National Comprehensive Cancer Network®

2026

NCCN Guidelines for Patients®

Cancer care recommendations from leading experts at the National Comprehensive Cancer Network® (NCCN®)

Colorectal Cancer Screening



Made possible by

National Comprehensive Cancer Network® Foundation

Available online at NCCN.org/patientguidelines



NCCN Guidelines for Patients®

The essential guide for people facing cancer.

Based on care recommendations from leading cancer experts.

Explains high-quality cancer care provided at state-of-the-art cancer centers.

Reviewed and revised every year.

Did you know that top cancer centers across the United States work together to improve cancer care? This alliance of leading cancer centers is called the National Comprehensive Cancer Network® (NCCN®).

Because cancer care is always evolving, NCCN develops and frequently updates evidence-based cancer care recommendations used by health care providers worldwide. These recommendations are known as the NCCN Clinical Practice Guidelines in Oncology (NCCN Guidelines®).

The NCCN Guidelines for Patients plainly explain these expert recommendations, so you can talk with your care team about the best care for you.

These NCCN Guidelines for Patients are based on the NCCN Guidelines® for Colorectal Cancer Screening, Version 2.2026 — April 23, 2026.

View the NCCN Guidelines for Patients free online: NCCN.org/patientguidelines

Find an NCCN Cancer Center near you: NCCN.org/cancercenters

Learn how the NCCN Guidelines for Patients are developed: NCCN.org/patient-guidelines-process

Connect with us

@NCCNorg @NCCNVideo NCCN @NCCNorg

Supporters

National Comprehensive Cancer Network® Foundation

We translate complex cancer care into trusted guidance and fund the next generation of researchers shaping tomorrow's care.

NCCN independently adapts, updates, and hosts the NCCN Guidelines for Patients. Our corporate supporters do not participate in the development of the NCCN Guidelines for Patients and are not responsible for the content and recommendations contained therein.

FIGHT™ COLORECTAL CANCER

Fight Colorectal Cancer (Fight CRC) is a leading patient-empowerment and advocacy organization providing balanced and objective information on colon and rectal cancer research, treatment, and policy. Serving as relentless champions of hope, focused on funding promising, high-impact research endeavors while equipping advocates to influence legislation and policy for the collective good. Learn more at fightcolorectalcancer.org and follow-on social media @FightCRC!



The way forward starts here.

National Comprehensive Cancer Network® Foundation

Give Now

Contents

4 Chapter 1
About colorectal cancer screening

10 Chapter 2
Screening in people at average risk

21 Chapter 3
Screening in people at increased risk

28 Chapter 4
Other resources

31 Words to know

33 NCCN Contributors

34 NCCN Cancer Centers

36 Index

NCCN Guidelines for Patients and illustrations herein may not be reproduced in any form for any purpose without the express written permission of NCCN. No one, including doctors or patients, may use the NCCN Guidelines for Patients for any commercial purpose and may not claim, represent, or imply that the NCCN Guidelines for Patients that have been modified in any manner are derived from, based on, related to, or arise out of the NCCN Guidelines for Patients. The NCCN Guidelines are a work in progress that may be redefined as often as new significant data become available. NCCN makes no warranties of any kind whatsoever regarding its content, use, or application and disclaims any responsibility for its application or use in any way.

NCCN Foundation seeks to support the millions of patients and their families affected by a cancer diagnosis by funding and distributing NCCN Guidelines for Patients. NCCN Foundation is also committed to advancing cancer treatment by funding the nation's promising doctors at the center of innovation in cancer research. For more details and the full library of patient and caregiver resources, visit NCCN.org/patients.

National Comprehensive Cancer Network (NCCN) and NCCN Foundation
3025 Chemical Road, Suite 100, Plymouth Meeting, PA 19462 USA

PLEASE NOTE that by downloading/using this NCCN Content, you agree to the terms of the NCCN End-User License Agreement (https://www.nccn.org/end-user-license-agreement) and you MAY NOT distribute this Content or use it with any artificial intelligence system, machine learning model, or large language model or other artificial intelligence tool.

Copyright © 2026 National Comprehensive Cancer Network, Inc. All Rights Reserved.

1
About colorectal cancer screening

5 What is screening?

6 Polyps and lesions

8 Determining your risk

9 How can I get the best care?

Screening prevents colorectal cancer by finding and removing polyps before they become cancer. If cancer has started to develop, screening can find it early, when a cure is more likely.

Colorectal cancer refers to cancers that form in the colon or rectum. These organs make up the large intestine, also called the large bowel.

In the colon, the food you eat becomes feces (stool). Stool is held in the rectum until it leaves the body during a bowel movement.

