Cancer screenings

	Screening test	Cancer	Purpose	Suggested interval	Risks	Notes	Look for…
All	1. FIT/FOB 2. Colonoscopy	Colorectal (CRC)	Fecal test is detection too Colonoscopy is prevention (polyp removal)	Annual for FIT/FOB 3-5 years for colonoscopy	Perforation (1/~1500) Bleeding (1/~750) Anaesthesia complications	CRC grows slowly (8+ years), and polyp removal is curative. Colonoscopy is strongest preventive screening tool in medicine. Screening every 10 years reduces death by up to 75%. FIT/FOB are reasonable for detecting more advanced tumours, but not “early” detection like colonoscopy.	Look for blood in stool, new constipation, new diarrhoea, “pencil poops”, iron deficiency anaemia, unexplained loss of appetite. Emphasis on new, persistent and progressive changes. Often a very “quiet” disease until advanced. Colonoscopy takes precedence.
	Gastroscopy Can include *H.pylori* breath test too	Gastric/Esophageal	Risk stratification, detection	Once at ~40, then every 10 yrs if normal	Perforation (1/~10,000) Bleeding Dental injuries Sore throat, gassy	Gastric grows slowly (gastritis to metaplasia to tumour >10 years), Shorten interval if gastritis or metaplasia identified. Miss rate ~9%. Esophageal can be faster, but mostly if Barrett’s (0.3% per year). If no Barrett’s, risk is extremely low.	Can be subtle or asymptomatic. Heartburn, bloated after eating, early satiety. Red flags: difficulty swallowing, weight loss
	Alpha feto-protein (AFP) blood test. PIVKA blood test. Abdominal ultrasound (optional)	Liver (HCC)	Early detection, potential cure	Depends on risk factors (HBV/HCV, cirrhosis, fibrosis). For high risk, every 6 months. Normal person AFP every year.	No risk from blood test or ultrasound Potential benign lesion detection requiring followup	HCC can grow fairly rapidly. Doubling time 3-6 months. AFP test around 60% predictive. Tumour of >8mm can be visualised by ultrasound. Early detection often curable by surgery.	Essentially no symptoms in early stages. Late stage: abdominal discomfort, nausea, ascites, jaundice
	Low-dose chest CT	Lung (a whole family of cancers: adenocarcinoma, SCC, large cell, neuroendocrine)	Early detection / black swans Also detects aortic problems, aneurysms, congenital issues	Every 2–3 years	Radiation (1-2mSv. For context, normal background 3mSv per year). So roughly 50-100% more than baseline. Many false positives, harmless lesions	Controversial. Not recommended at population level for non-smokers by any society or medical system. However, lung cancer in never-smokers is still one of most common cancers. Attia recommends every 1y, since preclinical detectable phase is often 1-2 years. Still no guarantee (aggressive cancers can spread in <6 months).	No symptoms in early stages. Seek evaluation if >3 weeks of unexplained coughing, chest pain, shortness of breath, wheezing. Red flags: blood in cough, weight loss, bone pain
	Visual exam (self + clinician)	Skin (MM, BCC, SCC)	Early detection, cure	Every 6 months (self-check) Annual (dermatologist)	No risk other than false positive, biopsy or unnecessary removals	Melanoma risk is non-zero even in low-risk populations. Higher with Fitzpatrick III or less skin. Unrelated to UV exposure. Typically starts as a mole which visibly changes over several months. Curable until vertical invasion. SCC/BCC more common, less deadly, usually in sun-exposed areas.	Highly-pigmented lesions. Rapid change in appearance. **ABCDE** (**a**symmetry, irregular **b**order or bleeding, uneven **c**olour, **d**iameter >6mm, **e**volving appearance). Check: face, ears, scalp, neck, chest, abdomen, arms, between fingers, under arms, back, buttocks, legs, toes, soles of feet. Nail beds present as a dark streak/line.
	Self-exam Dentist checkup	Oral	Early detection	Dental check every 6 months Self-vigilance is highly effective	No risk	Screening varies by dentist, but should at least spot suspicious lesions, discolouration. Rarely look at throat. Oropharyngeal cancer again associated with HPV - young people should vaccinate	2-3 weeks of: non-healing ulcers, red/white patch, persistent sore throat or hoarseness, ear pain (particularly one-sided), seek medical followup
Men	Self-exam	Testicular	Early detection, cure	Monthly self-check	No risk	Rare, but early detection is simple and effective. Early stage is highly curable. Can progress very rapidly, so monthly screening is best. Very easy to follow up by ultrasound, which can distinguish benign/cancer	Roll each testicle between fingers and thumb. Should be smooth and firm like a boiled egg. Warning signs are harder feeling, painless lump (inside or on surface), swelling on one side, or a lump that does not move. (Imagine a pebble in a boiled egg).
	PSA blood test	Prostate (PC)	Early detection	Every 1–2 years from 40	No risk from blood test	Start earlier if family history. Yearly PSA is good to establish personal baseline and see a trend. Rapid rise (PSA velocity) is more worrying than slow rise. Avoid ejaculation/bike before test. If higher, re-test in 3 months.	
Women	HPV + Pap test	Cervical (CC)	Prevention	Every 3-5 years	Discomfort, spotting True complications very rare	CC is very slow and linear growing. HPV to pre-cancer 5-10y, pre-cancer to cancer 5-10y. Thus 3-5y is suitable screening interval. CC largely driven by chronic HPV. Most people 40+ are infected at some point, 6-7% have long-term high risk infections. Younger people should vaccinate.	
	Mammography	Breast	Early detection	Annually (based on age, higher frequency >50yo)	Low dose radiation (0.4 mSv) Many false positives Detection of slow-growing cancers which are not dangerous, but will require surgery/treatment	Yearly, or 2x per year if higher risk. Breast cancer highly variable - slow or aggressive, non-linear progression. Mammography not great at population level (reduces 1 death per 2,000 women screened)	Self-checks no longer reccommended. But self-vigilance and awareness is effective. Look for new skin dimpling (orange peel)/puckering, nipple inversion, redness, nipple discharge (particularly clear, blood or one-sided). Learn baseline and be sensitive to changes. Note: area is large, including arm pits, collar bone, sternum.
Nobody	Brain CT or MRI	Brain (GBM etc)	In theory, early detection Can detect meningioma, aneurysms etc	Not recommended	Many false positives. No survival benefit proven	Often finds benign meningiomas which will not kill you in a normal lifetime, but require follow-up. GBM extremely aggressive (thankfully rare). Median diagnosis age is 64yo. Small tumours often cause symptoms anyway. No proven survival benefit of detection.	
	CT May be covered by abdominal ultrasound, but not failsafe	Pancreatic	In theory, early detection		Many false positives. No survival benefit proven	Spreads very quickly. Often occurs and spreads between tests.	
	Transvaginal ultrasound	Ovarian	In theory, early detection		Many false positives Ultrasound cannot identify tumour from cysts.	No effective screening tool. Deep location. Spreads quickly into peritoneum, even at very early stage. No proven survival benefit. Interestingly, 5 years oral contraceptive use, pregnancy and breast feeding are highly protective (40-50% reduction)	
	Transvaginal ultrasound	Endometrial			Huge numbers of false positives Poor imaging	Biopsy is best method. Note: for HRT, progestin paired with oestrogen lowers risk	Careful monitoring of bleeding is a more sensitive tool. New, irregular, heavy, post-coital should be investigated. Post-menopause, any bleeding should be investigated.