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Re: Senate Bill 579 *Health Care Facilities -- Restrooms -- Requirements*

Position: **SUPPORT**

February 25, 2021

Honorable Chair Kelley, Vice-Chair Feldman, and Senate Finance Committee:

I write today in support of [SB579](#), which would require all public restrooms in hospitals, clinics, and other health care facilities to provide touchless options for receiving paper towels and exiting the restroom. This legislation will aid in disease prevention, which is incredibly important now-- almost a full year into the COVID-19 pandemic.

As an Emergency Department Nurse at Medstar Union Memorial Hospital in the City of Baltimore, I see a wide variety of patients come through the ER on any given shift. If a patient does not require a catheter, hand-held urinal, or bedside commode in their room, they must use the public restroom available in the Department. This means that any number of patients frequent this restroom each day, as well as any visitors that accompany them.

Union Memorial is a National Hand Trauma Center. Throughout a shift, many of these patients come in actively bleeding or covered in blood. Hand trauma likely will not prevent a patient from making their way to the restroom. Likewise, if a patient comes in with abdominal pain, though fairly debilitating, excessive vomiting also does not prevent an individual from using the public restroom. Even if that patient used the towels and sanitizers provided in their patient room, they may have other bacteria on their hands from holding the bucket or simply touching their own bodily fluids. As they touch common places within the restroom, they could be leaving behind a plethora of microorganisms for the next person to pick up.

After dealing with almost a full year of life-altering changes because of the Coronavirus pandemic, **everyone** is more cautious about their overall hygiene practices and where germs may be hiding on frequently touched surfaces. It is imperative that we take every step possible to improve public confidence in sanitization efforts. According to a recent study by the American Society of Clinical Oncology (attached), there was a 46.4% weekly decrease in diagnosis of new cancers during the pandemic. To the average person, this seems like fewer people have cancer. The reality is that individuals are too afraid of COVID to see their doctor and be diagnosed.

Since the COVID crisis began, our Emergency Department has seen a steep increase in congestive heart failure patients that waited until the last minute to seek help out of fear of going to the hospital. By the time they do arrive, their condition has declined past the point of a positive outcome. The patient may be in acute distress; need intubation or other more aggressive treatments; and require a prolonged hospital stay.

The only way to move forward is to take precautionary measures that will increase confidence in disease mitigation. By providing more hygienic, hands-free options in public health care restrooms, this legislation will ease the fears of all Marylanders.

I urge a favorable report on SB579.

Sincerely,

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Research Letter | Oncology

Changes in the Number of US Patients With Newly Identified Cancer Before and During the Coronavirus Disease 2019 (COVID-19) Pandemic

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Introduction

In response to the coronavirus disease (COVID-19) pandemic, the American Society of Clinical Oncology recommends, "to conserve health system resources and reduce patient contact with health care facilities,... that cancer screening procedures that require clinic/center visits, such as screening mammograms and colonoscopy, be postponed for the time being."¹ A *Washington Post* headline reported, "Patients with heart attacks, strokes, and even appendicitis vanish from hospitals."² A study from 9 high-volume US cardiac catheterization laboratories³ found a 38% decrease in patients treated for ST-elevation myocardial infarction, considered a life-threatening condition. In this study, we analyzed weekly changes in the number of patients with newly identified cancer before and during the COVID-19 pandemic.

Author affiliations and article information are listed at the end of this article.

Methods

This cross-sectional study included patients across the United States who received testing for any cause by Quest Diagnostics and whose ordering physicians assigned them *International Statistical Classification of Diseases and Related Health Problems, Tenth Revision (ICD-10)* codes associated with any of 6 cancer types (ie, breast, colorectal, lung, pancreatic, gastric, and esophageal) from January 1, 2018, to April 18, 2020. Each patient was counted once, at the first instance of each *ICD-10* code

Figure. Newly Identified Cancers, Baseline Mean and Weekly During the Coronavirus Disease 2019 Pandemic

