American Cancer Society | NATIONAL COLORECTAL CANCER ROUNDTABLE

Inside the New American Cancer Society Colorectal Cancer Screening Guidelines:

Insights from ACS Senior Vice President of Cancer Screening, Robert Smith, PhD

June 10, 2026
3:00–4:00pm ET

Disclosures

Our speakers do not have any disclosures to share.

Purpose of Today's Presentation:

1. Introduce the updated ACS CRC Screening Guidelines.
2. Explain key evidence and rationale that informed the recent updates.
3. Describe the major changes to the guidelines and discuss their implications for practice and implementation.
4. Q&A

Today's Presenters

Gloria Coronado, PhD

Associate Director, Population Sciences,
Professor, University of Arizona
ACS NCCRT Vice-Chair

Robert Smith, PhD

Senior Vice President, Cancer Screening, ACS
ACS NCCRT Senior Scientific Advisory

About the American Cancer Society National Colorectal Cancer Roundtable (ACS NCCRT)

ACS NCCRT Mission, Vision & Values

OUR MISSION: To reduce colorectal cancer (CRC) incidence and mortality in the US through coordinated leadership, strategic planning, and advocacy

OUR VISION: Provide leadership and expertise to support nationally coordinated efforts to end colorectal cancer as we know it, for everyone.

OUR VALUES: Cancer affects everyone, but it doesn't affect everyone equally. To ensure we all can prevent, detect, treat, and survive colorectal cancer, we must work to eliminate barriers and address the needs of everyone. We believe all people should have a fair and just opportunity to live a longer, healthier life free from colorectal cancer regardless of how much money they make, the color of their skin, their sexual orientation, gender identity, disability status, or where they live.

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ACS NCCRT Snapshot

History: Established by the ACS, in partnership with the CDC, in 1997, to serve as an umbrella organization to engage all types of stakeholders who are committed to save more lives from CRC.

Mission: To reduce CRC incidence and mortality in the US through coordinated leadership, strategic planning, and advocacy.

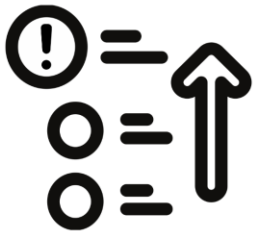
Membership: Collaborative partnership of 240+ member organizations, including nationally known experts, thought leaders, and decision makers.

Operations: Work is coordinated by the ACS NCCRT Team, and is conducted year-round by our members with guidance and support from our volunteer leaders.

Convening: Each year the **ACS NCCRT Annual Meeting** addresses important topics and sets the agenda for the following year.

What Do We Do?

ACS NCCRT serves as a trusted and neutral convener to:



Establish Strategic Priorities Across the CRC Continuum

MEMBER ENGAGEMENT
National meetings, summits, focus groups, surveys.

MEMBER COORDINATION
Creating RT priorities & strategies with input from members.

Advance Systems, Practices, and Policy Change Solutions

RESOURCE CREATION
Resources for implementing evidence-based interventions.

CONTENT CREATION
Campaigns, thought leadership, research activities.

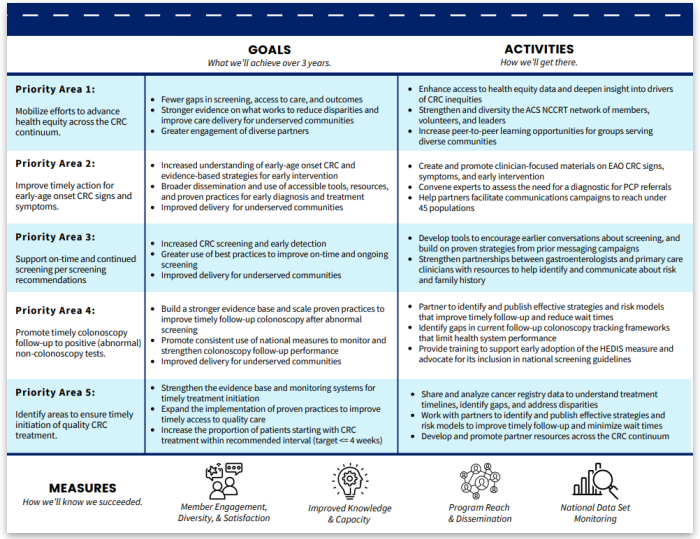
Promote Evidence-Based Strategies and Translate them into Practice

PROFESSIONAL EDUCATION
Webinars, technical assistance, newsletters, social media.

ACADEMIC AND PROFESSIONAL LITERATURE
Journal publications, trade journals.

WEBSITES & RESOURCE CENTERS

ACS NCCRT 3-Year Strategic Roadmap



	GOALS *What we'll achieve over 3 years.*	ACTIVITIES *How we'll get there.*
Priority Area 1: Mobilize efforts to advance health equity across the CRC continuum.	• Fewer gaps in screening, access to care, and outcomes • Stronger evidence on what works to reduce disparities and improve care delivery for underserved communities • Greater engagement of diverse partners	• Enhance access to health equity data and deepen insight into drivers of CRC inequities • Strengthen and diversity the ACS NCCRT network of members, volunteers, and leaders • Increase peer-to-peer learning opportunities for groups serving diverse communities
Priority Area 2: Improve timely action for early-age onset CRC signs and symptoms.	• Increased understanding of early-age onset CRC and evidence-based strategies for early intervention • Broader dissemination and use of accessible tools, resources, and proven practices for early diagnosis and treatment • Improved delivery for underserved communities	• Create and promote clinician-focused materials on EAO CRC signs, symptoms, and early intervention • Convene experts to assess the need for a diagnostic for PCP referrals • Help partners facilitate communications campaigns to reach under 45 populations
Priority Area 3: Support on-time and continued screening per screening recommendations	• Increased CRC screening and early detection • Greater use of best practices to improve on-time and ongoing screening • Improved delivery for underserved communities	• Develop tools to encourage earlier conversations about screening, and build on proven strategies from prior messaging campaigns • Strengthen partnerships between gastroenterologists and primary care clinicians with resources to help identify and communicate about risk and family history
Priority Area 4: Promote timely colonoscopy follow-up to positive (abnormal) non-colonoscopy tests.	• Build a stronger evidence base and scale proven practices to improve timely follow-up colonoscopy after abnormal screening • Promote consistent use of national measures to monitor and strengthen colonoscopy follow-up performance • Improved delivery for underserved communities	• Partner to identify and publish effective strategies and risk models that improve timely follow-up and reduce wait times • Identify gaps in current follow-up colonoscopy tracking frameworks that limit health system performance • Provide training to support early adoption of the HEDIS measure and advocate for its inclusion in national screening guidelines
Priority Area 5: Identify areas to ensure timely initiation of quality CRC treatment.	• Strengthen the evidence base and monitoring systems for timely treatment initiation • Expand the implementation of proven practices to improve timely access to quality care • Increase the proportion of patients starting with CRC treatment within recommended interval (target <= 4 weeks)	• Share and analyze cancer registry data to understand treatment timelines, identify gaps, and address disparities • Work with partners to identify and publish effective strategies and risk models to improve timely follow-up and minimize wait times • Develop and promote partner resources across the CRC continuum
MEASURES *How we'll know we succeeded.*	*Member Engagement, Diversity, & Satisfaction*	*Improved Knowledge & Capacity*	*Program Reach & Dissemination*	*National Data Set Monitoring*

We are dedicated to reducing **colorectal cancer mortality & mortality disparities** by focusing our efforts around these five priority areas:

1. **Mobilize** national and community-level efforts that will lead to health equity across the CRC continuum.
2. **Improve** timely action for early-age onset CRC signs and symptoms.
3. **Support** on-time screening as soon as eligible and continued participation per screening recommendations.
4. **Promote** timely colonoscopy follow-up to positive (abnormal) non-colonoscopy tests.
5. **Identify** areas to ensure timely initiatives of quality CRC treatment.

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Newly Updated ACS Colorectal Cancer Screening Guidelines

NCCRT Update on ACS Colorectal Cancer Screening Guidelines

June 10, 2026

Robert A. Smith, PhD

SVP, Early Cancer Detection Science, and Director, American Cancer Society Center for Early Cancer Detection

Screening Guideline Developers Must Consider the Descriptive Epidemiology of the Disease

- The burden of disease in the population must be an important health problem overall
  - It also must be important for the age group when screening is first recommended, and similar considerations apply to an age to stop screening
  - Basically, benefits must outweigh harms.
- Screening tests must be accurate, treating occult disease must result in reduced morbidity and mortality, and benefits must outweigh harms

Colorectal Cancer (CRC) In the U.S.