The bowel wall is made of layers of tissue. Cancer starts in the innermost layer that comes in contact with stool.

What is screening?

Screening is testing for a health problem in someone without any signs or symptoms of the problem.

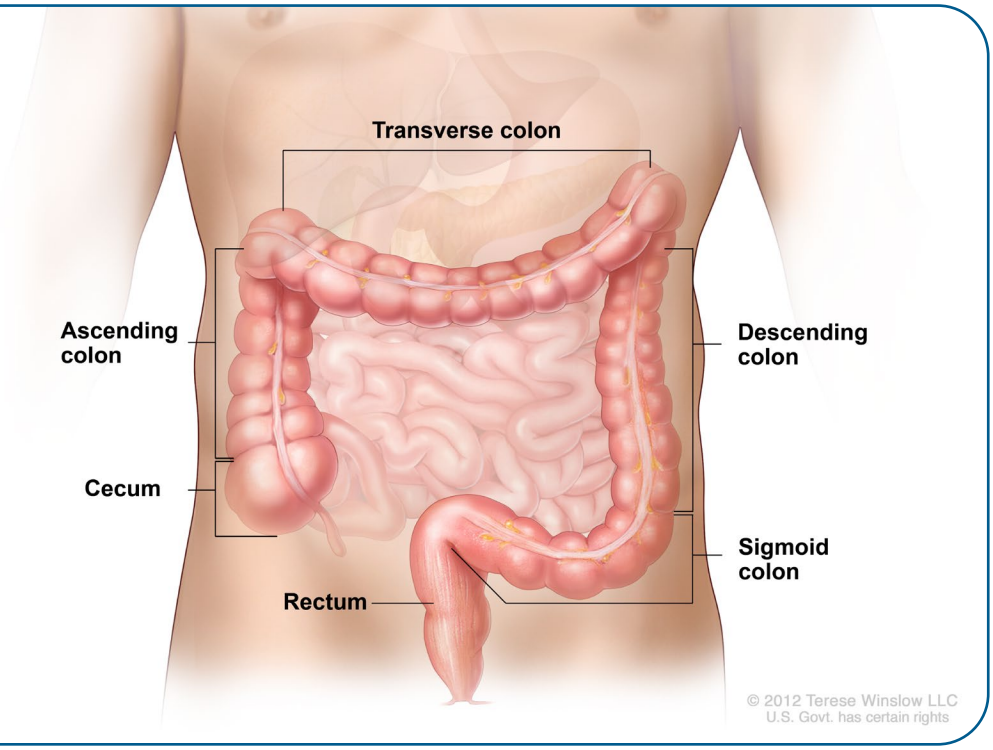
Your provider will consider your age, health history, and family health history to determine your risk of developing colorectal cancer. Your risk determines when you should start screening, how often you will need screening, and which method(s) are recommended for you.

Most people are at average risk and have several types of screening tests to choose from.

In the United States, American Indians/Alaska Natives and Black individuals are more likely to develop, and to die of, colorectal cancer.

The large bowel

The colon makes up most of the large bowel. After digested food becomes stool in the colon, it stays in the rectum until you have a bowel movement.



Polyps and lesions

Polyps are growths on the inner lining of the large bowel. Some types are more likely to form cancer than others.

Removing polyps can prevent cancer before it starts. Most can be removed during a colonoscopy, using a minor procedure called polypectomy. A pathologist examines the removed polyp(s) under a microscope to determine the polyp type and growth pattern, and to make sure that cancer hasn't started to develop.

Adenomas

Adenomas are the most common type of polyp. Over time, an adenoma can become invasive cancer. Cancer that forms from an adenoma is called an **adenocarcinoma**. It's the most common type of colorectal cancer.

When viewed under a microscope, 1 of 3 growth patterns can be seen in an adenoma: tubular (most common), villous, and tubulovillous.

