



Provincial Health Services Authority

BC Cancer Screening Guidelines

Version: October 2024

In British Columbia, there are four province-wide screening programs:



Breast Screening



Cervix Screening



Colon Screening



Lung Screening

For more information about cancer screening, visit www.screeningbc.ca.

Support Your Patient's Participation in Screening

Health professionals play an important role in supporting their patients' participation in cancer screening. When you discuss the purpose of screening, benefits and risks, what to expect, and recommendations with your patients, you can strongly impact their decision and improve the quality of their care and overall experience. The way you explain the results and additional tests can also influence their adherence to follow-up care and routine screening.

One way to start the conversation about screening is by asking your patient: "I'd like to talk to you today about [type] screening. Before we begin, could you tell me what you already know or have heard about [type] screening?" Their response will allow you to determine their initial understanding about screening and build the conversation around new or clarifying information, which will support their decision to screen. Listen for any fears, concerns, or traumas the patient may have or have heard others experience that could shape how you engage them in the discussion.



Look for the **Conversation Tip** icon throughout the Guidelines for discussion prompts and reminders.

What is the purpose of cancer screening?

Cancer screening means finding cancer or signs of cancer early, **before** symptoms appear, when it is likely more treatable.

What are the benefits of cancer screening?

- **Can help prevent certain types of cancer:** Detecting, treating or removing precancerous lesions in the cervix and colon can prevent them from developing into cancer.
- **Can help detect cancer at its earliest stages:** Finding cancer early means that it is less likely to have spread and treatment can start earlier in the course of the disease. This allows for more treatment options and a better chance of recovery.

What are the risks of cancer screening?

- **False positives:** Results may indicate an abnormality when there is none. This may lead to unnecessary follow-ups, sometimes surgery, and cause increased stress and anxiety during this time.
- **False negatives:** Results may be normal when there are precancerous or cancerous lesions present. This may lead to missed or delayed diagnoses and/or treatments.
- **Overdiagnosis:** Results may find cases of cancer that are very slow growing and are not expected to cause any problems during the patient's lifetime. This may lead to treatment that may not benefit or have unintended consequences for the patient.
- **False reassurance:** A negative result does not mean that the patient is at lower risk of cancer.

If your patient has a negative test result, encourage them to monitor their health, be aware of any changes and continue behaviours that will lower their cancer risk. **If a patient is experiencing symptoms, refer for diagnostic testing to determine the cause of the symptom(s), regardless of the screening test result.** A screening test result is not required for referral.

- **Pain or discomfort:** The patient may experience uncomfortable pressure during a mammogram, or discomfort and/or bleeding during and/or after a Pap test.
- **Exposure to radiation:** The benefits of regular breast and/or lung screening outweigh the risks posed by the small amount of radiation the patient is exposed to. The chances of getting cancer through repeated radiation exposure is very low.¹
- **Unintended complications from diagnostic or follow-up test:**
 - **Breast screening:** Possible risks from a breast biopsy include an allergic reaction to the anesthetic/freezing (highly unlikely if the patient has received freezing with no reaction previously, such as at the dentist), infection at the biopsy site, bleeding from the biopsy site, not getting a sample of the abnormal tissue, dizziness, and fainting. Biopsies may leave a scar that fades over time. The patient may be called back for additional imaging or procedures.
 - **Cervix screening:** Follow-up for cervical abnormalities, including colposcopy, may cause pinching or cramping sensations during the procedure, or lead to long-term consequences for future pregnancy (pre-term birth or low birth weight).
 - **Colon screening:** Complications from a colonoscopy may include a reaction to the bowel preparation or medication used for sedation, heart or lung problems, an infection, bleeding from the colon and/or perforation of the colon (hole in the colon).
 - **Lung screening:** The patient may feel some soreness or discomfort after a lung biopsy and may need to rest for 1 to 2 days. Rare but possible risks of a lung biopsy include bleeding, infection or a pneumothorax (collapsed lung).

What can your patient do to lower their cancer risk?

- Practice sun safety
- Quit commercial tobacco
- Be physically active
- Eat a balanced diet
- Maintain a healthy weight
- Reduce exposure to air pollution and radon
- Limit alcohol consumption
- Get vaccinated to protect against HPV
- Go for routine cancer screening

For more information about cancer prevention, visit www.bccancer.bc.ca/prevent/.



¹ Rampinelli C, De Marco P, Origgi D, et al. Exposure to low dose computed tomography for lung cancer screening and risk of cancer: secondary analysis of trial data and risk-benefit analysis. *BMJ*. 2017;356:j347.