158,850

Estimated new cases in 2026[1]

55,000

Estimated deaths in 2026[1]

3%

Increase per year 2013 to 2022 under age 50.[1]

American Indian and Alaska Native

Populations have the highest CRC burden.[2]

In US adults younger than 50 years, CRC is now the leading cause of cancer death in men and 2nd in women.[4]

65%

of U.S. adults, aged 45-75 reported being **up-to-date with CRC screening** in 2023.[3]

Lower Screening Rates[3]

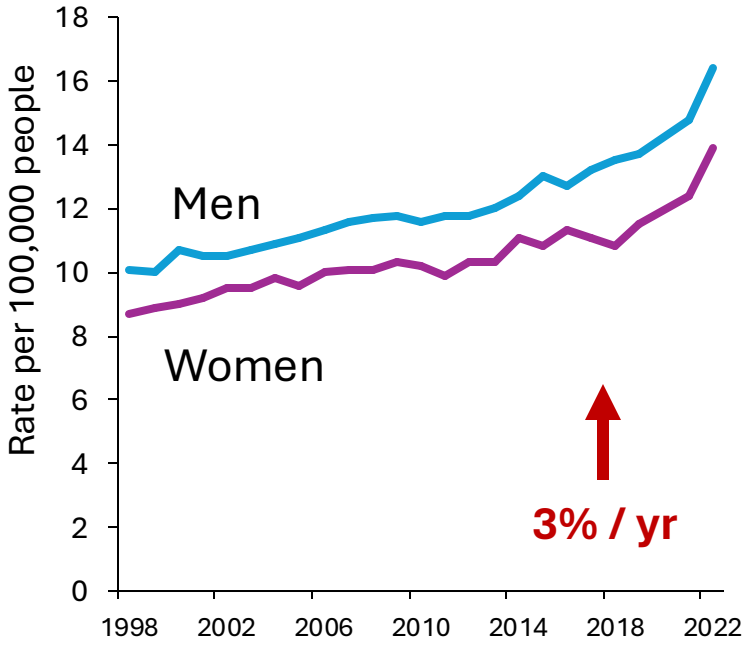
Lack of insurance.

Lower socioeconomic status.

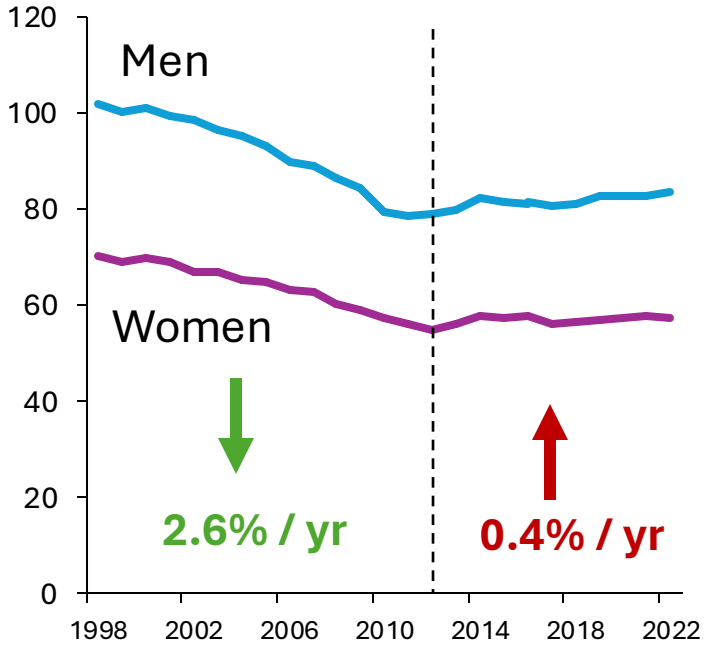
1 Siegel RL, et al. Cancer statistics, 2026. CA Cancer J Clin 2026;76(1) | **2** Siegel, RL, et al. *Colorectal Cancer Statistics, 2026*. CA Cancer J Clin. 2026;76(2) | **3** *Cancer Prevention & Early Detection Facts & Figures 2025-2026*. Atlanta: American Cancer Society; *2025-2026.*; **4**. JAMA. Feb 17 2026;335(7):632–634

Trends in colorectal cancer incidence by age, 1998–2022

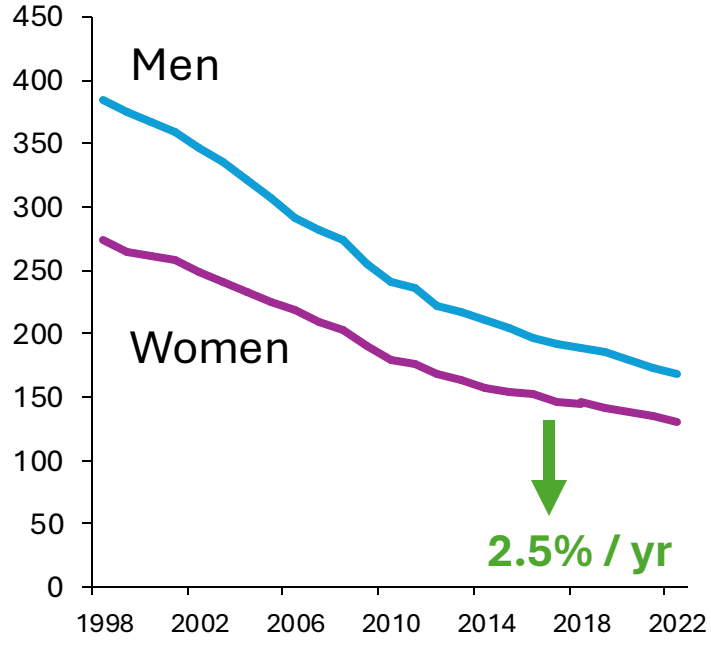
20-49 years



50-64 years



65+ years



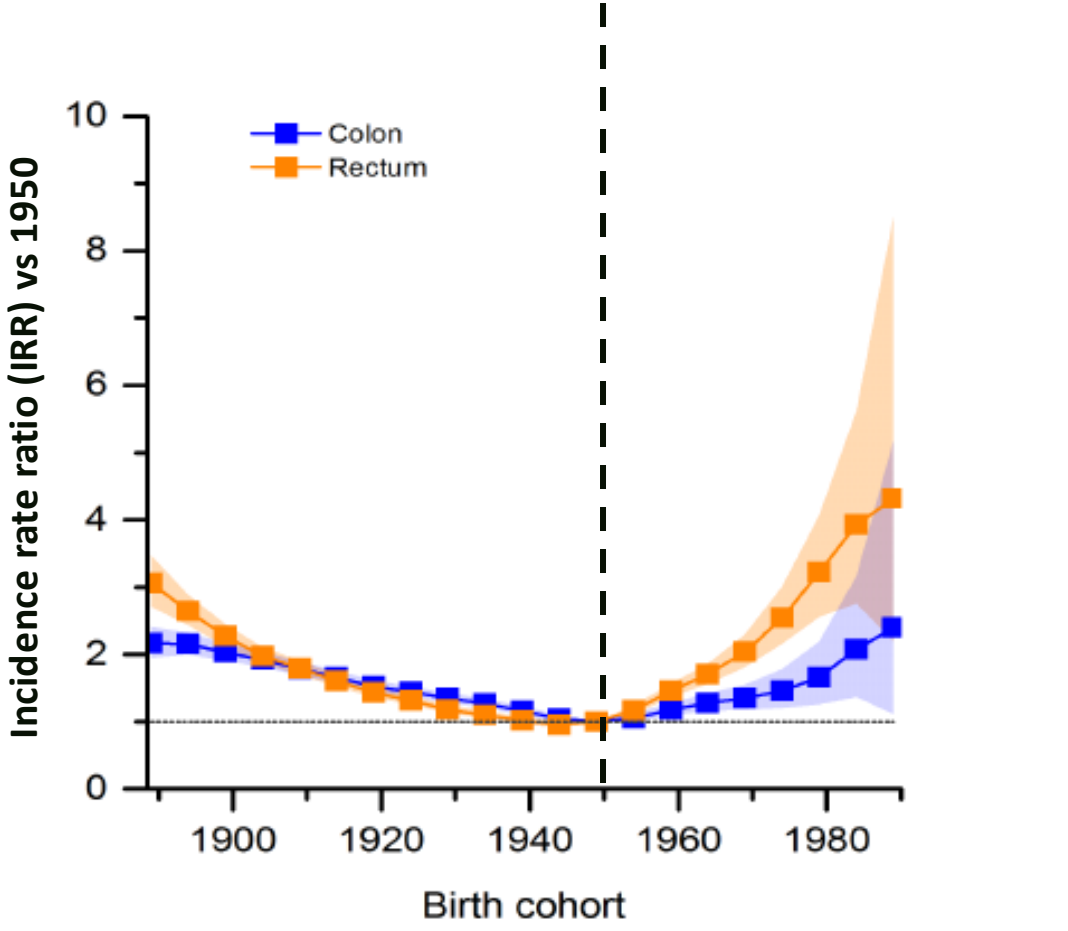
Siegel et al. Colorectal Cancer Statistics 2026, *CA Cancer J Clin.*

Colorectal Cancer Incidence Patterns in the United States, 1974–2013

Rebecca L. Siegel, Stacey A. Fedewa, William F. Anderson, Kimberly D. Miller, Jiemin Ma, Philip S. Rosenberg, Ahmedin Jemal

