History of ACS Recommendations for the Early Detection of Cancer in People Without Symptoms

The following tables give the history of cancer detection tests that have been recommended by the American Cancer Society for people who are at *average* risk for cancer (unless otherwise specified) and do not have any specific symptoms. These recommendations have changed over time as new tests have become available and as more evidence for or against the value of some of these tests has emerged.

People who are at *increased* risk for certain cancers may need to follow a different testing schedule, such as starting at an earlier age or being tested more often. Those with symptoms that could be related to cancer should see their doctor right away.

This is not meant to be an official document for American Cancer Society recommendations.

Breast cancer

Dates	***Test***	***Age***	***Frequency***
Pre 1980	Breast self-exam (BSE)	Start during high school years	Monthly
	Clinical breast exam	20 and over	"Periodically"

	(CBE)		
	Mammogram (starting in 1976)	35 - 39	Only if personal history of breast cancer
		40 - 49	May have mammogram if they or their mother or sisters had breas cancer
		50 and over	May have mammograms yearly
1980 - 1982	Breast self-exam (BSE)	Start during high school years	Monthly
	Clinical breast exam (CBE)	20 - 39	Every 3 years
		40 and over	Yearly
	Mammogram	35 - 39	Baseline mammogram
		40 - 49	Consult personal physician
		50 and over	Yearly
1983 - 1991	Breast self-exam (BSE)	20 and over	Monthly
	Clinical breast exam (CBE)	20 - 39	Every 3 years
		40 and over	Yearly
	Mammogram	35 - 39	Baseline mammogram
		40 - 49	Every 1-2 years
		50 and over	Yearly

1992 - March 1997	Breast self-exam (BSE)	20 and over	Monthly
	Clinical breast exam (CBE)	20 - 39	Every 3 years
		40 and over	Yearly
	Mammogram	40 - 49	Every 1-2 years
		50 and over	Yearly
March 1997 - May 2003	Breast self-exam (BSE)	20 and over	Monthly
	Clinical breast exam (CBE)	20 - 39	Every 3 years
		40 and over	Yearly
	Mammogram	40 and over	Yearly
May 2003 - October 2015*,**	Breast self-exam (BSE)	20 and over	Optional. Women should be told about benefits and limitations of BSE. They should report any new symptoms to their health care professional.
	Clinical breast exam (CBE)	20 - 39	Part of a periodic health exam, preferably every 3 years
		40 and over	Part of a periodic health exam, preferably every year
	Mammogram	40 and over	Yearly, continuing for as long as a woman is in good health
October 2015 - present**,***	Mammogram	40 - 44	Women in this age group should have the choice to start annual screening with mammograms if they wish to do so. The risks of screening as well as the potential benefits should be considered.
		45 - 54	Yearly
		55 and	Every 2 years; women should also have the chance to continue

		over	yearly screening if they choose to. Screening mammograms shou continue as long as a woman is in good health and is expected to live at least 10 more years.

**May 2003 - May 2007: Women at increased risk (family history, genetic tendency, past breast cancer) should talk with their doctors about the benefits and limitations of starting mammography screening earlier, having additional tests (breast ultrasound, MRI), or having more frequent exams.*

***May 2007 - Present: Women at high risk based on certain factors should get an MRI and a mammogram every year. This includes women with about a 20% or greater risk using risk assessment tools based mainly on family history, women who had radiation therapy to the chest when they were between the ages of 10 and 30 years, and women who either have or who are at high risk for mutations in certain genes that greatly increase their breast cancer risk.*

**** All women should be familiar with the known benefits, limitations, and potential harms associated with breast cancer screening.*

Cervical cancer

Dates	***Test***	***Age***	***Frequency***
Pre 1980	Pap test	Not specified	As part of a regular check-up
1980 - 1987	Pap test	20 and over; under 20 if sexually active	Yearly, but after 2 negative exams 1 year apart, at least every 3 years
	Pelvic exam	20 – 39	Every 3 years
		40 and over	Yearly
1987 - 2002	Pap test	18 & over or sexually active	Yearly, but after 3 consecutive normal exams, less frequ at the discretion of the doctor
	Pelvic exam	18 & over or sexually active	Yearly
2003 - 2012	Pap test	Start 3 years after first vaginal intercourse but no later than 21	Yearly with conventional Pap test or every 2 years with based Pap test

