Summary of Cancer Expert Working Group on Cancer Prevention and Screening (CEWG) Recommendations on Cancer Screening

<table>
<tr><th>Cancer Type</th><th>Population</th><th colspan="2">For Asymptomatic Population at Average risk</th><th>For Asymptomatic Persons at Increased Risk</th></tr>
<tr><td rowspan="4">1. Cervical cancer</td><td rowspan="4">Women</td><td colspan="2">1. Women aged 25-64 who ever had sex should have regular cervical screening.</td><td rowspan="4">6. Women aged 21 to 24 who ever had sexual experience and with risk factors for HPV infection or cervical cancer are considered at increased risk. They should receive screening based on the doctor’s assessment and recommendations.

7. Other women at high risk of developing cervical cancer may require more frequent screenings based on the doctor’s assessment.</td></tr>
<tr><td>25 to 29 years of age</td><td>2. Screening by cytology every 3 years after two consecutive normal annual screenings</td></tr>
<tr><td>30 to 64 years of age</td><td>3. Screening by:
(a) cytology every 3 years after two consecutive normal annual screenings; or
(b) human papillomavirus (HPV) testing every 5 years; or
(c) co-testing (cytology and HPV testing) every 5 years.</td></tr>
<tr><td>65 years of age or above</td><td>4. May discontinue screening if routine screenings within 10 years are normal.

5. Should be screened if they have never had cervical screening</td></tr>
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Cancer Type	Population	For Asymptomatic Population at Average risk	For Asymptomatic Persons at Increased Risk
2. Colorectal cancer	Men and Women	1. Individuals aged 50 to 75 years should consider screening by: (a) annual or biennial faecal occult blood test (FOBT); or (b) sigmoidoscopy every 5 years; or (c) colonoscopy every 10 years	2. For carriers of mutated gene of Lynch Syndrome, it is recommended to screen by colonoscopy every 1-2 years from age 25 onwards. 3. For carriers of mutated gene of familial adenomatous polyposis (FAP), it is recommended to screen by sigmoidoscopy every 2 years from age 12. 4. For individuals with one first-degree relative diagnosed with colorectal cancer at or below 60 years of age, or more than one first-degree relatives with colorectal cancer irrespective of age at diagnosis, and without hereditary bowel syndromes, screening by colonoscopy every 5 years beginning at the age of 40 or 10 years prior to the age at diagnosis of the youngest affected relative, but not earlier than 12 years of age is recommended. As an alternative, the individuals at increased risk may consider Faecal Immunochemical Test (FIT) every 1 or 2 years after understanding the pros and cons of FIT as compared with colonoscopy.

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<tr><td>3. Breast cancer</td><td>Women</td><td colspan="2">1. Breast self-examination is not recommended as a screening tool for breast cancer for asymptomatic women. Women are recommended to be breast aware (be familiar with the normal look and feel of their breasts) and seek medical attention promptly if suspicious symptoms arise.
2. There is insufficient evidence to recommend clinical breast examination or ultrasonography as a screening tool for breast cancer for asymptomatic women.
3. It is recommended that risk-based approach should be adopted for breast cancer screening.</td></tr>
<tr><td></td><td></td><td>4. Women aged 44-69 with certain combinations of personalised risk factors* are recommended to use the online breast cancer risk assessment tool (www.cancer.gov.hk/bctool) for estimating the risk of developing breast cancer. Those assessed to be at increased risk of breast cancer are recommended to consider mammography screening every 2 years.

5. Magnetic resonance imaging (“MRI”) is not recommended for breast cancer screening in women at general population.

* including presence of history of breast cancer among first-degree relative, a prior diagnosis of benign breast disease, nulliparity and late age of first live birth, early age of menarche, high body mass index and physical inactivity</td><td>6. Women at moderate risk (i.e. family history of only one first-degree female relative with breast cancer diagnosed at ≤50 years of age; or two first-degree female relatives diagnosed with breast cancer after the age of 50 years) are recommended to have mammography every 2 years. MRI is not recommended for breast cancer screening in women at moderate risk.