JNCI J Natl Cancer Inst (2017) 109(8): djw322

People born ~1950:
lowest risk of colorectal cancer



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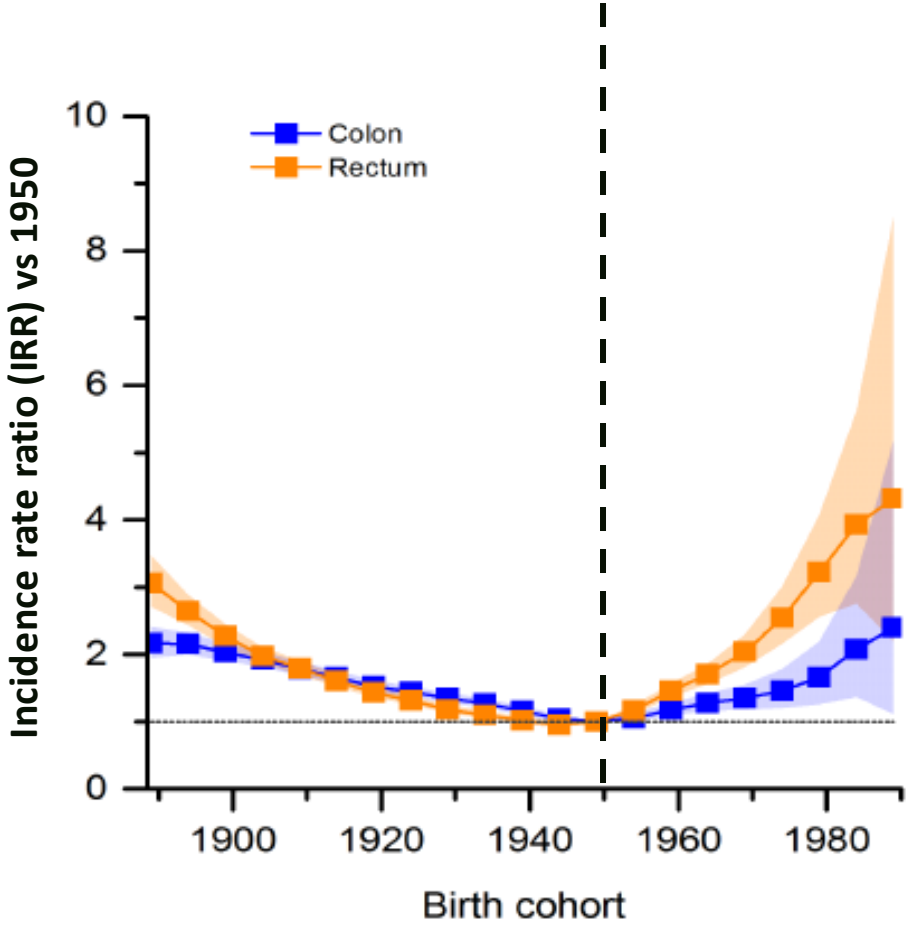


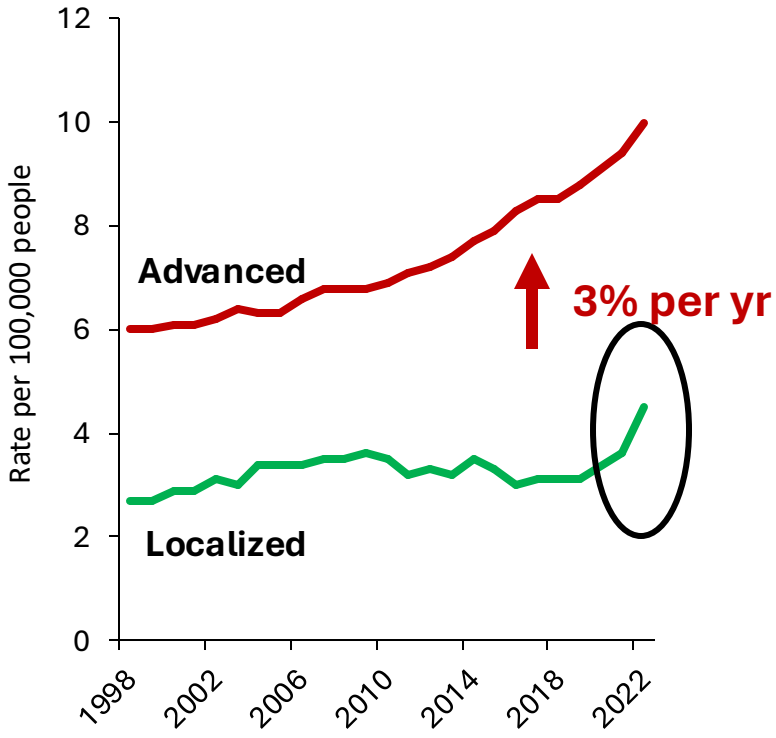
People born in 1990s:

4x the risk of rectal cancer

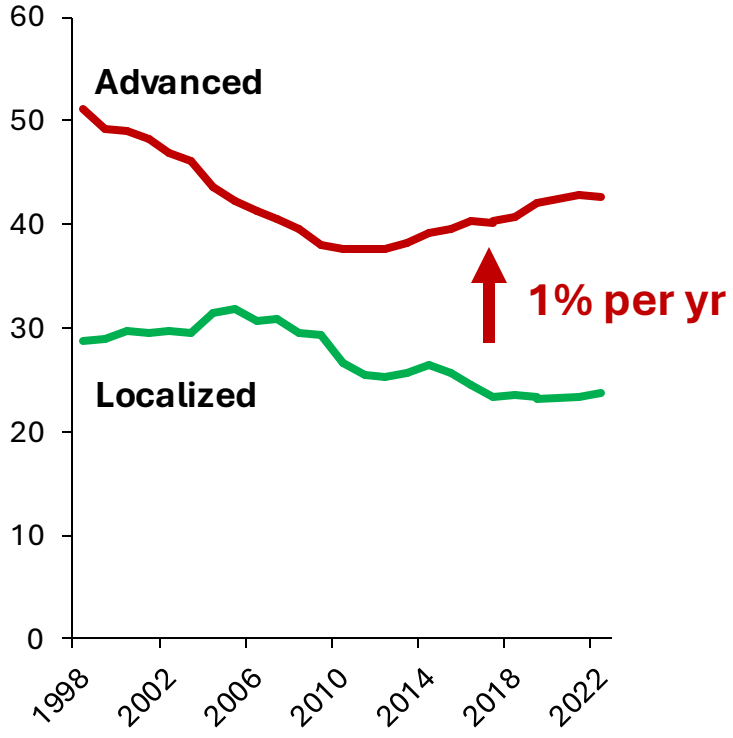
2x the risk of colon cancer

Trends in stage-specific incidence by age, 1998-2022

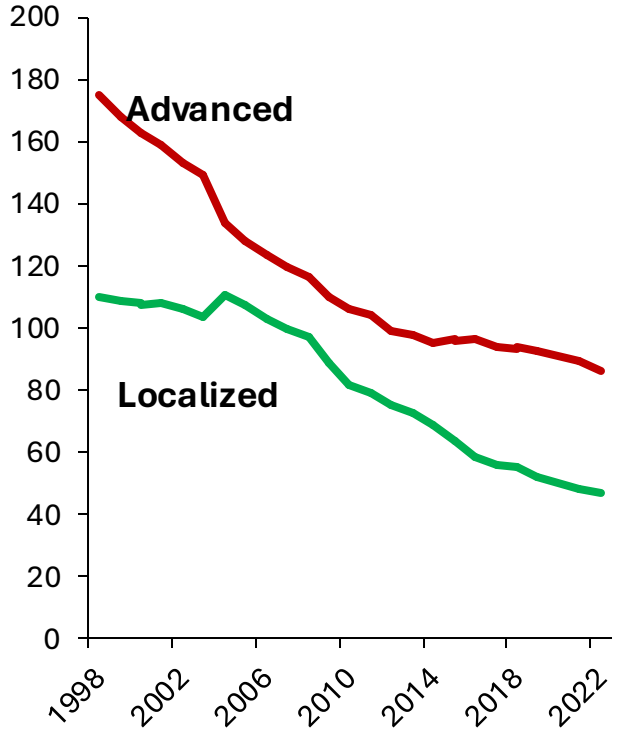
20-49 years



50-64 years



65+ years

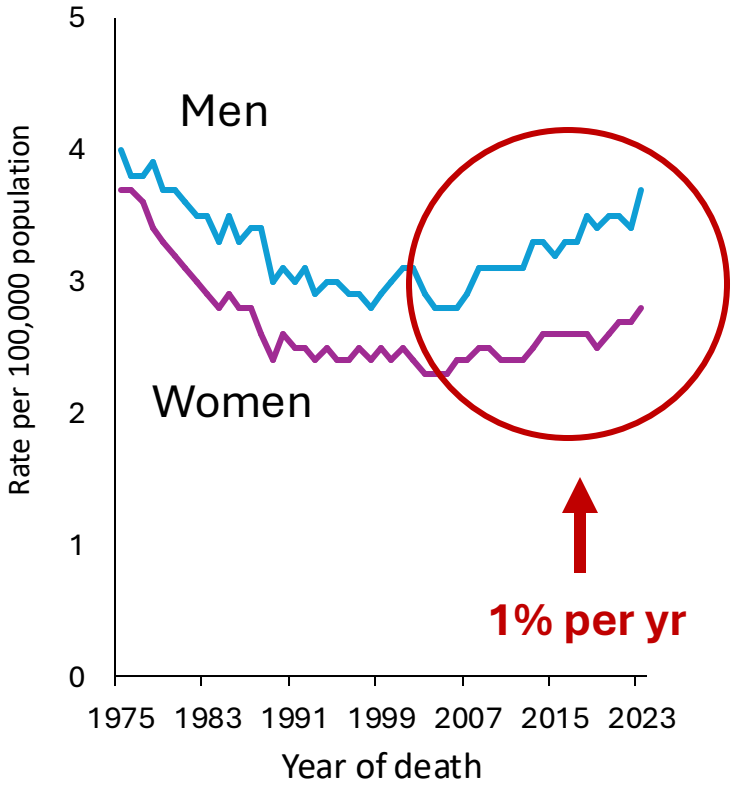


3 in 4 cases before 50 years are advanced

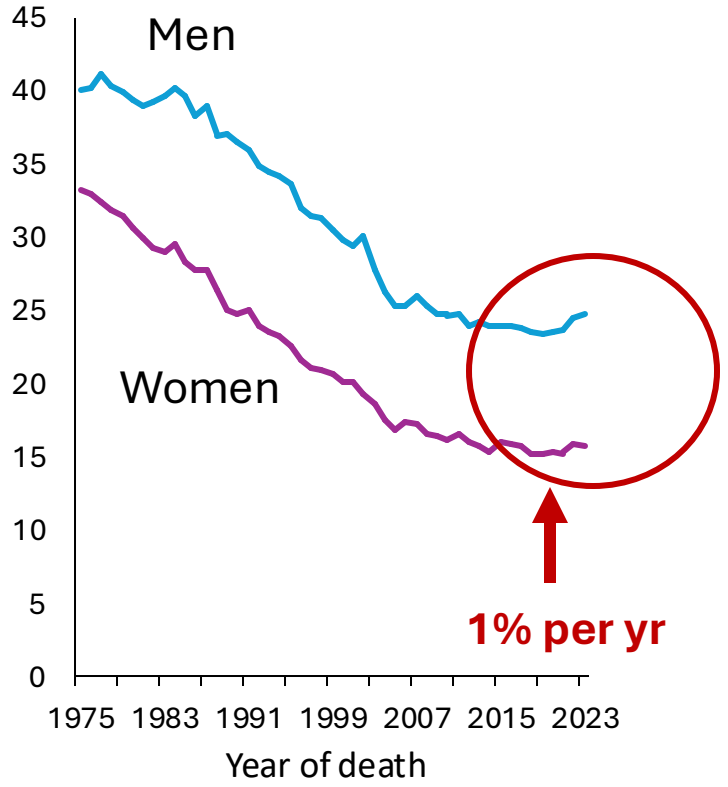
Siegel et al. Colorectal Cancer Statistics 2026, *CA Cancer J Clin.*

Trends in colorectal cancer death rates by age, 1975–2023

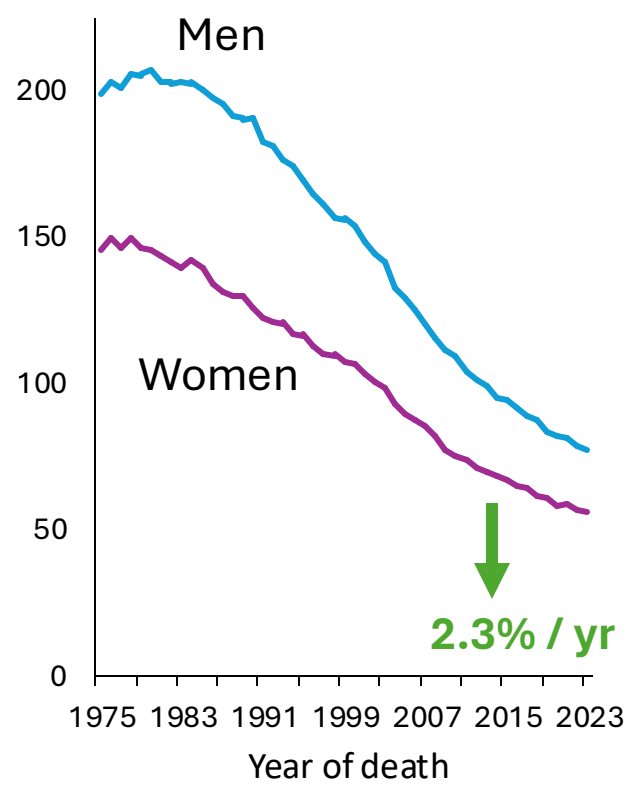
20-49 years



50-64 years



65+ years



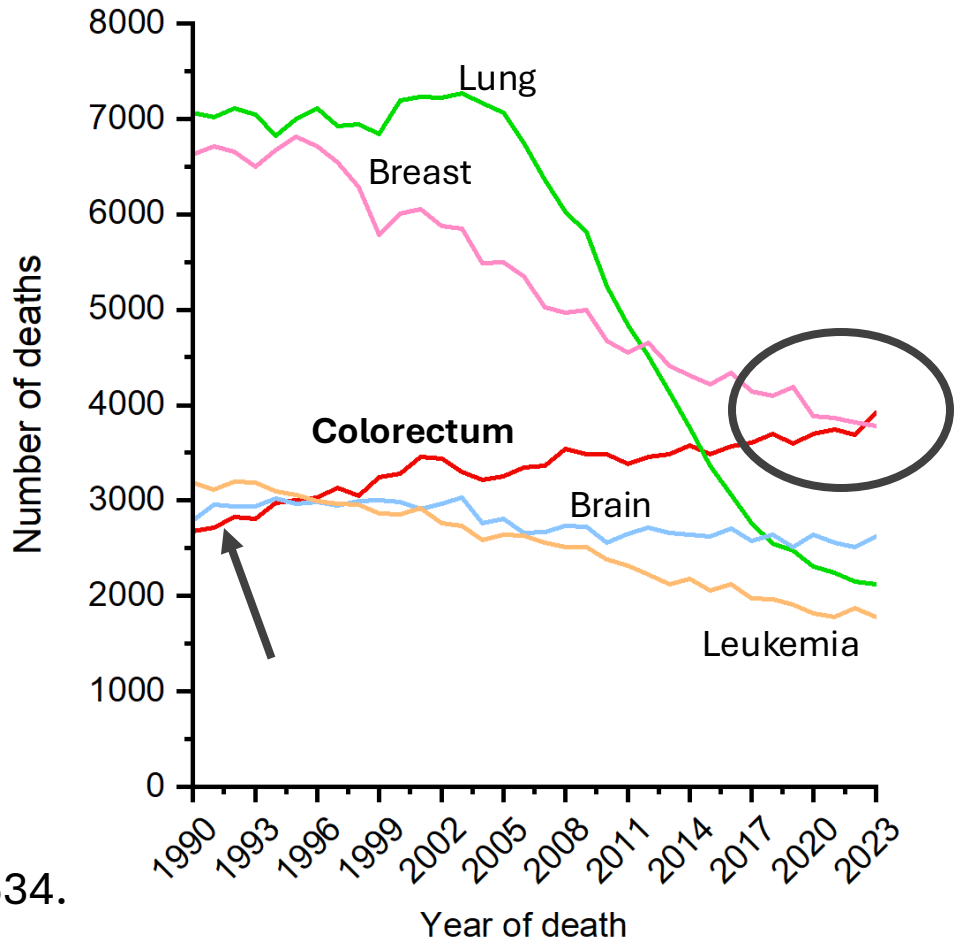
Siegel et al. Colorectal Cancer Statistics 2026, *CA Cancer J Clin*.