Breast Screening Guidelines:

Should my patient get a screening mammogram?

Most women, and many Two-Spirit, transgender or gender-diverse individuals, ages 40 and older can have a screening mammogram. For those at higher risk for breast cancer, screening may be recommended to start earlier.

For people who have or have not had Chest Construction Surgery, or who have breast (chest) tissue from taking gender-affirming hormones, refer to the [Screening Strategy Based on Anatomy Present](#) section for more information.

	Patient Characteristics	Recommendation	Referral
Average Risk	Age 39 and younger	Routine screening mammogram is not recommended (refer to High Risk section below).	
	Age 40 to 49	Screening mammography is available every 2 years. Speak with the patient about the benefits and limitations of mammography.	<p>No referral required. Patient can call a breast screening centre directly or 1-800-663-9203 to book their appointment.</p>  <p>Inform the patient that they will need to identify a health care provider (physician, nurse practitioner, naturopath or walk-in clinic) who can follow-up with them if needed.</p>
	Age 50 to 74	Routine screening mammogram every 2 years.	
	Age 75 and older	Screening mammography is available every 2 or 3 years if the patient is in good general health. Speak with the patient about the benefits and limitations of mammography.	
Higher than Average Risk	Age 40 to 74		
	1 st degree relative ² with a history of breast cancer	Routine screening mammogram every year.	<p>No referral required. Patient can call a breast screening centre directly or 1-800-663-9203 to book their appointment.</p>  <p>Inform the patient that they will need to identify a health care provider (physician, nurse practitioner, naturopath or walk-in clinic) who can follow-up with them if needed.</p>

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² Parent, child, full sibling

	Patient Characteristics	Recommendation	Referral
Higher than Average Risk (cont'd)	Atypical ductal hyperplasia (ADH)	Routine screening mammogram every year.	Refer patient for diagnostic imaging .
	Atypical lobular hyperplasia (ALH)		
	Classical lobular carcinoma in situ (LCIS)		
	Age 75 and older		
	1 st degree relative ² with a history of breast cancer	Screening mammography is available every year if the patient is in good general health. Speak with the patient about the benefits and limitations of mammography.	No referral required. Patient can call a breast screening centre directly or 1-800-663-9203 to book their appointment.  Inform the patient that they will need to identify a health care provider (physician, nurse practitioner, naturopath or walk-in clinic) who can follow-up with them if needed.
Atypical ductal hyperplasia (ADH)			
Atypical lobular hyperplasia (ALH)			
Classical lobular carcinoma in situ (LCIS)			
High Risk	Age 25 to 74		
	Thoracic radiation ³ between age 10 to 30	Routine screening mammogram every year.	Initial referral required if patient is <40 years old. Recommend referral to the Late Effects, Assessment and Follow-Up Clinic if not done already.
	Age 30 to 74		
	Very strong family history: <ul style="list-style-type: none">2 close female relatives⁴ on the same side of the family diagnosed with breast cancer before age 50; or,3 or more close female relatives⁴ on the same side of the family diagnosed with breast cancer, with at least one diagnosed before age 50	Routine screening mammogram every year.	Initial referral required if patient is <40 years old. Recommend referral to Hereditary Cancer Program if not done already.

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³ Typically refers to chest wall radiation therapy for pediatric and adolescent cancers

⁴ Mother, sister, daughter, aunt, grandmother, great-aunt

	Patient Characteristics	Recommendation	Referral
High Risk (cont'd)	Known BRCA1 or BRCA2 carrier, or other pathogenic gene variant ⁵ carrier	Routine screening mammogram every year.	Initial referral required if patient is <40 years old. Recommend referral to Hereditary Cancer Program if not done already.
	Untested family member of a BRCA1 or BRCA2 carrier, or other known pathogenic gene variant ⁵ carrier		
	Age 75 and older		
	Thoracic radiation ³ between age 10 to 30	Screening mammography is available every year if the patient is in good general health. Speak with the patient about the benefits and limitations of mammography.	No referral required. Patient can call a breast screening centre directly or 1-800-663-9203 to book their appointment.  Inform the patient that they will need to identify a health care provider (physician, nurse practitioner, naturopath or walk-in clinic) who can follow-up with them if needed.
	Very strong family history: <ul style="list-style-type: none">2 close female relatives⁴ on the same side of the family diagnosed with breast cancer before age 50; or,3 or more close female relatives⁴ on the same side of the family diagnosed with breast cancer, with at least one diagnosed before age 50		
	Known BRCA1 or BRCA2 carrier, or other pathogenic gene variant ⁵ carrier		
	Untested family member of a BRCA1 or BRCA2 carrier, or other known pathogenic gene variant ⁵ carrier		