7. Women at high risk (e.g. confirmed carriers of BRCA1/2 deleterious mutations, strong family history of breast or ovarian cancer, etc.) should seek advice from doctors; and

(a) have mammography screening every year;
(b) begin screening at age 35 or 10 years prior to the age at diagnosis of the youngest affected relative (for those with family history), whichever is earlier, but not earlier than age 30.
(c) for confirmed carriers of BRCA1/2 deleterious mutations or women who had radiation therapy to chest for treatment between age 10 and 30 years (e.g. for Hodgkin’s disease), consider additional annual screening by MRI.</td></tr>
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Cancer Type	Population	For Asymptomatic Population at Average risk	For Asymptomatic Persons at Increased Risk
4. Lung cancer	Men and Women	1. Primary prevention is the most important strategy for reducing the risk of developing lung cancer. Current smokers should quit smoking and non-smokers should never start smoking.	
		2. Routine screening for lung cancer (including chest X-ray, sputum cytology, or low-dose computed tomography (LDCT)) is not recommended for asymptomatic persons at average risk.	3. There is currently insufficient data to assess the benefit vs harm and cost-effectiveness of LDCT screening and its associated criteria such as target groups and optimal screening protocol in the local setting. Based on overseas literature, asymptomatic persons with heavy smoking history (i.e., more than 20-30 pack-year* and who either currently smoke or have quit for not more than 10-15 years) that put them at increased risk of lung cancer may benefit from LDCT screening. In the majority of overseas recommendations, the usual starting and finishing age for screening is 50-55 years and 74-80 years respectively, and screening is most commonly performed annually or biennially. Since the local applicability of these criteria has not been sufficiently characterised, persons with heavy smoking history are advised to discuss with their doctors the benefits and harms (including false-positive findings and potential follow up investigations) of LDCT screening before making an informed and individualised decision. 4. Screening for lung cancer with chest X-ray or sputum cytology is not recommended. * pack-year = multiply number of packs of cigarettes per day by number of years smoked

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5. Prostate cancer	Men	1. There is insufficient scientific evidence to recommend for or against population-based prostate cancer screening in asymptomatic men by Prostate-Specific Antigen ("PSA") and/or Digital Rectal Examination ("DRE"). 2. For asymptomatic men considering prostate cancer screening, CEWG encourages them to discuss with their doctor about individual circumstances and make informed decision on whether or not to go for prostate cancer screening.	3. Men at increased risk, namely African American men or those with one or more first-degree relatives diagnosed with prostate cancer before age 65, should consider seeking advice from doctors regarding the need for and approach of screening. While the screening blood test to be considered is PSA, the DRE may also be done as part of screening. The PSA screening should start at an age not earlier than 45 until age 70, and the interval should not be more frequent than once every 2 years.
6. Liver cancer	Men and Women	1. Routine screening with alpha-fetoprotein ("AFP") or ultrasonography ("USG") for asymptomatic persons at average risk is not recommended.	2. People with chronic hepatitis B virus ("HBV") or hepatitis C virus ("HCV") infection, or liver cirrhosis regardless of the cause are at increased risk of hepatocellular carcinoma ("HCC"). Depending on certain criteria such as age, family history, presence of cirrhosis and other clinical parameters, some subgroups are at higher risk and should consider receiving periodic surveillance (e.g. every 6-12 months) with AFP and USG. People with chronic HBV or HCV infection, or liver cirrhosis should thus seek advice from doctors to determine their need for and approach of cancer surveillance.
7. Naso-pharyngeal cancer	Men and Women	1. There is insufficient evidence to recommend a population-based nasopharyngeal cancer ("NPC") screening programme for asymptomatic people using IgA against specific Epstein-Barr virus ("EBV") viral antigens and EBV DNA test.	2. Family members of NPC patients may consider seeking advice from doctors before making an informed decision about screening.

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8. Thyroid cancer	Men and Women	1. Screening for thyroid cancer is not recommended in asymptomatic persons at average risk.	2. Persons at increased risk, including those with a history of head or neck irradiation in infancy or childhood, familial thyroid cancer or family history of multiple endocrine neoplasia type 2 ("MEN2"), should consider seeking advice from doctors regarding the need for and approach of screening.
9. Ovarian cancer	Women	1. Screening for ovarian cancer is not recommended in asymptomatic women at average risk.	2. Women at increased risk, such as with strong family history of ovarian/breast cancer or inherited deleterious gene mutations (e.g. *BRCA1/2*, Lynch syndrome), should consider seeking advice from doctors for assessment of their ovarian cancer risk and the need for and approach of screening.
10. Pancreatic cancer	Men and Women	1. Screening for pancreatic cancer (including screening by serum biomarker CA19-9) is not recommended in asymptomatic persons at average risk.	2. There is currently insufficient evidence to recommend screening of pancreatic cancer for persons at increased risk by any standardised protocol. Persons with strong family history of pancreatic cancer, specific genetic syndromes, or carrying genetic susceptibility traits that put them at significantly increased risk of pancreatic cancer may consider seeking advice from doctors for individual assessment.

Important note: The relevant benefits and risks should always be discussed with your healthcare provider before undergoing cancer screening.

For the complete recommendations, please visit www.chp.gov.hk/en/static/100854.html.

Centre for Health Protection
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