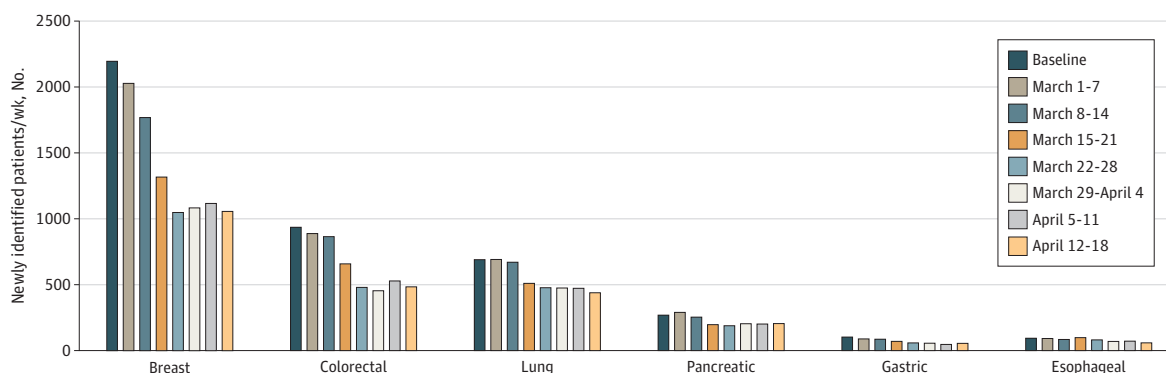


Table. Demographic Information for Patients With Newly Identified Cancer

Cancer type	January 6, 2019, to February 29, 2020			March 1 to April 18, 2020		
	Patients, No.	Women, No. (%)	Age, mean (SD), y	Patients, No.	Women, No. (%)	Age, mean (SD), y
Breast	132 513	132 513 (100)	64.3 (12.7)	9475	9475 (100)	63.0 (13.0)
Colorectal	56 744	28 056 (49.6)	66.7 (13.4)	4377	2109 (48.2)	65.4 (13.3)
Lung	41 671	22 332 (53.7)	70.1 (10.6)	3753	1960 (52.3)	69.3 (11.0)
Pancreatic	16 268	8083 (49.8)	67.6 (12.7)	1547	820 (53.0)	66.8 (12.8)
Gastric	5744	2454 (42.8)	67.4 (13.5)	471	180 (38.2)	66.7 (13.8)
Esophageal	5658	1354 (24.0)	68.4 (11.4)	557	142 (25.5)	69.5 (11.0)

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starting in January 2018. The weekly count was tracked starting with the first full calendar week of 2019 through April 18, 2020. This study followed the Strengthening the Reporting of Observational Studies in Epidemiology (STROBE) reporting guideline for cross-sectional studies. This study was deemed exempt by the Western Institutional Review Board in accordance with 45 CFR §160 and §164 because no study participant provided specimens or information not already existing as part of health care operations.

Mean (SD) weekly numbers of newly diagnosed patients (Poisson regression for count), along with mean ages (2-sided *t* test) and sex distributions (χ^2 test), were compared between baseline period (January 6, 2019, to February 29, 2020) and the COVID-19 period (March 1 to April 18, 2020) at a significance level of $P < .05$. Data analyses were performed using SAS Studio 3.6 on SAS version 9.4 (SAS Institute).

Results

This study included 278 778 patients, 258 598 (92.8%) from the baseline period and 20 180 (7.2%) from the COVID-19 period. Among all patients, 209 478 (75.1%) were women, and the mean (SD) age was 66.1 (12.7) years. During baseline, the mean (SD) weekly number of newly identified patients was 2208 (335) with breast cancer, 946 (134) with colorectal cancer, 695 (88) with lung cancer, 271 (39) with pancreatic cancer, 96 (14) with gastric cancer, and 94 (14) with esophageal cancer. During the pandemic, the weekly number fell 46.4% (from 4310 to 2310) for the 6 cancers combined, with significant declines in all cancer types, ranging from 24.7% for pancreatic cancer (from 271 to 204; $P = .01$) to 51.8% for breast cancer (from 2208 to 1064; $P < .001$) (Figure). The mean age of cancer patients in the COVID-19 period was within 1 year of that for patients in the baseline period; patients diagnosed with esophageal cancer in the COVID-19 period were slightly older than those diagnosed in the baseline period (mean [SD] age, 69.5 [11.0] years vs 68.4 [11.4] years; $P = .04$), but patients with all other cancers were younger (eg, breast cancer: mean [SD] age, 63.0 [13.0] years vs 64.3 [12.7] years; $P < .001$). Statistically, sex distribution in the 2 periods was the same in all cancers except for pancreatic, which had fewer women in the baseline group than the COVID-19 group (8083 of 16 248 [49.8%] vs 820 of 1546 [53.0%]; $P = .01$) (Table). The decrease had generally leveled beginning the week starting March 29, 2020 (Figure).

Discussion

Our prepandemic data represented a good share of the National Cancer Institute weekly incidence estimates of the 6 cancers, ranging from 16% (lung cancer) to 42% (breast cancer).⁴ A potential limitation of this study is that the association of delayed diagnoses of cancer with outcomes likely depends on the final stage of disease at diagnosis, relative to baseline, and associated treatment implications (curative vs palliative).

Our results indicate a significant decline in newly identified patients with 6 common types of cancer, mirroring findings from other countries.⁵ The Netherlands Cancer Registry has seen as much as a 40% decline in weekly cancer incidence, and the United Kingdom has experienced a 75% decline in referrals for suspected cancer since COVID-19 restrictions were implemented.⁵

While residents have taken to social distancing, cancer does not pause. The delay in diagnosis will likely lead to presentation at more advanced stages and poorer clinical outcomes. One study suggests a potential increase of 33 890 excessive cancer deaths in the United States.⁶ Our findings are consistent with previous research,^{1-3,5} and they call for urgent planning to address the consequences of delayed diagnoses. Planning may entail more robust digital technology to strengthen clinical telehealth offerings and other patient-clinician interactions, including self-service scheduling across specialties and well-designed collection processes.

ARTICLE INFORMATION

Accepted for Publication: July 8, 2020.

Published: August 4, 2020. doi:10.1001/jamanetworkopen.2020.17267

Correction: This article was corrected on September 10, 2020, to fix the percentage of patients included in the COVID-19 period and the number of women with pancreatic cancer in the baseline and COVID-19 periods, to correct errors in the date ranges that appear in the Figure legend, and to add a column for esophageal cancer in the Figure.

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Author Contributions: Dr Kaufman and Ms Chen had full access to all of the data in the study and take responsibility for the integrity of the data and the accuracy of the data analysis.

Concept and design: All authors.

Acquisition, analysis, or interpretation of data: Chen.

Drafting of the manuscript: Kaufman, Chen, Niles.

Critical revision of the manuscript for important intellectual content: All authors.

Statistical analysis: Chen, Niles.

Administrative, technical, or material support: Fesko.

Conflict of Interest Disclosures: Drs Kaufman and Fesko, Ms Chen, and Mr Niles reported being employed by and owning stock in Quest Diagnostics outside the submitted work.

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