⁵ BRCA1, BRCA2, ATM, CDH1, CHEK2, NBN, NF1, PALB2, PTEN, STK11, TP53, or others identified by the Hereditary Cancer Program

	Patient Characteristics	Recommendation	Referral
Symptomatic	<p>Symptomatic, includes:</p> <ul style="list-style-type: none"> • A mass, lump, thickening or any change in the breast that is new or stays over time • A lump that gets bigger or the whole breast gets smaller or bigger • Nipple starts to draw in • Dimpling or puckering of the skin of the breast • Nipple changes or discharge • Breast is red, swollen or hot • A lump under the arm or in the armpit 	Do not screen. Refer for diagnostic imaging .	

Screening Strategy Based on Anatomy Present

Anatomy	Recommendation
Chest (Breast) Tissue	
TTGD patient with NO history of chest reduction/chest construction surgery (bilateral subcutaneous mastectomy)	Screen as per sex assigned at birth (refer to previous table).
TTGD patient with history of chest reduction surgery (simple reduction mammoplasty)	
Chest Tissue AFTER Chest Construction or Breast Construction/Augmentation Surgery	
TTGD patient with removal of most, but not all, breast tissue (some tissue used to contour shape of the chest)	Screening mammogram is not recommended. Recommend regular follow-up. If at high-risk or other concern, consider physical exam and/or diagnostic ultrasound or other modality.
TTGD patient with breast implants	Ineligible for screening through the BC Cancer Breast Screening Program. Recommend regular follow-up. If at high-risk or other concern, consider physical exam and/or diagnostic ultrasound or other modality.
Breast Tissue Associated with Estrogen-Based GAHT (Gender-Affirming Hormone Therapy)	
Taking estrogen for at least 5 years	Screen as per Breast Screening Guidelines (refer to previous table).

Management of Screening Mammogram Results

Result	Management and Patient Follow-Up
Normal (Negative)	<p>The patient will receive their results in the mail within 3 weeks. They will receive a reminder letter in the mail when they are due for their next mammogram.</p> <p> Reinforce to the patient that regular screening is important to monitor for any changes.</p>
Abnormal (Positive)	<p>More tests are needed to determine next actions: further testing, surveillance, diagnosis management and/or treatment.</p> <p>BC Cancer Breast Screening will send the results directly to you and facilitate the fast-track referral for the patient's first round of diagnostic testing. A diagnostic facility will call the patient to book the additional recommended testing. Once complete, you will receive the diagnostic results and recommendations to share with your patient.</p> <p> Explain to the patient that an abnormal result does not mean they have cancer. Additional testing will provide more information to help determine if any changes are of concern and/or if any treatment is needed. Additional tests can include one or more of the following:</p> <ul style="list-style-type: none"> • Diagnostic mammogram: Takes x-rays of the area of concern • Ultrasound: Uses sound waves to produce an image of the area • Needle biopsy: Takes sample of tissue from the area of concern <p><i>If diagnostic testing confirms no cancer:</i> Reinforce to the patient that regular screening is important to monitor for any changes.</p> <p><i>If diagnostic testing confirms cancer or another condition:</i> Reinforce to the patient that follow-up care is important to achieve the best treatment results.</p>

Breast Density Assessment

The BC Cancer Breast Screening Program includes a breast density assessment with screening mammogram results. Both you and your patient will receive a copy of the assessment.

The assessment will be reported as one of the four BI-RADS (Breast Imaging Reporting and Data System) categories in the breast composition assessment scale, with BI-RADS A having the least amount of dense tissue and BI-RADS D having the most amount of dense tissue:

BI-RADS Category	Description
BI-RADS A	Almost entirely fatty
BI-RADS B	Scattered areas of fibroglandular density
BI-RADS C	Heterogeneously dense, which may obscure small masses
BI-RADS D	Extremely dense, which lowers the sensitivity of mammography



Remind your patient that:

- Regardless of their breast density, it is important to continue to get regular screening mammograms.
- Mammograms are the only screening modality proven to be effective in decreasing a woman's risk of dying from breast cancer. The ability of mammography to detect cancer remains high for all breast density categories.
- No screening test is perfect and dense breast tissue can make it harder to find cancer on a mammogram. It is important to investigate all breast changes, even if a recent mammogram was normal.