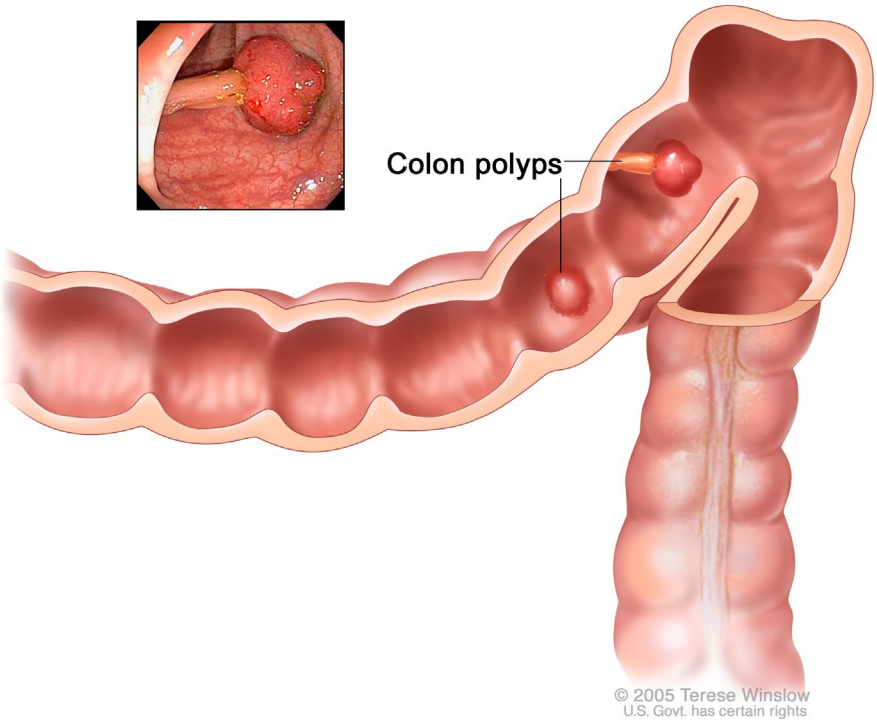
Adenomas with any of the following features are more likely to become cancer than those without:

- Size larger than 1 centimeter (cm)
- High-grade (fast-growing) dysplasia
- Villous or tubulovillous growth pattern

A traditional serrated adenoma (TSA) is a rare adenoma with a villous growth pattern.

Polyps

Polyps are growths on the lining of the bowel wall. Cancer is more likely to form in some types of polyps than others. Adenomas and sessile serrated polyps (SSPs) increase the risk of colorectal cancer.



Sessile serrated polyps

Sessile serrated polyps (SSPs), also called sessile serrated lesions (SSLs), are smooth and subtle. They lie flat against the bowel wall and don't have a stem.

Like adenomas, SSPs can become invasive cancer. People who have had several SSPs typically need more frequent screening with colonoscopy.

When viewed under a microscope, the border of serrated polyps appears jagged, like a saw blade.

Hyperplastic polyps

Hyperplastic polyps are a low-risk type of serrated polyp.

While small hyperplastic polyps rarely form cancer cells, those larger than 1 cm may increase cancer risk. More frequent screening is typically recommended for large hyperplastic polyps.

Stay alert for these symptoms

Cancer screening is for people with no signs or symptoms of colorectal cancer. If you have signs or symptoms, the aim of testing is to find the problem and make a diagnosis. Contact your health care provider if you have any of the following signs or symptoms.



Bloody stools



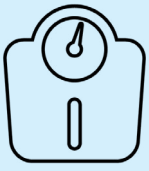
Change in bowel habits



Iron-deficiency anemia



Abdominal pain



Unexplained weight loss

Determining your risk

Your doctor will consider your age, health history, and family health history to determine if you are at average or increased risk of developing colorectal cancer.

Most people are at average risk. Your risk determines when you should start screening, how often you need screening, and which method(s) are recommended for you. See the chart below to learn if you are at average or increased risk.

Are you at average or increased risk of colorectal cancer?

Average risk

Age 45-75 years

AND

No history of colorectal cancer or advanced polyps in first-degree relatives (birth parents, full siblings, biological children)

AND

You've never been diagnosed with any of these conditions

Increased risk

Family history of colorectal cancer, advanced adenomas, or advanced sessile serrated polyps

OR

You've been diagnosed with any of the following conditions:

- Colorectal cancer
- Adenomas or sessile serrated polyps
- Inflammatory bowel disease (IBD)
- Cystic fibrosis
- A childhood, adolescent, or young adult cancer
- A hereditary colorectal syndrome:
  - Lynch syndrome
  - Classical or attenuated familial adenomatous polyposis
  - *MUTYH*-associated polyposis
  - Peutz-Jeghers syndrome
  - Juvenile polyposis syndrome
  - Serrated polyposis syndrome
  - Cowden syndrome/*PTEN* hamartoma tumor syndrome
  - Li-Fraumeni syndrome

How can I get the best care?

Advocate for yourself. You have an important role to play in your care. Many people feel more satisfied when they actively take part in planning their cancer care.

The NCCN Guidelines for Patients will help you play a larger role in your care. Discuss the recommendations in this guide with your care team. Ask questions about your options and share your goals and concerns.

Don't know what to ask? You're not alone. That's why we include suggested questions to ask at the end of chapters. Keep reading to find the best care for you.

