Annex 3

Current Recommendations from Cancer Expert Working Group on Cancer Prevention and Screening on Screening for Nine Selected Cancers

Cancer	For asymptomatic population at average risk	For persons at increased risk
A. Colorectal cancer	1. Individuals aged 50 to 75 years should consider screening by one of the screening methods including: (a) annual or biennial faecal occult blood test; or (b) sigmoidoscopy every five years; or (c) colonoscopy every ten years.	2. For carriers of mutated gene of Lynch Syndrome, it is recommended that screening for colorectal cancer by colonoscopy every one to two years from age 25 onwards. 3. For carriers of mutated gene of familial adenomatous polyposis, it is recommended screening by sigmoidoscopy every two 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, colonoscopy should be performed every five years beginning at the age of 40 or ten years prior to the age at diagnosis of the youngest affected relative, but not earlier than 12 years of age. * Recommendation on genetic testing for colorectal cancer: For colorectal cancer patients with identifiable genetic mutations, two-tier screening by genetic testing followed by endoscopic examination can be offered to their family members to reduce the number of unnecessary investigations, as well as to reduce the risk of potential complications.
B. Lung cancer	For general or high risk populations: 1. Routine screening for lung cancer with chest X-ray or sputum cytology is not recommended. 2. There is insufficient evidence to recommend for or against lung cancer screening by low dose computed tomography in asymptomatic persons or for mass screening.	

Cancer	For asymptomatic population at average risk	For persons at increased risk
C. Breast cancer	1. There is insufficient evidence to recommend for or against population-based mammography screening for asymptomatic women at average risk in Hong Kong. 2. There is insufficient evidence to recommend regular breast self-examination as a screening tool. Women are advised to be breast aware (be familiar with the normal look and feel of their breasts) and visit doctors promptly if suspicious symptoms appear. 3. There is insufficient evidence to recommend clinical breast examination. 4. Individuals considering breast cancer screening should be adequately informed by doctors about the benefits and harms.	5. 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) should discuss with their doctors the pros and cons of breast cancer screening before deciding whether to start screening by mammography every two to three years. 6. Women at **high risk** (e.g. confirmed carriers of *BRCA1* or *BRCA2* deleterious mutations, family of breast or ovarian cancer) should seek advice from doctors; and (a) have mammography screening every year; (b) begin screening at age 35 or ten 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; and (c) for confirmed carriers of *BRCA1* or *BRCA2* deleterious mutations or women who had radiation therapy to chest for treatment between age ten and 30 years, consider additional annual screening by Magnetic Resonance Imaging.

Cancer	For asymptomatic population at average risk	For persons at increased risk
D. Prostate cancer	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, the 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, including 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 two years.
E. Liver cancer	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 cirrhosis regardless of 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 six to12 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.

Cancer	For asymptomatic population at average risk	For persons at increased risk
F. Cervical cancer	1. Women aged 25 to 64 who ever had sexual experience are recommended to have cervical cancer screening by cytology every three years after two consecutive normal annual smears. 2. Screening may be discontinued in women aged 65 or above if three previous consecutive smears within ten years are normal. 3. Women at or above 65 years of age who have never had a cervical smear should have the test.	4. Women aged 21 to 24 who ever had sexual experience and with risk factors for human papillomavirus acquisition/ persistence or cervical cancer (e.g. early first sexual intercourse, multiple sexual partners, tobacco use) are considered at increased risk. They may be screened by cytology every three years after two consecutive normal annual smears, depending on doctor's assessment. 5. Other women at high risk of developing cervical cancer may require more frequent screens based on doctor's assessment.
G. Nasopharyngeal cancer	1. There is insufficient evidence to recommend a population-based NPC screening programme for asymptomatic people using IgA against specific Epstein-Barr virus ("EBV") viral antigens and EBV DNA test.	2. Family members of nasopharyngeal cancer patients may consider seeking advice from doctors with relevant expertise before making an informed decision about screening.

Cancer	For asymptomatic population at average risk	For persons at increased risk
H. Thyroid cancer	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, should consider seeking advice from doctors regarding the need for and approach of screening.
I. Ovarian cancer	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, BRCA2,* Lynch Syndrome), should consider seeking advice from doctors for assessment of their ovarian cancer risk and the need for and approach of screening.