For more information to support your conversations with patients about breast density, refer to the [Breast Density Discussion Guide](#).

Cervix Screening Guidelines:

Should my patient get cervix screening?

Anyone with a cervix, including women and TTGD⁶ individuals, age 25 to 69 should get screened regularly for cervical cancer.

Patient Characteristics ⁷		Recommendation
Asymptomatic — Average Risk	Age 24 and younger	Routine screening is not recommended.
	Age 25 to 69	
	With a cervix	Screen with a vaginal swab or a provider-collected liquid-based cytology (LBC) sample.
	Have or have not received the HPV vaccine	
	Have had any sexual contact ⁸ with another person of any gender	
	Pregnant	Screen with a provider-collected liquid-based cytology (LBC) sample if screening is due or overdue. Screening is not necessary as a routine part of pre-natal screening for those who are up to date with screening. Self-screening is not recommended for patients who are pregnant.
	Cervix removed, with no prior history of CIN ⁹ 2, CIN 3 or AIS ¹⁰	Routine screening is not recommended.
	Subtotal hysterectomy (cervix not removed), with no prior history of CIN 2, CIN 3, AIS or cervical carcinoma	Screen with a vaginal swab or a provider-collected liquid-based cytology (LBC) sample.
	Cervix removed and has history of CIN 2, CIN 3 or AIS	Screen with a provider-collected liquid-based cytology (LBC) sample from the vaginal vault at 12 months post-hysterectomy. The sample will be tested for both HPV and cytology (cotest). Any positive HPV test or a high-grade or glandular cytology result should be referred directly to colposcopy. After a negative cotest, screening can be discontinued.
	Has a neovagina	Screening is not recommended.
	Never had sexual contact ⁸	Routine screening is not recommended. Delay screening until initiation of sexual contact.
	Uses a pessary	Screen with a provider-collected liquid-based cytology (LBC) sample. Self-screening is not recommended for patients who are using a pessary.

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⁶ Two-Spirit, transgender and gender-diverse

⁷ For more details about the patient characteristics, read the [BC Cancer Cervix Screening Program Overview](#).

⁸ Sexual contact includes intercourse and digital or oral sexual contact involving the genital area with a person of any gender.

⁹ Cervical intraepithelial neoplasia

¹⁰ Adenocarcinoma in situ

Patient Characteristics ⁷		Recommendation
Asymptomatic — Average Risk	Age 69 and older	
	Had a negative HPV screen between age 65 and 69 and under no active surveillance of pre-cursor abnormalities	Screening is not recommended.
	Inadequate screening history or has not screened in past 5 years and generally well	Screen with a vaginal swab or provider-collected liquid-based cytology (LBC) sample. Stop routine screening if result is HPV negative.
High Risk	Immunocompromised	<p>Screen with a vaginal swab or provider-collected liquid-based cytology (LBC) sample every 3 years.</p> <p>Stop screening at age 74 if:</p> <ul style="list-style-type: none"> • there has been a negative HPV screening test between age 65 and 69 and under no active surveillance of pre-cursor abnormalities; or • discharged from colposcopy and have had a negative cotest (HPV and cytology testing) at 12-month follow-up.
	Exposed to diethylstilbestrol (DES) in utero	Screen with annual colposcopic evaluation of both the cervix and vagina with a cotest (HPV and cytology testing) until age 69.
	Received excisional treatment for CIN 2 and CIN 3	
	Discharged from colposcopy	<p>At 12-months post-discharge, screen with a cotest (HPV and cytology testing) using a single provider-collected liquid-based cytology (LBC) sample through primary care provider:</p> <ul style="list-style-type: none"> • If HPV negative and cytology is NILM, ASCUS or LSIL: Routine HPV-based screening at 3-year intervals (average risk) or 1-year interval (immunocompromised). • If HPV positive or cytology is ASC-H, HSIL or AGC: Re-refer to colposcopy. <p>Stop screening at age 69 (average risk) or age 74 (immunocompromised) if patient has had a negative cotest (HPV and cytology testing) and under no active surveillance of pre-cursor abnormalities.</p>