		30 and over	After 3 normal results in a row, screening can be every years. An alternative is a Pap test plus HPV DNA testing every 3 years.*
		70 and over	After 3 normal Pap tests in a row within the past 10 yea women may choose to stop screening**
	Pelvic exam	Not specified	Discuss with health care provider
2012 - 2020[1]	Pap test	21 - 29	Every 3 years*
	Pap test plus HPV DNA test	30 - 65	Every 5 years* An alternative is screening with a Pap test alone every 3 years*
		Over 65	A woman should stop screening unless she had a serio cervical pre-cancer or cancer in the last 20 years
2020 - present[2]	Primary HPV test-(preferred)	25 - 65	Every 5 years* Alternatives include: A Co-test (Pap test plus HPV test) every 5 years* OR A Pap test alone every 3 years*
		Over 65	Screening should stop if regular screening tests have be normal the past 10 years and there is no history of serio cervical pre-cancer or cancer in the last 25 years.

**Doctors may suggest a woman be screened more often if she has certain risk factors, such as a history of DES exposure, HIV infection, or a weak immune system*

***Women with a history of cervical cancer, DES (diethylstilbestrol) exposure, or who have a weak immune system should continue screening as long as they are in reasonably good health*

[1] *These guidelines are not meant to apply to women who have been diagnosed with cervical cancer. These women should have follow-up testing as recommended by their healthcare team.*

[2]. *These guidelines are not meant to apply to women who have been diagnosed with*

cervical cancer or pre-cancer. These women should have follow-up testing as recommended by their healthcare team.

Colon and rectum (colorectal) cancer

Dates	***Test***	***Age***	***Frequency***
Pre 1980	Proctosigmoidoscopy	40 and over	As part of a regular check-up
1980 - 1989	Digital rectal exam (DRE)	40 and over	Yearly
	Fecal occult blood test (FOBT)	50 and over	Yearly
	Proctosigmoidoscopy	50 and over	After 2 normal exams 1 year apart, every 3 to 5 years
1989 - 1997	Digital rectal exam (DRE)	40 and over	Yearly
	Fecal occult blood test (FOBT)	50 and over	Yearly
	Sigmoidoscopy (preferably flexible)	50 and over	Every 3 to 5 years, based on advice of physician
1997 - 2001	Follow 1 of these 3 schedules*:		
	Fecal occult blood test AND Flexible sigmoidoscopy	50 and over	Yearly Every 5 years
	Colonoscopy	50 and over	Every 10 years
	Double-contrast barium enema (DCBE)	50 and over	Every 5 to 10 years
2001 - March 2008	Follow 1 of these 5 schedules*:		
	Fecal occult blood test (FOBT)** or Fecal immunochemical test[1] (FIT)***	50 and over	Yearly

	Flexible sigmoidoscopy***	50 and over	Every 5 years
	FOBT** or FIT[1] AND Flexible sigmoidoscopy***	50 and over	Yearly Every 5 years
	Colonoscopy	50 and over	Every 10 years
	Double-contrast barium enema (DCBE)	50 and over	Every 5 years
March 2008 – May 2018	Follow one of these schedules[2]:		
	Flexible sigmoidoscopy[3]	50 and over	Every 5 years
	Colonoscopy	50 and over	Every 10 years
	Double-contrast barium enema (DCBE)[3]	50 and over	Every 5 years
	CT colonography (virtual colonoscopy)[3]	50 and over	Every 5 years
	Guaiac-based fecal occult blood test (FOBT)**,[3]	50 and over	Yearly
	Fecal immunochemical test (FIT)**,[3]	50 and over	Yearly
	Stool DNA test[3]	50 and over	Every 3 years[4]
June 2018 - present	Get screened regularly between ages 45 and 75, as long as you are in good health. People ages 76 to 85 should talk with their health care provider about whether to continue screening. People over 85 should no longer be screened. Screening can be done with any of these tests/schedules:		
	Fecal immunochemical test (FIT)**,[3]	See above	Yearly
	Guaiac-based fecal occult blood test (gFOBT)**,[3]	See above	Yearly
	Stool DNA test[3]	See above	Every 3 years

	Colonoscopy	See above	Every 10 years
	CT colonography (virtual colonoscopy)[3]	See above	Every 5 years
	Flexible sigmoidoscopy[3]	See above	Every 5 years