Research Letter

JAMA

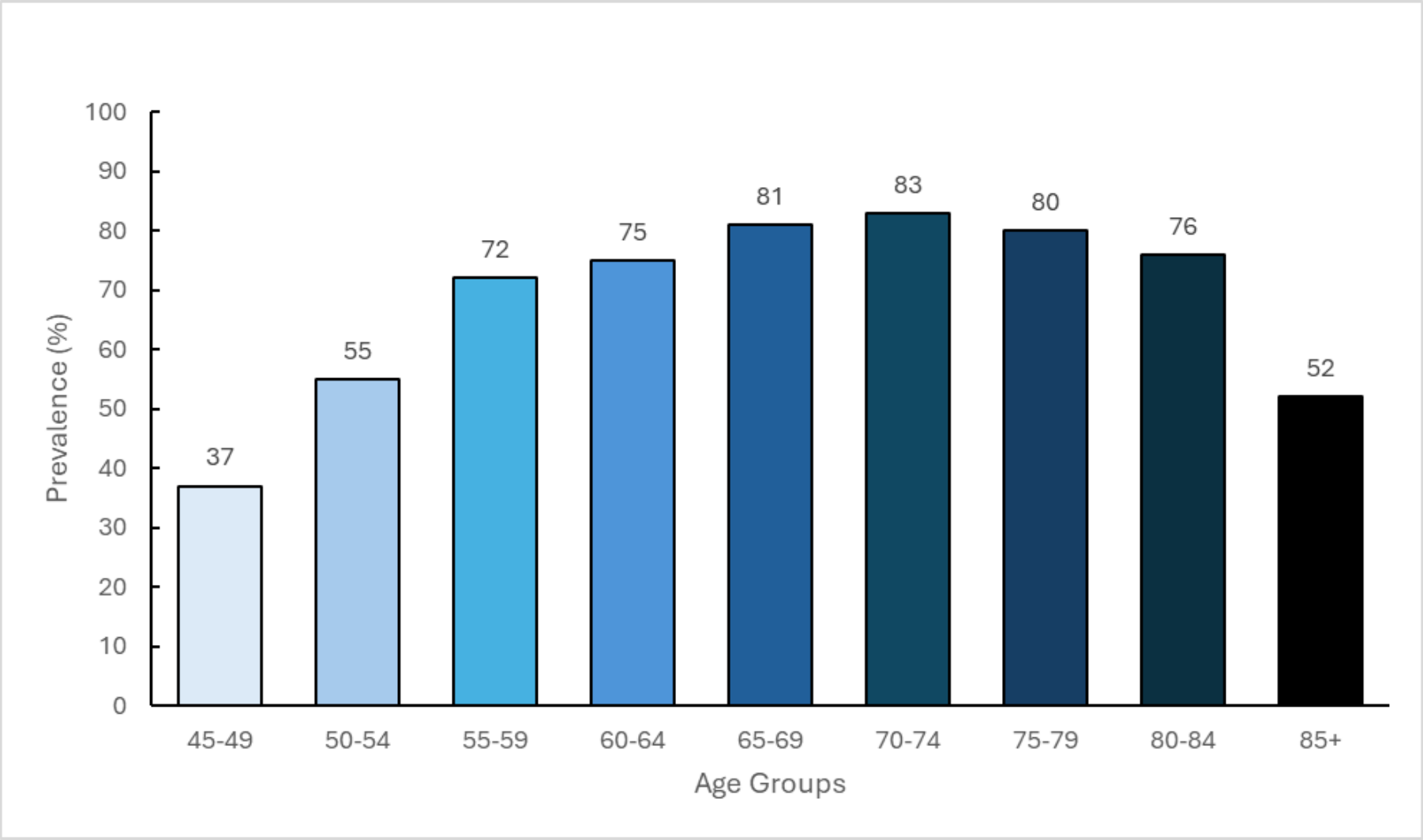
Leading Cancer Deaths in People Younger Than 50 Years

Rebecca L. Siegel, MPH[1]; Nikita Sandeep Wagle, PhD, MBBS, MHA[1]; Ahmedin Jemal, DVM, PhD[1]



JAMA. Feb 17 2026;335(7):632–634.

CRC Screening (%). Adults 45 Years and Older, by Age, US, NHIS, 2023



Keep in mind that these are up-to-date rates, meaning a sizable fraction of the 85+ group was screened in the past 10 years.

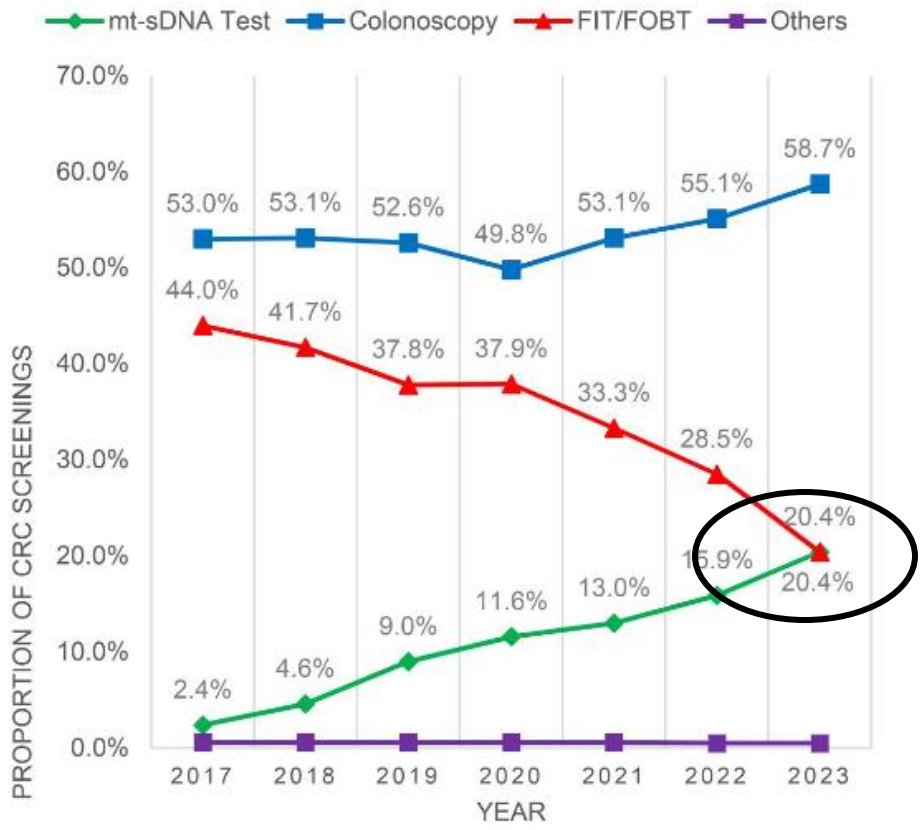
Estimates stratified by age are crude rates. Up to date colorectal cancer screening is defined as a gFOBT/FIT, sigmoidoscopy, colonoscopy, computed tomography colonography, or sDNA test in the past 1, 5, 10, 5 and 3 years, respectively. Source: National Health Interview Survey, 2023

Current Medical Research and Opinion, Oct 2025

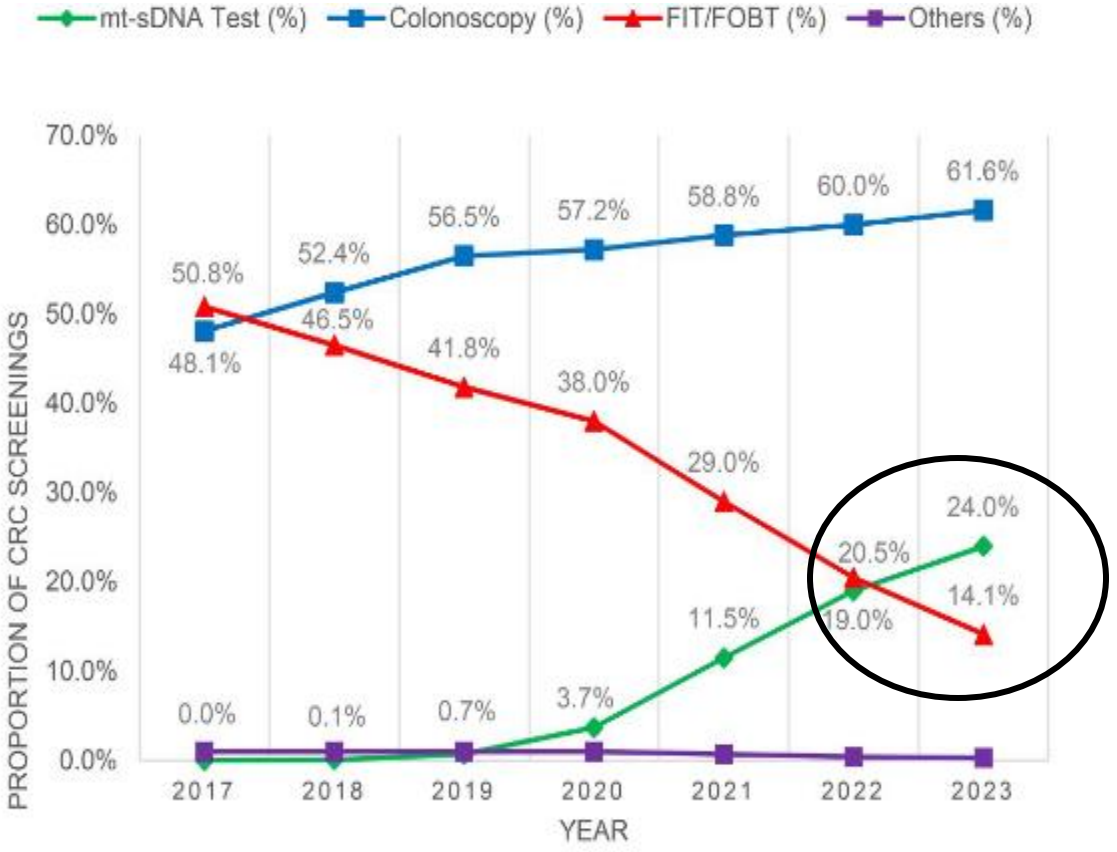
Utilization of colorectal cancer screening modalities in the United States (2017–2023): a national multi-payer claims database analysis