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Patient Characteristics ⁷		Recommendation
High Risk (cont'd)	Received excisional treatment for endocervical adenocarcinoma in situ (AIS)	
	Discharged from colposcopy	<p>At 12-months post-discharge, screen with a cotest (HPV and cytology testing) using a single provider-collected liquid-based cytology (LBC) sample through primary care provider:</p> <ul style="list-style-type: none"> • If HPV negative and cytology is NILM, ASCUS or LSIL: Routine HPV-based screening at 3-year intervals (average risk) or 1-year interval (immunocompromised). • If HPV positive or cytology is ASC-H, HSIL or AGC: Re-refer to colposcopy. <p>Stop screening at age 69 (average risk) or age 74 (immunocompromised) if patient has had a negative cotest (HPV and cytology testing) and under no active surveillance of pre-cursor abnormalities.</p>
Symptomatic	History of invasive carcinoma and discharged from cancer treatment (surgery or radiation) by oncologist or colposcopy clinic	<p>The patient's colposcopist or oncologist is responsible for outlining the post-treatment follow-up of a patient diagnosed with cervical cancer for the first 5 years.</p> <p>Once discharged, routine screening is not recommended. Ongoing surveillance for recurrence by someone experienced in cervical disease is recommended.</p>
	Symptomatic, includes: <ul style="list-style-type: none"> • Post coital bleeding • Abnormal uterine bleeding • Persistent vaginal discharge that cannot be explained by benign causes such as infection 	<p>Do not screen. The patient should have a speculum examination by someone with experience in gynecologic exams. Referral to a colposcopist is appropriate and may be expedited if the clinical suspicion is high.</p> <p>Providers can perform a cotest (HPV and cytology testing) with a single provider-collected LBC sample. A cotest is not required for referral and referral should not be delayed pending results of the cotest.</p>



Management of Cervix Screening Results

Pap Test Interpretation	Management and Patient Follow-Up
HPV Invalid	<p>Repeat HPV testing. Unless a cotest (HPV and cytology testing) was recommended, a self-screening kit will be sent to the patient at the time of the invalid result notification.</p> <p>If repeat test is invalid, refer to colposcopy.</p>
Unsuitable for Testing	<p>If specimen identification cannot be confirmed or the sample cannot be tested (e.g., broken container), the Cervical Cancer Screening Laboratory will reject the sample.</p> <p>Unless a cotest (HPV and cytology testing) was recommended, a self-screening kit will be sent to the patient at the time of the invalid result notification.</p>

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Unsatisfactory Samples	<p>Samples that are inadequate for cytology interpretation due to poor preservation or obscuring elements.</p> <p>Unless a cotest (HPV and cytology testing) was recommended, a self-screening kit will be sent to the patient at the time of the invalid result notification.</p>
High-Risk HPV Negative	<p>Re-screen in 5 years.</p> <p>Shorter screening interval recommendation for immunocompromised patients and after treatment for CIN 2, CIN 3 or AIS.</p> <div>  Reinforce to the patient that regular screening is important to monitor for any changes. </div>
High-Risk HPV 16/18 Positive	<p>Colposcopy is recommended.</p> <ul style="list-style-type: none"> • If screening is performed with a provider-collected liquid-based cytology (LBC) sample, the Cervical Cancer Screening Laboratory will perform a cytological evaluation to aid in the colposcopist's decision. • If screening is performed with self-screening, colposcopist will collect a cytology sample to aid with management decisions. <div>  Share BC Cancer's resources about colposcopy and what to expect with the patient. </div>
High-Risk HPV Other Positive with No Cytology Result	<p>Cytology is recommended.</p> <p>For immunocompromised patients, colposcopy is recommended.</p>
High-Risk HPV Other Positive with ASC-H, HSIL or AGC Cytology	<p>Colposcopy is recommended.</p> <div>  Share BC Cancer's resources about colposcopy and what to expect with the patient. </div>
High-Risk HPV Other Positive with Unknown or Unsatisfactory Cytology Result	<p>Follow-up cervix screening with primary care provider.</p> <p>If cytology samples are reported as Unsatisfactory on 2 different occasions, colposcopy is recommended.</p>
High-Risk HPV Other Positive with Negative (NILM), ASCUS or LSIL Cytology	<p>Repeat HPV test in 12 months:</p> <ul style="list-style-type: none"> • If HPV Negative: Return to routine screening. • If HPV Positive: Refer to colposcopy. <ul style="list-style-type: none"> — If screening is performed with a provider-collected liquid-based cytology (LBC) sample, the Cervical Cancer Screening Laboratory will perform a cytological evaluation to aid in the colposcopist's decision. — If screening is performed with self-screening, colposcopist will collect a cytology sample to aid with management decisions.