**A digital rectal exam should be done at the same time as sigmoidoscopy, colonoscopy, or DCBE. **For FOBT or FIT, highly-sensitive versions of the tests should be used with the take-home multiple sample method. A FOBT or FIT done during a digital rectal exam in the doctor's office is not adequate for screening. ***Yearly FOBT or FIT plus flexible sigmoidoscopy every 5 years is preferred over either option alone. [1] The fecal immunochemical test (FIT) was adopted as part of the ACS guidelines in 2003. [2] The first 4 tests (flexible sigmoidoscopy, colonoscopy, DCBE, and CT colonography) are designed to find both early cancer and polyps. The last 3 tests (FOBT, FIT, and Stool DNA test) will primarily find cancer and not polyps. The first 4 tests are preferred if they are available to you and you are willing to have one of these more invasive tests. [3] If test results are positive (abnormal), colonoscopy should be done. [4] The 3-year interval was specified in 2014. When the guidelines were published in 2008, the interval was not specified.*

Endometrial cancer -- see also cervical cancer

Dates	***Test***	***Age/Risk***	***Frequency***
Pre 1980	Pap test	Not specified	As part of a regular check-up
	Pelvic exam	At menopause	Not specified
	Endometrial tissue sample	At menopause (only in those at high risk*)	Not specified
1980 - 1987	Pap test	20 and over; under 20 if sexually active	Yearly, but after 2 negative exams 1 year apart, at least every 3 years

	Pelvic exam	40 and over	Yearly
	Endometrial tissue sample	At menopause (only in those at high risk*)	Not specified
1987 - 1992	(Pap test recommendations were separated out as screening for cervical cancer - see above.		
	Pelvic exam	40 and over	Yearly
	Endometrial tissue sample	At menopause (only in those at high risk*)	Not specified
1992 - 2001	Pelvic exam	40 and over	Yearly
	Endometrial tissue sample	At menopause (only in those at high risk*)	At the discretion of the physician
2001 - present		At menopause (average risk)	Women should be informed about the risks and symptoms of endometrial cancer, and strongly encouraged to report any unexpected bleeding or spotting to their doctor
		At menopause (increased risk**)	Women should be informed about the risks and symptoms of endometrial cancer, and strongly encouraged to report any unexpected bleeding or spotting to their doctor. They should also be informed about the potential benefits, risks, and limitations of early endometrial cancer detection.
	Endometrial biopsy	35 and over	Should be offered yearly. Women should also be informed about the risks and symptoms of endometrial cancer, and about the potential benefits, risks, and limitations of early endometrial cancer detection

		(high risk***)	

High risk was defined as having a history of infertility, obesity, failure of ovulation, abnormal uterine bleeding, or use of estrogen therapy or tamoxifen.

**Increased risk was defined as a history of estrogen therapy or tamoxifen, late menopause, having no children, infertility or failure to ovulate, obesity, diabetes, or high blood pressure.*

***High risk was defined as women with or at risk for hereditary non-polyposis colorectal cancer (HNPCC) due to a known or suspected gene mutation.*

Lung cancer

Dates	***Test***	***Age***	***Frequency***
Pre 1980	Chest x-ray	Not specified	Supported use of chest x-ray for those in whom lung cancer is most often found (heavy smokers, asbestos workers, etc.)
1980 - 2013	None	Not specified	No recommendation
2013 - May 2018	Low-dose CT of the chest	55 to 74 years (in certain individuals)	Doctors should discuss the benefits, limitations, and potential harms of lung cancer screening with patients who are in fairly good health*, in the correct age range, have at least a 30 pack-year history of smoking**, and are still smoking or have quit within the last 15 years. If patients decide to go forward with screening, they should have low-dose CT of the chest yearly through age 74 as long as they remain in good health.
June 2018 - August 2021	Low-dose CT of the chest	55 to 74 years (in certain individuals)	The ACS recommends annual screening in adults ages 55 to 74 years in fairly good health* who: currently smoke or have quit within the past 15 years; have at least a 30-pack-year smoking history**; get counseling about quitting smoking (for current smokers); have discussed with their doctor the potential benefits, limits, and harms of screening; and have access to a center experienced in lung cancer screening and treatment.
August 2021 - present	Low-dose CT of the chest	50 to 80 years (in certain	The most recent version of the ACS lung cancer screening guideline [from 2018] is being taken down while we review new scientific evidence to be included in the next update. While this important

		individuals	update is being completed, the ACS advises that clinicians, and individuals at risk for lung cancer, follow the recently updated recommendations for annual lung cancer screening from the U.S. Preventive Services Task Force (USPSTF), the American Academy of Family Physicians (AAFP), or the American College of Chest Physicians.