How this guide can help you

Making decisions about cancer care is stressful. There's a lot to learn, and you don't know what the future holds.

Use this guide to get the information and support you need.

Patients, doctors, and other health care professionals trust the NCCN Guidelines for Patients. This guide uses clear, everyday language to explain current cancer care recommendations made by respected experts in the field. Their recommendations are based on the latest research and practices at leading cancer centers.

Your health is unique to you, so your cancer care should be, too. As you read this guide, you'll learn which treatments are likely to provide the best results for you. And you'll be better prepared to talk with your care team.

2
Screening in people at average risk

11 Screening starts at age 45

11 Colonoscopy

15 Flexible sigmoidoscopy

16 Stool-based screening

17 Blood-based screening

18 CT colonography

20 Key points

20 Questions to ask

People at average risk of colorectal cancer should start screening at age 45. There are several screening methods available. Talk to your doctor about the benefits and drawbacks of each.

Screening starts at age 45

People at average risk of colorectal cancer should start screening at age 45. People in good health should continue screening until age 75.

If you're between 76 and 85 years of age, cancer screening is a personal decision. Talk with your health care provider about the possible benefits and risks of screening, taking into account your overall health and any prior screening results.

Colorectal cancer screening isn't needed for people over 85 years of age.

People with an average risk of colorectal cancer have several options for screening, described next. Ask your doctor about the benefits and risks of each.

Colonoscopy

In the United States, colonoscopy is the most used screening test for colorectal cancer. Colonoscopy allows a health care provider, usually a gastroenterologist, to examine the entire large bowel and remove any abnormal growths.

Your doctor will insert a long, thin device with a light and a camera into your anus and gently guide it through the entire large bowel. They will view your colon on a monitor and look for abnormal growths.

If any polyps or lesions are found, they will remove them during the procedure using a cutting tool. This is called **polypectomy**. The number, size, and location of any polyps will be noted in a colonoscopy report.

Rarely, a large polyp or area of cancer can't be removed during screening colonoscopy. In this case, your doctor will remove samples for testing (a biopsy).

Ages 45 to 75

Get screened (unless you have a serious health condition).

Ages 76 to 85

Screening is a personal decision. Talk to your doctor about the benefits and risks for you.

Ages 86 and above

Screening isn't needed.

The removed polyps or biopsy samples will be sent to a lab for testing. An expert called a pathologist will examine the tissues under a microscope. If any cancer cells are found, a cancer diagnosis will be made.

The diagnosis will be included in a pathology report, along with other details of the tissue tests. The next steps of care will be based on the details of your colonoscopy and the pathology findings.

What to expect

For your doctor to clearly see the bowel wall, the bowel needs to be free of stool. This bowel prep involves taking strong laxatives and following a liquid diet. Follow the prep instructions carefully. If your bowel isn't clear enough, you may have to reschedule or repeat the test.

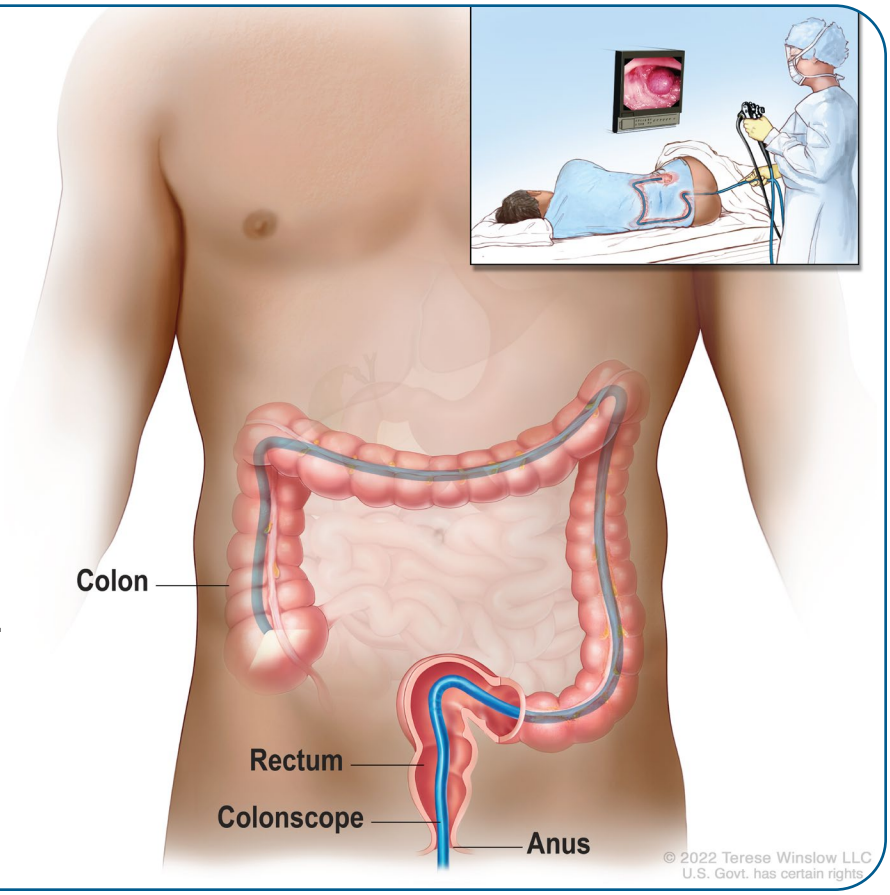
You'll likely wear a hospital gown. The test will be performed while you lie on your side. If you opted to be asleep for the procedure, you'll be given an intravenous sedative.