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Negative for intraepithelial lesion or malignancy (NILM)	<p>Re-screen in 3 years.</p> <p> Reinforce to the patient that regular screening is important to monitor for any changes.</p>
Low Grade Cytology <ul style="list-style-type: none"> Atypical squamous cells of undetermined significance (ASCUS) Low grade squamous intraepithelial lesion (LSIL) 	<p>The Cervical Cancer Screening Laboratory will triage the sample to reflex HPV testing.</p> <ul style="list-style-type: none"> If HPV Negative: Return to routine screening. If HPV 16/18 Positive: Colposcopy is recommended. If HPV Other Positive: Repeat HPV test in 12 months.
High Grade Cytology <ul style="list-style-type: none"> Atypical Squamous Cells of Undetermined Significance (Cannot Rule Out High Grade Lesion) (ASC-H) High-Grade Squamous Intraepithelial Lesion (HSIL), moderate dysplasia High-Grade Squamous Intraepithelial Lesion (HSIL), severe dysplasia Atypical Endocervical Glandular Cells—Not Otherwise Specified (AGC-NOS) Atypical Endocervical Glandular Cells—Favour Neoplasia (AGC-FN) Endocervical Adenocarcinoma In Situ (AIS) 	<p>Colposcopy is recommended.</p> <p> Share BC Cancer's resources about colposcopy and what to expect with the patient.</p>
Benign Endometrial Cells in Cervical Samples	<p>Cervical cytology examination has poor sensitivity for endometrial carcinoma and should not be used as a screening test to either rule in or rule out an endometrial abnormality.</p>
Atypical Endometrial Cells or Endometrial Carcinoma	<p>Colposcopy is recommended or refer to gynecologist for further evaluation which should include an endometrial biopsy.</p>
Possible Extrauterine Carcinoma or Rare Malignancies	<p>Features of possible extrauterine carcinoma or rare malignancies may be identified in cytology samples collected from participants who are HPV positive.</p> <p>Managed on a case-by-case basis and may need a multidisciplinary team approach for management. Contact the Cervical Cancer Screening Laboratory for clarification of the results if needed.</p>

Colon Screening Guidelines:

Should my patient get colon screening?



Generally, anyone between the ages of 50 to 74 with no symptoms should get screened with a Fecal Immunochemical Test (FIT) every 2 years.

	Patient Characteristics	Recommendation	Referral
Asymptomatic — Average Risk	Age 49 and younger	Routine FIT screening is not recommended.	
	Personal history of low-risk precancerous lesion(s)	FIT or colonoscopy is recommended. Refer to the Colonoscopy Follow-up Algorithm for the recommended pathway and screening interval.	If patient is younger than age 74, depending on the recommendation, either refer for colonoscopy using the Colonoscopy Referral Form or refer for FIT using the Standard Lab Requisition .
	Age 50 to 74		
	Personal history of low-risk precancerous lesion(s)	FIT or colonoscopy is recommended. Refer to the Colonoscopy Follow-up Algorithm for the recommended pathway and screening interval.	If patient is younger than age 74, depending on the recommendation, either refer for colonoscopy using the Colonoscopy Referral Form or refer for FIT using the Standard Lab Requisition .
	Never screened or screening interval elapsed and No personal or family history of colorectal cancer	Routine FIT screening every 2 years.	Use Standard Lab Requisition : Select 'FIT (Age 50-74 asymptomatic q2y) Copy to Colon Screening Program'.
	Normal FIT within 2 years	Routine FIT screening is not recommended. Patient is up to date with colon screening.	
	Normal colonoscopy within 10 years		
	Normal CT colonography within 5 years		
	Age 75 to 84	Assess patient's risk of colorectal cancer and risk of colonoscopy. Harm can outweigh benefit; use clinical judgement.	If proceeding with screening, use Standard Lab Requisition and select 'FIT No copy to Colon Screening Program'. Patient will not be registered in the program. Refer directly to a specialist for follow-up when indicated.
	Age 85 and older	Routine FIT screening is not recommended.	