Mallik Greene[a], Shrey Gohil[a], Brad Stieber[a], A. Burak Ozbay[a], Quang A. Le[a], Raja Kakuturu[a], Joseph W. LeMaster[b], Michael Dore[c], A. Mark Fendrick[d], Joseph C. Anderson[e] and Jordan J. Karlitz[a]

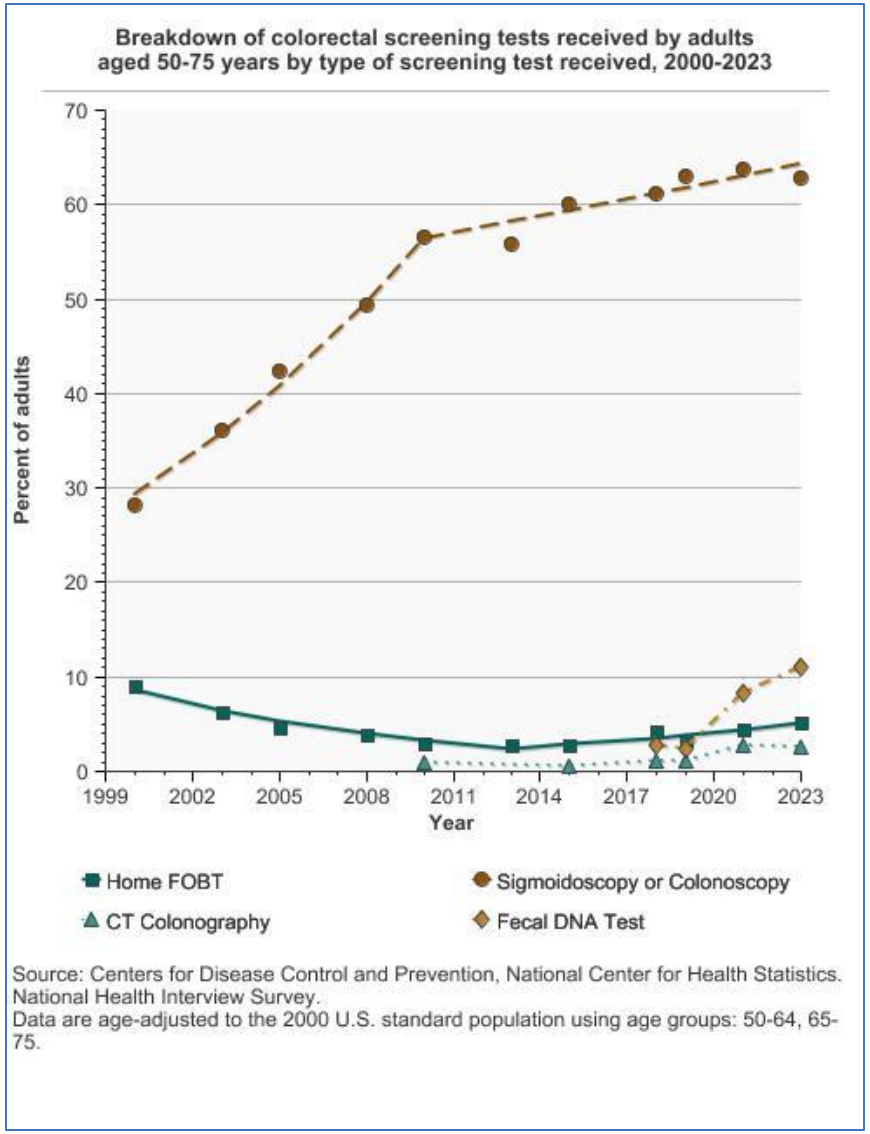
45+ years



45-49 years



Breakdown of colorectal screening tests received by adults aged 50-75 years by type of screening test received, 2000-2023



Detailed Trend Graphs	Most Recent Estimates (2023)	
	Percent of adults	95% Confidence Interval
Home FOBT	5.1	4.6 - 5.6
Sigmoidoscopy or Colonoscopy	62.8	61.7 - 63.9
CT Colonography	2.5	2.2 - 2.9
Fecal DNA Test	11.1	10.5 - 11.8

https://progressreport.cancer.gov/

What's New in the 2026 CRC Guideline Update?

Received: 27 March 2026 | Accepted: 30 March 2026
DOI: 10.3322/caac.70083

ARTICLE

Colorectal cancer screening: An update to the American Cancer Society guideline, 2026

Andrew M. D. Wolf MD[1] | Richard M. Hoffman MD, MPH[2] | Louise C. Walter MD[3] | Charnita Zeigler-Johnson PhD, MPH[4] | Timothy R. Church PhD[5] | Carmen E. Guerra MD, MSCE[6] | Elena B. Elkin PhD, MPA[7] | Ruth Etzioni PhD[8] | Abbe Herzig PhD[9] | Kevin C. Oeffinger MD[10] | Rebecca B. Perkins MD, MSc[11] | Sana Raoof MD, PhD[12] | Ya-Chen Tina Shih PhD[13] | Steven J. Skates PhD[14] | Tyler B. Kratzer MPH[15] | Deana Manassaram-Baptiste PhD, MPH[16] | Robert A. Smith PhD[16]

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ABSTRACT
Colorectal cancer (CRC) is a leading cause of cancer incidence and mortality in the United States, with rates recently increasing among adults younger than 65 years. In 2018, the American Cancer Society (ACS) lowered the recommended age to initiate screening for average-risk adults to age 45 years. Since then, new molecular-based screening tests—a multitarget stool RNA test (mt-sRNA), a next-generation

- The ACS transitioned CRC screening guidelines to a living guideline methodology
- The 2018 ACS CRC guideline recommendations were carried over to 2026
- One upgraded test and two new tests were included in the 2026 guideline
  - Cologuard Plus (ng mt-sDNA) replaces Cologuard on the guideline
  - ColoSense, a mt-sRNA test was added to the guideline
  - Shield, a blood-based DNA test was added to the guideline

American Cancer Society guideline for colorectal cancer screening, 2026 update. | **Recommendations**

The American Cancer Society (ACS) recommends that adults **aged 45 years and older** with an **average risk[b]** of developing colorectal cancer undergo regular screening with either a **high-sensitivity stool-based test or a structural (visual) examination**, depending on patient preference and test availability.

Patients should be informed that a positive result on a noncolonoscopy screening test requires timely follow-up with a colonoscopy to complete the screening process.

The recommendation to begin screening at age 45 years is a ***qualified recommendation***.

The recommendation for regular screening in adults aged 50 years and older is a ***strong recommendation***.

The ACS recommends that average-risk adults in good health with a life expectancy of greater than 10 years continue colorectal cancer screening through the age of 75 years (***qualified recommendation***).

The ACS recommends that clinicians individualize colorectal cancer screening decisions for individuals aged 76 through 85 years, based on patient preferences, life expectancy, health status, and prior screening history (***qualified recommendation***).

The ACS recommends that clinicians discourage individuals older than 85 years from continuing colorectal cancer screening (***qualified recommendation***).

a A strong recommendation conveys the consensus that the benefits of adherence to that intervention outweigh the undesirable effects that may result from screening. Qualified recommendations indicate there is clear evidence of benefit (or harm) of screening but less certainty about the balance of benefits and harms or about patients' values and preferences that could lead to different decisions about screening. **b** These recommendations represent guidance from the ACS for persons without a history of adenomatous polyps or colorectal cancer and those who are not at increased risk for colorectal cancer because of a strong family history of colorectal cancer, a confirmed or suspected hereditary colorectal cancer syndrome (such as familial adenomatous polyposis or Lynch syndrome), or a personal history of inflammatory bowel disease or of receiving radiation to the abdomen (belly) or pelvic area to treat a prior cancer.

