving care for all.

The NYC Health Department is working to reduce the impact of screenable cancers in several ways. These include education, outreach, and policy to reduce tobacco use and overconsumption of alcohol; programs, media and educational materials to support and encourage cancer screening; programs to increase access to fruits and vegetables; improving the built environment to make physical activity an easier choice; and promoting vaccination against HPV, which reduces the risk of cervical cancer. To learn more about Health Department programs, as well as options for people who need help getting insurance or finding low- or no-cost cancer screening, visit nyc.gov and search for the specific topic. Cancer is treatable and can be survivable, especially if it is caught early through screening.

²² Wolf AMD, Oeffinger KC, Shih, TY. Screening for lung cancer: 2023 guideline update from the American Cancer Society. *CA Cancer J Clin.* 2024 Jan-Feb;74(1):50-81. doi: 10.3322/caac.21811.

²³ U.S. Preventive Services Task Force. Final Recommendation Statement. Breast Cancer: Screening. April 30, 2024. Accessed September 15, 2025.

²⁴ Jones BA, Patterson EA, Calvocoressi L. Mammography screening in African American women. *Cancer.* 2003 Jan 1;97(1 Suppl):258-72. doi: 10.1002/cncr.11022.

²⁵ U.S. Preventive Services Task Force. Final Recommendation Statement. Breast Cancer: Screening. April 30, 2024. Accessed September 15, 2025.

Limitations

This analysis has several limitations. Screening, incidence, and mortality data all come from different sources, so they cannot be directly compared. Screening data are self-reported and people may not remember exactly when they were last screened. They may also include in their reporting some diagnostic tests that are similar to or the same as the screening tests, such as colonoscopies that were ordered due to symptoms. Mortality data are restricted to NYC residents and deaths within city limits; this was done to avoid including deaths of people who traveled to the city for specialty cancer care but excludes deaths of NYC residents that occurred

elsewhere. Not all patients have stage-at-diagnosis data recorded. Neighborhood poverty does not necessarily correspond with individual residents' income; however, individual income data are not available for incidence and mortality. Incidence and mortality numbers by neighborhood were too small to allow comparisons by race and ethnicity for different neighborhood poverty levels.

Racial and ethnic identity is self-reported for the screening data, but for incidence and mortality, this information comes from medical records and death certificates, which may not always correctly reflect a person's

identity. It should also be noted that population-level data do not necessarily apply to any one individual. The broad racial and ethnic groups used here are composed of diverse subgroups which may have different patterns of screening, incidence, and mortality. More specific subgroups, as well as racial and ethnic groups that have smaller populations in NYC, such as Native Americans/Alaska Natives, are not separated out here because the analysis would not be statistically reliable. There is a need for future work to identify additional and more specific patterns.

Technical information

Geographic areas

Public Use Microdata Areas (PUMAs) are geographic areas defined by the Census Bureau.²⁶ They divide states or similar entities into areas with at least 100,000 people and usually no more than 200,000 people and may combine multiple census tracts. PUMAs do not necessarily represent areas with homogeneous populations by race/ethnicity, income, or any other measure beyond geographic location. However, they do provide a way to begin to explore geographic differences in screening, incidence and mortality rates. This then allows for new questions and a closer look at potential drivers of health inequities as well as potential solutions.

Data Sources

Community Health Survey (2023, 2024) (CHS) is conducted annually by the Health Department with about 9,000 - 10,000 non-institutionalized adults ages 18 and older. Estimates are age-adjusted to the U.S. 2000 standard population. Since 2021, the CHS has used a random sample of NYC mailing addresses, with mailings sent to households asking the adult with the most recent birthday to take the survey and most surveys are self-completed online. For more survey details, visit nyc.gov/health/survey.

The **New York State Cancer Registry** collects information including where in the body tumors are located, stage at diagnosis, and some additional details about tumor types and treatment, as well as sociodemographic information. Information comes primarily from hospitals where people with cancer are diagnosed or treated. Physicians, dentists, laboratories, and other health care providers are required by law to notify the New York State Department of Health about cancer cases.

New York City Vital Statistics data are compiled from death certificates issued in NYC. Cause of death is coded according to the International Classification of Diseases -10th Revision framework (ICD-10). The codes for underlying cause of death used for this document were: lung cancer (C34), colorectal cancer (C18, C19, & C20), prostate cancer (C61), breast cancer (C50), cervical cancer (C53).

Vital Statistics data are often reported as all deaths within New York City limits. However, NYC has several NCI-designated comprehensive cancer centers, which may attract patients from surrounding areas and even elsewhere in the country for treatment. For this report, analysis was restricted to city residents since the demographic make-up of non-resident patients may differ from that of NYC as a whole. Incidence and mortality data were age-adjusted to the U.S. 2000 standard population using five age groups: 0-24 years old, 25-44 years old, 45-64 years old, 65-84 years old and 85 years or older.

NYC DOHMH Population Estimates, modified from U.S. Census Bureau interpolated intercensal population estimates (2000 - 2021, updated September 2022), were used to calculate incidence and mortality rates.

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Appendix: <https://www.nyc.gov/assets/doh/downloads/pdf/episrv/cancer-inequities-epi-research-report-appendix-2026.xlsx>

²⁶ 2020 Public Use Microdata Areas (PUMAs). US Census Bureau. <https://www.census.gov/programs-surveys/geography/guidance/geo-areas/pumas.html>. Updated September 7, 2023. Accessed October 23, 2024.