	Patient Characteristics	Recommendation	Referral
High Risk	Personal history of high-risk precancerous lesion(s)	FIT or colonoscopy is recommended. Refer to the Colonoscopy Follow-up Algorithm for the recommended pathway and screening interval.	If patient is younger than age 74, depending on the recommendation, either refer for colonoscopy using the Colonoscopy Referral Form or refer for FIT using the Standard Lab Requisition .
	Personal history of colorectal cancer	Routine FIT screening is not recommended. Refer for ongoing follow-up with a specialist.	
	Inflammatory bowel disease <ul style="list-style-type: none">• Crohn’s disease• Ulcerative colitis• Ulcerative proctitis		
	High-risk family history of colorectal cancer		
	One 1 st degree relative ¹¹ with colorectal cancer diagnosed under age 60 or Two or more 1 st degree relatives with colorectal cancer diagnosed at any age <i>*If one 1st degree relative diagnosed with colorectal cancer over age 60, screen as average risk.</i>	Routine FIT screening is not recommended. Colonoscopy is recommended every 5 years. Refer for colonoscopy at age 40 or 10 years younger than the age of diagnosis of the patient’s youngest 1 st degree relative — whichever is first.	If patient is younger than age 74, refer for colonoscopy using the Colonoscopy Referral Form .
Symptomatic	Symptomatic, includes: <ul style="list-style-type: none">• Anemia• Abdominal pain• Rectal bleeding• Change in bowel habits	Do not screen. Refer for diagnostic testing.	

¹¹ Parent, child, full sibling

Management of FIT Results

Result	Management and Patient Follow-Up
Normal (Negative)	<p>Re-screen with a FIT in 2 years.</p> <p>The patient can access their results through MyCareCompass or by contacting your clinic. The patient will not be notified by mail if their FIT result is normal. The patient will receive a reminder letter in the mail when it is time for them to screen again.</p> <p> Reinforce to the patient that regular screening is important to monitor for any changes.</p>
Abnormal (Positive)	<p>The patient will receive their results in the mail within 5 to 10 business days after their sample is returned to the lab.</p> <p>BC Cancer will facilitate a referral for a colonoscopy to the patient's Health Authority. The Health Authority will contact the patient, assess their condition, and book a colonoscopy procedure if appropriate, or if other monitoring and/or treatment is advised.</p> <p> Explain to the patient that abnormal FIT results are common and do not mean they have cancer, but follow-up care is important to investigate the cause of the blood detected in their sample. Reassure them that you will support and guide them through the follow-up process.</p> <p><i>If diagnostic testing confirms no cancer:</i> Reinforce to the patient that regular screening is important to monitor for any changes.</p> <p><i>If diagnostic testing confirms cancer or another condition:</i> Reinforce to the patient that it is important to attend follow-up to achieve the best treatment results.</p>






Lung Screening Guidelines:

Should my patient get a low-dose CT (LDCT) scan?

Generally, anyone between the ages of 55 to 74, who is considered high-risk for lung cancer and does not have any symptoms, may be eligible for screening.

	Patient Characteristics	Recommendation
Average Risk	Age 54 and younger	Routine screening is not recommended.
	Age 55 to 74	
	Never smoked in the past	Routine screening is not recommended.
	Age 75 and older	Routine screening is not recommended.
High Risk	Age 55 to 74	
	Has a significant history of regularly smoking commercial tobacco (cigarettes, cigars, etc), currently or in the past	<p>Encourage patient to call 1-877-717-5864 and the Lung Screening Program will conduct their risk assessment over the phone to confirm their screening eligibility.</p> <p>For patients who you consider may experience barriers to self-referral (e.g., language barrier, screening hesitancy), complete and fax the Risk Assessment Request Form to 1-604-877-6115. A Program Navigator will contact the patient by phone to determine screening eligibility.</p> <p>If your patient cannot be contacted by phone or would need support answering the risk assessment questions, you could complete the assessment together with the patient and fax the responses to the Lung Screening Program. The Lung Screening Program will review your assessment and facilitate referral for screening if the patient is eligible. Email lungscreeningprogram@bccancer.bc.ca to request a copy of the questionnaire.</p> <p>If the patient is considered eligible, routine screening is recommended annually or biennially.</p>
Symptomatic	Symptomatic, includes: <ul style="list-style-type: none"> Coughing that does not go away or gets worse Coughing up blood or rust-coloured sputum (spit or phlegm) Shortness of breath or chest pain that is always felt and gets worse with deep breathing or coughing Unexplained weight loss of more than 5 kilograms in the past year 	Do not screen. Refer for diagnostic testing.