Wolf A.M.D. et al. Colorectal Cancer Screening: 2026 ACS Guideline Update. CA Cancer J Clin. 2026. https://doi.org/10.3322/caac.70083

American Cancer Society guideline for colorectal cancer screening, 2026 update. | **Recommendations** (continued 2)

Preferred screening options

- Stool-based tests:
  - High-sensitivity fecal immunochemical test | *every year*
  - High-sensitivity guaiac-based fecal occult blood test | *every year*
  - Multitarget stool DNA test (original or next-generation) | *every 3 years*
  - Multitarget stool RNA test | *every 3 years*
- Direct visual examinations:
  - Colonoscopy | every *10 years*
  - Computed tomography colonography | *every 5 years*
  - Flexible sigmoidoscopy | *every 5 years*

Wolf A.M.D. et al. Colorectal Cancer Screening: 2026 ACS Guideline Update. CA Cancer J Clin. 2026. https://doi.org/10.3322/caac.70083

JAMA Oncology | Brief Report

JAMA Oncol. 2025;11(2):162-167. doi:10.1001/jamaoncol.2024.5381

Estimation of Cancer Deaths Averted From Prevention, Screening, and Treatment Efforts, 1975-2020

Katrina A. B. Goddard, PhD; Eric J. Feuer, PhD; Jeanne S. Mandelblatt, MD, MPH; Rafael Meza, PhD; Theodore R. Holford, PhD; Jihyoun Jeon, PhD; Iris Lansdorp-Vogelaar, PhD; Roman Gulati, MS; Natasha K. Stout, PhD; Nadia Howlader, PhD; Amy B. Knudsen, PhD; Daniel Miller, BA; Jennifer L. Caswell-Jin, MD; Clyde B. Schechter, MD; Ruth Etzioni, PhD; Amy Trentham-Dietz, PhD; Allison W. Kurian, MD, MSc; Sylvia K. Plevritis, PhD; John M. Hampton, MS; Sarah Stein, PhD; Liyang P. Sun, MS; Asad Umar, DVM, PhD; Philip E. Castle, PhD

Table 2. Cancer Deaths Averted From Prevention and/or Screening, and Treatment Advances vs Counterfactual

Intervention, calendar years, and age range considered	Total cancer deaths averted with all interventions[a]	Cancer deaths averted, No. (%)[a,b]		Cancer deaths averted from total cancer deaths in absence of all interventions, %		
		Prevention and/or screening in the presence of treatment advances (scenario 4 − scenario 3)	Treatment advances only (scenario 3 − scenario 1)	Prevention and/or screening in the presence of treatment advances (scenario 4 − scenario 3)/scenario 1	Treatment advances only (scenario 3 − scenario 1)/scenario 1	Total cancer deaths in absence of all interventions (scenario 1)
Female breast cancer[c]						
• Mammography • 1975-2020 • Persons aged ≥25 y	1 030 000	260 000 (25)	770 000 (75)	10	28	2 710 000
Cervical cancer[d]						
• Pap testing and HPV testing • 1975-2020 • All ages	160 000	160 000 (100)	Negligible	43	Negligible	370 000
Colorectal cancer[e]						
• Screening modalities in USPSTF guidelines • 1975-2020 • All ages	940 000	740 000 (79)	200 000 (21)	21	6	3 450 000

American Cancer Society guideline for colorectal cancer screening, 2026 update. | **Recommendations** (continued 3)

Recommendation for blood-based colorectal cancer screening

- **Blood-based screening tests are not preferred screening options at this time; they should be recommended only to individuals who decline or have not completed one of the preferred colorectal cancer screening tests.**
  - Blood-based tests should not be ordered without prior discussion with the patient.
  - Patients who choose a blood-based test should be informed that:
    - Blood-based tests have lower sensitivity than high-sensitivity stool-based tests and direct visual examinations in detecting advanced precancerous lesions and stage I colorectal cancers, limiting their effectiveness for reducing colorectal cancer incidence and mortality relative to the preferred options (see Table 2).
    - If their blood-based test is positive, patients will need to undergo a follow-up colonoscopy to complete the screening process.
    - Manufacturers have not specified a recommended testing interval; however, the Centers for Medicare and Medicaid Services specifies a 3-year interval for Medicare beneficiaries.

Wolf A.M.D. et al. Colorectal Cancer Screening: 2026 ACS Guideline Update. CA Cancer J Clin. 2026. https://doi.org/10.3322/caac.70083

Next-generation multitarget stool DNA test

- Primary evidence: BLUE-C study (ClinicalTrials.gov identifier NCT04144738)
- Evidence suggests: next-generation assay achieves **improved specificity** while maintaining comparable sensitivity for CRC and APL
- Diagnostic performance: at least as accurate as the original mt-sDNA assay
- Screening average-risk populations every 3 years from ages 45 to 75 years achieves favorable life-years gained relative to the number of lifetime colonoscopies required
- Reductions in CRC incidence and mortality comparable to those achieved with FIT and mt-sRNA testing when applied at recommended intervals

Detection of:	Sensitivity
Colorectal cancer	93.9%
Advanced precancerous lesions	43.4%
Stage 1 cancer	94%
Detection on colonoscopy:	**Specificity**
No colorectal cancer or advanced precancerous lesions	89.8%
No neoplasia	92.4%

The **3-year screening interval** is supported by modeling evidence and CMS coverage determination. Longitudinal screening outcomes study is ongoing to evaluate optimal screening interval.

Gagrat et al. (2024), Imperiale, et al. (2024), Wolf et al. (2026). | Abbreviations: CMS, Centers for Medicare & Medicaid Services; CRC, colorectal cancer.

Multitarget Stool RNA (mt-sRNA) Test

- Primary evidence: CRC-PREVENT (ClinicalTrials.gov identifier NT04739722)
- Incorporates self-reported smoking status into the diagnostic algorithm. *Post-marketing, real-world setting evaluation needed.*
- Comparable level of false-positive when compared with existing molecular screening tests.
- Benefits: lifetime CRC cases and deaths averted, as well as life-years gained.
- Burdens: included the total number of required screening tests and harms related to colonoscopy complications.
- ***Not as consistently effective as other screening options relative to the number of colonoscopies required*** → **increased colonoscopy burden associated with the roughly 5-percentage-point lower specificity.**
- As of 5/27/2026, CMS has not issued a coverage determination for mt-sRNA testing.

Detection of:	Sensitivity
Colorectal cancer	94%
Colorectal cancer (45-49 years)	100%
Advanced precancerous lesions	45%
Stage 1 cancer	100%
High-grade dysplasia (≥ 10 adenomas)	65%
Detection on colonoscopy:	**Specificity**
No lesions	88%

Optimal screening interval for mt-sRNA testing is uncertain. New tests lack real-world and clinical study data evaluating test performance, adherence, and clinical outcomes across repeated screening rounds.

Barnell et al. (2023), Wolf et al. (2026). | Abbreviations: CMS, Centers for Medicare & Medicaid Services; CRC, colorectal cancer.

Blood-based testing

	Shield[1]	SimpleScreen[2]
Primary evidence:	ECLIPSE study (ClinicalTrials.gov identifier NCT04136002)	PREEMPT CRC study (ClinicalTrials.gov identifier NCT04369053)
Colorectal cancer	83.1% sensitivity	79.2% sensitivity
Advanced precancerous lesions	**13.2% sensitivity**	**12.5% sensitivity**
Colorectal cancer stage 1	64.7% sensitivity	57.1% sensitivity
Accurately identifying persons without any advanced colorectal neoplasia	89.6% specificity *Declines with increasing age*	91.5% specificity *Declines with increasing age*

80% of long-term CRC mortality benefit comes from detecting and removing precancerous lesions.[3]

Wolf et al. (2026) | **1** Chung et al. (2024). **2** Shaukat et al. (2025). **3** Heisser et al. (2024).

How do the 2026 ACS CRC Guidelines Compare with the USPSTF CRC Recommendations?

	2026 American Cancer Society[1]	2021 U.S. Preventative Services Task Force[2]
Age to Start	**45 years**	**45 years**
Testing options and intervals	**Preferred stool-based tests:** • High-sensitivity fecal immunochemical test (FIT), *every year* • High-sensitivity, guaiac-based fecal occult blood test (gFOBT), *every year* • Multitarget stool DNA (mt-sDNA) test (original or next-generation), *every 3 years* • Multitarget stool RNA test (mt-sRNA), *every 3 years* **Preferred direct visual exams:** • Colonoscopy, *every 10 y* • CT colonography, *every 5 y* • Flexible sigmoidoscopy, *every 5 y* Blood-based screening tests are not preferred screening options at this time; they should be recommended only to individuals who decline or have not completed one of the preferred colorectal cancer screening tests.	**Stool-based tests** • Fecal immunochemical test (FIT), every year • High-sensitivity, guaiac-based fecal occult blood test (gFOBT), every year • Multitarget stool DNA test (sDNA-FIT), every 3 years **Structural examinations** • Colonoscopy, *every 10 y* • CT colonography, *every 5 y* • Flexible sigmoidoscopy, *every 5 y* • Flexible sigmoidoscopy, every 10 years + FIT every year
Result Follow-up	A positive result on any non-colonoscopy screening test requires timely follow-up with colonoscopy, **preferably within 6 months**, to complete the screening process.	To achieve the benefits of screening, abnormal results from stool-based tests, CT colonography, and flexible sigmoidoscopy should be followed up with colonoscopy.
Age to end	Individualized decision **76 to 85** years	Selective screening **76 to 85** years

