# Cancer Screening Recommendations

## Select Cancer Screening for Average-Risk Patients

The Vermont Department of Health recommends that health care providers have informed discussions with patients about preventive cancer screenings. The current U.S. Preventive Services Task Force (USPSTF) recommendations are highlighted because they are consensus guidelines. USPSTF is an independent group of national experts in prevention and evidence-based medicine: **www.uspreventiveservicestaskforce.org.**

### BREAST CANCER

| Organization | Screening Recommendations |
|---|---|
| **USPSTF** (2016) | Mammography every 2 years for women age 50–74. Women age 40—49 who place a higher value on potential benefits than potential harms of may choose to begin biennial mammography screening. Current evidence is insufficient to assess the benefits and harms of digital breast tomosynthesis (DBT) as a primary screening method or for adjunctive screening using ultrasonography, magnetic resonance imaging, DBT, or other methods in women identified to have dense breasts on an otherwise negative screening mammogram. |
| **ACS** (2015) | Mammography annually for women age 45-54. Mammography every two years for women 55+, with the choice to continue annual screening. Women should have the option to begin annual screening between ages 40-44. Screening should continue as long as a woman's health is good and she has a life expectancy of 10 years or longer. ACS does not recommend clinical breast examination (CBE) among average-risk women at any age. |
| **ACOG** (2011) | Mammography annually for women age 40+. CBE every 1 to 3 years for women age 20–39; yearly age 40+. Educate women age 20+ regarding breast self-awareness. |

### CERVICAL CANCER

| Organization | Screening Recommendations |
|---|---|
| **USPSTF** (2012) | Pap test every 3 years for women age 21–65 (no screening < age 21). Or, for women age 30–65, Pap with HPV test every 5 years. Discontinue testing > age 65 if normal Pap result and otherwise low risk; or for women with no cervix. |
| **ACS** (2014), **ASCCP, ASCP, ACOG** (2012) | Same as USPSTF recommendations. For women age 30-65, Pap test plus HPV every 5 years is the preferred schedule (Pap alone every three years is acceptable). |

### COLORECTAL CANCER

| Organization | Screening Recommendations |
|---|---|
| USPSTF (2016) | Screening for colorectal cancer for adults age 50-75. Multiple screening strategies are available to choose from: (a) Guaiac-based fecal occult blood test (gFOBT) or fecal immunochemical test (FIT) annually, (b) FIT-DNA test every 1 or 3 years, (c) Colonoscopy every 10 years, (d) CT colonography or flexible sigmoidoscopy every 5 years or (e) Flexible sigmoidoscopy every 10 years plus FIT every year. |
| **ACS** (2016) | Beginning at age 50, follow one of these schedules: (a) flexible sigmoidoscopy every 5 years, (b) colonoscopy every 10 years, (c) double-contrast barium enema every 5 years, (d) CT colonography every 5 years, (e) gFOBT/FIT annually, or (f) stool DNA test every 3 years. |
| **ACG** (2009) | Colonoscopy every 10 years, beginning at age 50 is preferred. Alternative tests: flexible sigmoidoscopy every 5–10 years, or CT colonography every 5 years, or FIT test annually. |

The Vermont Department of Health guides the work of cancer prevention and control with the Vermont State Cancer Plan, a 5-year strategic plan to reduce the impact of cancer on Vermonters.

For more information, contact the Vermont Department of Health Comprehensive Cancer Control Program:

**Phone (toll-free in VT):** 866-331-5622

**Website:** HealthVermont.gov/cancer

VERMONT DEPARTMENT OF HEALTH

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# Select Cancer Screening for Average-Risk* Patients

## PROSTATE CANCER

| Organization | Screening Recommendations |
|---|---|
| **USPSTF** (2012) | Recommends against PSA-based screening for prostate cancer. |
| **ACS** (2014) | Recommends informed decision-making with doctor (starting at age 50) about whether to be tested for prostate cancer. African American men, or those with a father or brother with prostate cancer < age 65 should start discussion at age 45. |
| **NCCN** (2014) | Specifically focused on men opting to participate in an early detection program starting at age 45 after receiving the appropriate counseling on the pros and cons. Guidelines focus on active surveillance to address overdiagnosis. Scheduling of follow-up and testing depend on age, level of risk, and life expectancy. |
| **AUA** (2013) | Recommends against routine PSA screening in men under age 55 and those over 70 that have less than a 10 to 15 year life expectancy. Recommends shared decision-making for men age 55 to 69 years considering PSA screening, and proceeding based on a man's values and preferences. |

## LUNG CANCER

| Organization | Screening Recommendations |
|---|---|
| **USPSTF** (2013) | Annual low-dose computed tomography (LDCT) of adults age 55–80 who have a 30 pack-year smoking history and currently smoke or have quit within the past 15 years. |
| **ASCO, ACCP** (2012)<br>**ALA** (2013)<br>**ACS** (2014) | Similar to USPSTF recommendations, for age range 55-74. ACS and ALA emphasize that doctors should discuss the screening with patients to allow for informed decision-making of the risks and benefits of screening. A focus on the continuing risk of lung cancer and the importance of smoking cessation should be a high priority in screening discussions with current smokers. |

## SKIN CANCER

| Organization | Screening Recommendations |
|---|---|
| **USPSTF**<br>(Screening 2016)<br>(Counseling 2012) | Insufficient evidence to recommend for or against routine screening (whole body skin examination by a clinician) for average risk adults. Recommends sun safety counseling for individuals age 10–24 with fair skin. |
| **ACS** (2013) | Recommends skin check by doctor as part of a routine periodic health exam (no frequency specified). |

*This table is not inclusive of all cancer screening recommendations (by cancer type or organization). Other organizations that promote cancer screening guidelines include (but are not limited to) the National Cancer Institute, the American Academy of Family Physicians, and the American Medical Association.*

* These guidelines are for individuals at average-risk for select cancers. An individual's risk for cancer is based on two major categories: familial or genetic risk and environmental factors that may be causally related to cancer such as smoking, obesity, diet and physical activity. Two tools for counseling patients on individual risk and helping plan the type and frequency of screening procedures are listed below.

- The National Cancer Institute (NCI) breast cancer, colorectal cancer and melanoma risk assessment tools are designed for use by health providers with their patients. The tools and other information related to overall cancer risk assessment can be found at http://www.cancer.gov/.
- The Agency for Healthcare Research and Quality (AHRQ) Electronic Preventive Services Selector (ePSS) is a hands-on downloadable tool based on current USPSTF recommendations that is designed to help providers offer appropriate screening, counseling, and preventive medication services for their patients. The tool can be found at http://epss.ahrq.gov/.

***Acronyms:***

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| *ACCP:* | *American College of Chest Physicians* |
| *ACG:* | *American College of Gastroenterology* |
| *ACOG:* | *American College of Obstetricians & Gynecologists* |
| *ACS:* | *American Cancer Society* |
| *ALA:* | *American Lung Association* |
| *ASCCP:* | *American Society for Colposcopy & Cervical Pathology* |
| *ASCO:* | *American Society of Clinical Oncology* |
| *ASCP:* | *American Society for Clinical Pathology* |
| *AUA:* | *American Urological Association* |
| *NCCN:* | *National Comprehensive Cancer Network* |
| *USPSTF :* | *United States Preventive Services Task Force* |



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