Management of LDCT Results

Result	Management and Patient Follow-Up
No Concerning Findings	<p>Re-screen in 2 years. The radiologist did not notice anything of concern from the patient's LDCT scan.</p> <p>The patient will receive a reminder letter in the mail. You will receive a report when the LDCT scan has been completed. You will also receive a reminder if the patient has not scheduled their next screen after 4 weeks.</p> <p> Reinforce to the patient that regular screening is important to monitor for any changes.</p>
Low Chance of Cancer	<p>Re-screen in 1 year. The radiologist considers the patient to have a low chance of lung cancer but recommends continued monitoring of their lungs.</p> <p>The patient will receive a reminder letter in the mail. You will receive a report when the LDCT scan has been completed. You will also receive a reminder if the patient has not scheduled their next screen after 4 weeks.</p> <p> Reinforce to the patient that regular screening is important to monitor for any changes.</p>
Additional Screening Required	<p>Follow-up LDCT scan in 3 months. The radiologist has noticed some findings in the patient's LDCT scan that may be related to inflammation, infection or a need to monitor an area more closely.</p> <p>The patient will be contacted to arrange a follow-up LDCT scan in 3 months. You will also be notified of the result.</p> <p> Explain to the patient that this does not mean they have cancer, but it is important that they attend all follow-up to investigate what the scans are showing and determine if more scans or a biopsy is needed. Reassure them that you will support and guide them through the follow-up process.</p>
Follow-Up Required	<p>The radiologist has noticed some spots that require further investigation.</p> <p>The program will send a fast-track diagnostic work-up referral to a designated thoracic centre in the patient's health region. The patient will be contacted shortly by a chest specialist to arrange for a follow-up, which may include more scans or a biopsy. You will also be notified of the result.</p> <p> Explain to the patient that it is important that they attend all follow-up to investigate what the scans are showing and to determine if lung cancer is present. Reassure them that you will support and guide them through the follow-up process.</p>
Findings Not Related to Lung Cancer	<p>The radiologist has noticed additional actionable findings that are not related to cancer.</p> <p>The patient's results will be sent to you to decide if further action is needed. Please arrange for further investigation or treatment.</p> <p> Explain to the patient why the additional findings need to be investigated further or treated and the benefits in doing so, and that you will arrange the investigation or treatment. Reassure them that you will support and guide them through the follow-up process.</p>

Services, Forms and Resources

Below are the links to the services, forms and additional resources mentioned in this document.



Breast Screening

Services

- Breast Screening Centre Locator: www.bccancer.bc.ca/screening/breast/find-a-clinic/clinic-locator
- BC Cancer Hereditary Cancer Program: www.bccancer.bc.ca/our-services/services/hereditary-cancer
- BC Cancer Late Effects, Assessment and Follow-Up Clinic: www.bccancer.bc.ca/our-services/services/late-effects-assessment-follow-up

Forms and Additional Resources

- Breast Density Discussion Guide: www.bccancer.bc.ca/screening/Documents/Breast-Density-Discussion-Guide.pdf
- Fact Sheet: Higher Risk Surveillance for ADH, ALH and LCIS: www.bccancer.bc.ca/screening/Documents/Breast-Higher-Risk.pdf
- Requisition Form: Diagnostic Breast Imaging: www2.gov.bc.ca/assets/gov/health/practitioner-pro/bc-guidelines/outpatient_imaging_req.pdf



Cervix Screening

Services

- Cervical Cancer Screening Laboratory (CCSL): www.bccancer.bc.ca/health-professionals/clinical-resources/laboratory-services/cervical-cancer-screening

Forms and Additional Resources

- BC Cancer Cervix Screening Program Overview (with Follow-Up Diagram for ASCUS): www.bccancer.bc.ca/screening/Documents/Cervix-Program-Overview.pdf
- Patient Resources: Colposcopy: www.bccancer.bc.ca/screening/cervix/results/colposcopy



Colon Screening

Services

- MyCareCompass: www.bc.mycarecompass.lifelabs.com/

Forms and Additional Resources

- Requisition Form: Standard Outpatient Lab: www2.gov.bc.ca/assets/gov/health/forms/1901fil.pdf
- Referral Form: Colonoscopy: www.bccancer.bc.ca/screening/Documents/Colonoscopy-Referral-Form-FILLABLE.pdf
- Provider Notice: Colonoscopy Surveillance Guidelines: www.bccancer.bc.ca/screening/Documents/ColonoscopyFollow-up-Algorithm.pdf



Lung Screening

Forms and Additional Resources

- Risk Assessment Request Form: www.bccancer.bc.ca/screening/Documents/Lung-Screening-Referral-Form.pdf

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