1 Wolf et al. (2026), **2** U.S. Preventive Services Task Force (2021).

Original research

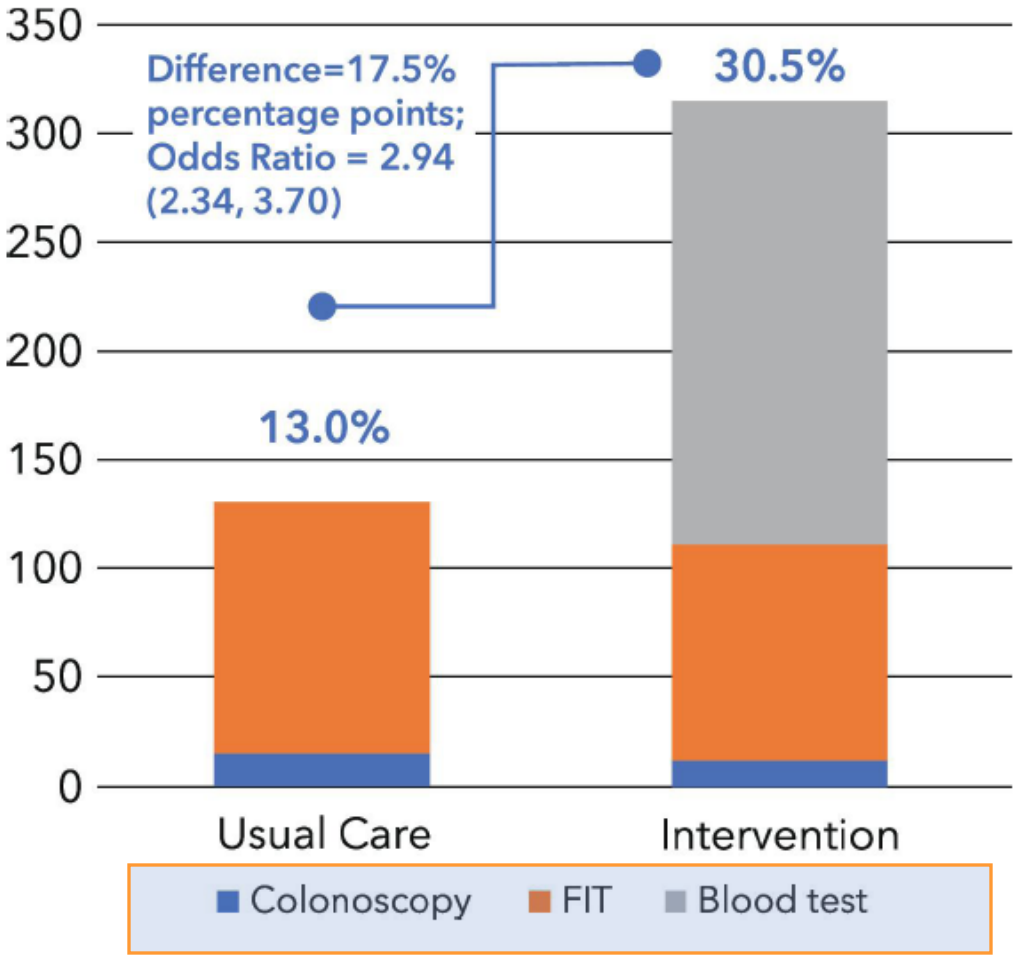
Blood-based colorectal cancer screening in an integrated health system: a randomised trial of patient adherence

Will people who had not completed a FIT for CRC screening complete a blood-based testing option if offered one during health encounters?

- Approximately 2,000 patients aged 45–75 years who were offered but did not complete an FIT in the prior 3–9 months, and *were scheduled for a clinical encounter, were randomized (1:1) to an invitation to be screened with a commercially available CRC blood test (Shield, Guardant Health) versus usual care.*
- 3-month CRC screening proportions in the two groups was measured.
- ***CRC screening proportions were 17.5 percentage points higher in the blood test group versus usual care (30.5% vs 13.0%; OR 2.94, 95% CI 2.34 to 3.70; p<0.001).***

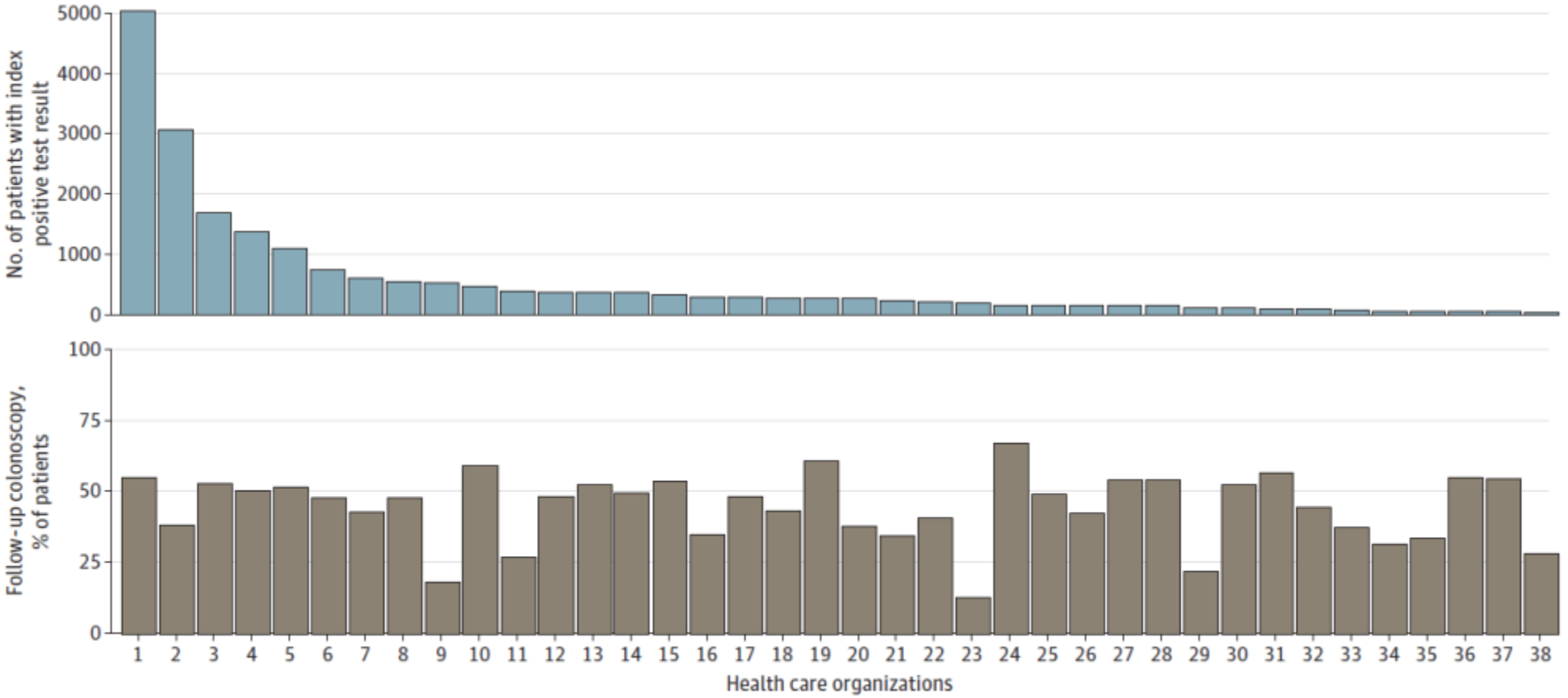
Coronado GD, et al. Gut 2024;73:622–628. doi:10.1136/gutjnl-2023-330980

Participation in colorectal cancer screening by study condition and test modality.



- ***Does a blood test draw people away from CRC tests they've previously used?***
- Not as much as is feared
- FIT and colonoscopy numbers are similar
- 41% of the intervention group that got any screening had never been screened, and most of them got the blood test.
- This study is *not* a measure of point of care screening, where convenience and misunderstanding of the limitations of blood-based tests may tip the scale.

Measure Performance, by Health Care Organization and Volume of Tests With Positive Results, 2018



Follow-up colonoscopy within 180 days of abnormal stool-based test ranged from 13.1% to 66.9% (median, 47.9%) across 38 health care organizations.

JAMA Network Open. 2024;7(3):e242693. doi:10.1001/jamanetworkopen.2024.2693

Conclusions

- **The largest barrier to prevention exists within the current landscape of CRC screening**
  - Preference for CRC screening tests varies in the population
  - So too does access…
  - The fullest potential for CRC prevention varies by CRC screening test types based on full, lifetime adherence—it is quite good for most recommended tests, but requires regular adherence
  - However, nonadherence with recommended screening guidelines is common, and more than a third of adults have never been screened or have dropped out
  - These enduring conditions erode the potential for CRC prevention and mortality reduction

Conclusions (2)—What can we do?

- We need *Systems* to improve adherence with the screening test of choice
- We need to improve the quality and accuracy of stool tests (FIT mainly)
- We need to improve the rate and timeliness of follow-up of all non-colonoscopy tests
- We need to improve the quality of colonoscopy
- We need to confront a growing shortage of gastroenterologists relative to population size and geography

Conclusions (3)—What can we do?

- We need better education of the dual opportunities of CRC screening to reduce CRC incidence and mortality
- We need to recognize that there will be some proportion of the population that will be non-adherent with any of the recommended tests
- We need to prepare for the introduction of blood-based tests.
  - Who will use these tests?
  - Will people who formerly were screened with tests with greater prevention potential choose these tests?
  - Will people who have never been screened undergo these tests?

Acknowledgements

- Molly Black
- Becky Siegel
- Tyler Kratzer
- Deana Baptist
- Liora Sahar
- The NCCRT staff, leadership, and members
- CrEST
- The ACS Guideline Development Group

Thank you

Q&A

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Thank You!

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