**Fairly good health was defined as not requiring home oxygen therapy, having other serious medical problems that would shorten their lives or keep them from having surgery, and having metal implants in the chest (such as pacemakers or spinal rods) that would interfere with the CT images.*

***Pack-years is the number of packs of cigarettes smoked per day multiplied by the number of years smoked. Someone who smoked a pack of cigarettes per day for 30 years has a 30 pack-year smoking history, as does someone who smoked 2 packs a day for 15 years.*

*+**NOTE**: This represents a language clarification, not a change in the guidelines, as the previous language was often misinterpreted.*

Prostate cancer

Dates	***Test***	***Age/Risk***	***Frequency***
1980 - 1992	No specific recommendation	(see “Cancer-related check-up (men & women)” table)	Part of the cancer-related check-up
1992 - 1997	Digital rectal exam (DRE)	40 and over	Yearly
	Prostate-specific antigen (PSA) blood test	50 and over	Yearly
1997 - 2000	Digital rectal exam (DRE) and prostate-specific antigen (PSA) blood test	50 and over (Earlier, i.e. 45, for men at high risk*)	Should be offered yearly (along with information on potential risks & benefits) men with at least a 10-ye life expectancy
2001 - 2008	Digital rectal exam (DRE) and prostate-specific antigen (PSA) blood test	50 and over (average risk)	Should be offered yearly (along with information on potential risks & benefits)

			men with at least a 10-ye life expectancy
		45 and over (high risk**)	Yearly (along with information on potential risks & benefits)***
2009 - 2010+	Health care professionals should discuss the potential benefits and limitations of prostate cancer early detection testing and offer the prostate-specific antigen (PSA) blood test and digital rectal exam (DRE). If, after this discussion, a man asks his health care professional to make the decision for him, he should be tested (unless there is a specific reason not to test).	50 and over (average risk) 45 and over (high risk**)	Discussion and offer of testing should be done yearly for men with at lea a 10-year life expectancy Discussion and offer of testing should be done yearly***
2010 - present	Men should have a chance to make an informed decision with their health care provider about whether to be screened for prostate cancer. The decision should be made after getting information about the uncertainties, risks, and potential benefits of prostate cancer screening. Men should not be screened unless they have received this information. After the discussion about screening, those men who want to be screened should be tested with the prostate specific antigen (PSA) blood test. The digital rectal exam (DRE) may also be done as a part of screening.	50 and over (average risk)	Discussion at age 50 for men with at least a 10-ye life expectancy and then periodically. If PSA is 2.5 ng/ml or greater, testing should be repeated yearl Men with a PSA of less th 2.5 ng/ml may be tested every other year.
		45 and over (high risk**)	Discussion at age 45 for men with at least a 10-ye life expectancy and then periodically. If PSA is 2.5 ng/ml or greater, testing should be repeated yearl Men with a PSA of less th 2.5 ng/ml may be tested every other year.****

**High risk defined as African American men or those with a strong family history - that is, those with 2 or more affected first-degree relatives (father, brothers).*

***High risk defined as African American men or those with a strong family history of 1 or more first-degree relatives (father, brother, son) diagnosed at an early age (younger than 65).*

****Men at even higher risk, due to several close relatives affected at an early age,*

should have this discussion with their health care professional at age 40. Depending on the results of this initial test, no further testing might be needed until age 45.

***** Men at even higher risk, due to several close relatives affected at an early age, should have this discussion with their health care professional at age 40. If PSA is 2.5 ng/ml or greater, testing should be repeated yearly. Men with a PSA of less than 2.5 ng/ml may be tested every other year.*

*+**NOTE**: This represents a language clarification, not a change in the guidelines, as the previous language was often misinterpreted.*

Cancer-related check-up

Dates	***Test***	***Age***	***Frequency***
Pre 1980	Physical exam	Not specified	"Regularly"
1980 - 2002	Physical exam* and health counseling	20-39	Every 3 years
		40 and over	Yearly
2003 - 2015	Physical exam** and health counseling***	20 and over	On the occasion of a periodic he exam

**Should include examinations for cancers of the thyroid, testicles, mouth, ovaries, skin, prostate, and lymph nodes.*

*** Should include examinations for cancers of the thyroid, testicles, mouth, ovaries, skin, and lymph nodes.*

****Should include counseling about tobacco, sun exposure, diet and nutrition, risk factors, sexual practices, and environmental and occupational exposures.*

Last Revised: August 27, 2021

Written by

The American Cancer Society medical and editorial content team (www.cancer.org/cancer/acs-medical-content-and-news-staff.html)

Our team is made up of doctors and oncology certified nurses with deep knowledge of cancer care as well as journalists, editors, and translators with extensive experience in medical writing.

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