TABLE 1

American Cancer Society Recommendations for the Early Detection of Cancer in Average-Risk Asymptomatic Adults*

Cancer type	Population	Test or procedure	Recommendation
Breast	Women, 40 to 54 years of age	Mammography	Women should undergo regular screening mammography starting at 45 years of age; women 45 to 54 years of age should be screened annually; women should have the opportunity to begin annual screening between 40 and 44 years of age
	Women, 55 years or older	Mammography	Women 55 years or older should transition to biennial screening or have the opportunity to continue screening annually; women should continue screening mammography as long as their overall health is good and they have a life expectancy of 10 years or more
Cervical	Women, 21 to 29 years of age	Pap test	Cervical cancer screening should begin at 21 years of age; for women 21 to 29 years of age, screening should be done every three years with conventional or liquid-based Pap tests
	Women, 30 to 65 years of age	Pap test and HPV DNA test	For women 30 to 65 years of age, screening should be done every five years with both the HPV test and the Pap test (preferred) or every three years with the Pap test alone (acceptable)
	Women, 66 years or older	Pap test and HPV DNA test	Women 66 years or older who have had three or more consecutive negative Pap tests or two or more consecutive negative HPV and Pap tests within the past 10 years, with the most recent test occurring in the previous five years, should stop cervical cancer screening
	Women who have had a total hysterectomy	Pap test and HPV DNA test	Women who have had a total hysterectomy should stop cervical cancer screening
Colorectal	Men and women, 50 years or older, for all tests listed	Guaiac-based FOBT with at least 50% sensitivity for cancer, or fecal immunochemical test with at least 50% sensitivity for cancer	Annual: Testing stool sampled from regular bowel movements with adherence to manufacturer's recommendation for collection techniques and number of samples is recommended; FOBT with the single stool sample collected on the clinician's fingertip during a digital rectal examination is not recommended; "throw in the toilet bowl" FOBTs also are not recommended; compared with guaiac-based tests for the detection of occult blood, immunochemical tests are more patient-friendly and are likely to be equal or better in sensitivity and specificity; there is no justification for repeating FOBT in response to an initial positive finding; patients should be referred for colonoscopy
		or	
		Multitarget stool DNA test†	Every three years, per manufacturer's recommendation
		or	
		Flexible sigmoidoscopy†	Every five years, flexible sigmoidoscopy can be performed alone, or consideration can be given to combining flexible sigmoidoscopy performed every five years with a highly sensitive FOBT or fecal immunochemical test performed annually
		or	
		Double-contrast barium enema†	Every five years
		or	
		Colonoscopy	Every 10 years
		or	
		CT colonography†	Every five years

continues

CT = computed tomography; FOBT = fecal occult blood test; HPV = human papillomavirus; Pap = Papanicolaou.

*—All individuals should become familiar with the potential benefits, limitations, and harms associated with cancer screening.
†—All positive test results must be followed up with colonoscopy.

TABLE 1 *(continued)*

American Cancer Society Recommendations for the Early Detection of Cancer in Average-Risk Asymptomatic Adults*

Cancer type	Population	Test or procedure	Recommendation
Endometrial	Women, at menopause	—	At the time of menopause, women should be informed about risks and symptoms of endometrial cancer and strongly encouraged to report any unexpected bleeding or spotting to their physicians
Lung	Current or former smokers 55 to 74 years of age in good health with at least a 30 pack-year history	Low-dose helical CT	Clinicians with access to high-volume, high-quality lung cancer screening and treatment centers should initiate a discussion about annual lung cancer screening with apparently healthy patients 55 to 74 years of age who have at least a 30 pack-year smoking history and who currently smoke or have quit within the past 15 years; a process of informed and shared decision making with a clinician related to the potential benefits, limitations, and harms associated with screening for lung cancer with low-dose CT should occur before any decision is made to initiate lung cancer screening; smoking-cessation counseling remains a high priority for clinical attention in discussions with current smokers, who should be informed of their continuing risk of lung cancer; screening should not be viewed as an alternative to smoking cessation
Prostate	Men, 50 years or older	Prostate-specific antigen test with or without digital rectal examination	Men who have at least a 10-year life expectancy should have an opportunity to make an informed decision with their clinician about whether to be screened for prostate cancer after receiving information about the potential benefits, risks, and uncertainties associated with prostate cancer screening; prostate cancer screening should not occur without an informed decision-making process

CT = computed tomography; FOBT = fecal occult blood test; HPV = human papillomavirus; Pap = Papanicolaou.

*—All individuals should become familiar with the potential benefits, limitations, and harms associated with cancer screening.
†—All positive test results must be followed up with colonoscopy.

Adapted with permission from Smith RA, Andrews KS, Brooks D, et al. Cancer screening in the United States, 2017: a review of current American Cancer Society guidelines and current issues in cancer screening. CA Cancer J Clin. *2017;67(2):103.*

2005 and 2015 as a result of the growing use of colonoscopy. Cervical cancer screening rates declined nearly 4% over the same period, and breast cancer screening rates have remained steady. Although rates of prostate cancer screening were stable between 2005 and 2010, there was an 18% decrease between 2010 and 2013, in addition to a decrease in the proportion of men who reported undergoing a routine prostate-specific antigen test in the previous year (from 38% in 2010 to 31% in 2013). Only 36% of men reported shared decision making for prostate cancer screening, and discussions often failed to fully address the risks and benefits. Because most available data on lung cancer screening were collected before organizations released their formal recommendations, more data are needed to determine the rates of lung cancer screening with low-dose computed tomography.

Guideline source: American Cancer Society

Evidence rating system used? No

Systematic literature search described? No

Guideline developed by participants without relevant financial ties to industry? No

Recommendations based on patient-oriented outcomes? Yes

Published source: *CA Cancer J Clin*. March/April 2017;67(2):100-121

Available at: http://onlinelibrary.wiley.com/doi/10.3322/caac.21392/abstract

Mara Lambert
AFP Senior Associate Editor ■