Colonoscopy takes less than an hour. Afterward, you may stay for another hour for any drugs that were used to wear off. Arrange to have someone drive you home afterward.

The next day, you'll likely feel normal. Contact your doctor if you have severe pain, vomiting, bloody stool, or weakness.

Colonoscopy

Colonoscopy is a procedure that allows your doctor to see and remove any abnormal tissue from the colon. A thin device is inserted through the anus, up the rectum, and into the colon. The device has a light, a camera, and a cutting tool.



No polyps found during colonoscopy

If no polyps are found during screening colonoscopy, you can wait 10 years until your next screen, and you can use any screening method.

Small polyp(s) removed during colonoscopy

If only small polyps are found and removed during colonoscopy, the timing of your next screening depends on the type(s) and features of the removed polyps. See **Guide 1**.

Guide 1
Small polyp(s) removed during colonoscopy: Time until next screening

This guide tells you when to rescreen (and with which method) after having 1 or more polyp(s) **smaller than 1 centimeter (cm)** removed by polypectomy. For reference, 1 cm is about the size of a single green pea or a small shirt button.

Hyperplastic polyps	
1 or more small hyperplastic polyps	Screen in 10 years with any method
Adenomas	
1 or 2 small adenomas with a tubular growth pattern	Repeat colonoscopy in 7 to 10 years
1 or more small adenomas with high-grade dysplasia or a villous or tubulovillous growth pattern	Repeat colonoscopy in 3 years
3 or more small adenomas (regardless of other features)	Repeat colonoscopy in 3 years
Sessile serrated polyps and lesions	
1 or 2 small SSP/SSL – no dysplasia	Repeat colonoscopy in 5 years
1 or more small SSP/SSL – with dysplasia	Repeat colonoscopy in 3 years
3 or more SSP/SSL (regardless of dysplasia)	Repeat colonoscopy in 3 years
Traditional serrated adenomas	
1 or more small TSA	Repeat colonoscopy in 3 years

A high number of polyps found

If 10 or more adenomas or SSPs/SSLs are found and removed in a single colonoscopy, screen again with colonoscopy in 1 year. The high number of polyps suggests you may have a hereditary cancer syndrome. Genetic counseling and testing are recommended.

Large pedunculated polyp(s) found during colonoscopy

Polyps bigger than 1 cm are considered large. For a large pedunculated polyp with no invasive cancer, rescreening with colonoscopy in 3 years is recommended.

If testing finds features of invasive cancer, see “If cancer is found” on this page.

Large sessile polyp(s) or flat lesions found during colonoscopy

For sessile polyps/lesions between 1 and 2 cm, or that were completely removed in one piece, colonoscopy in 3 years is recommended.

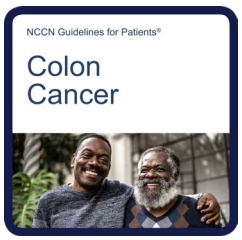
For sessile polyps/lesions 2 cm or larger, or that weren’t removed in one piece, colonoscopy in 6 to 12 months is recommended.

If testing of large sessile polyps or lesions finds invasive cancer, see "If cancer is found" on this page. Otherwise, referral to a treatment center with experts in large colorectal tumors is one possibility. Another is to be evaluated for surgery to remove the polyp.

If cancer is found

Information on treatment for colon and rectal cancer is available at NCCN.org/patientguidelines and on the NCCN Patient Guides for Cancer app.

These resources explain treatment based on the cancer’s mismatch repair (MMR) status and other features. The results of MMR testing are used to decide whether testing for Lynch syndrome is needed.





Flexible sigmoidoscopy

This visual screening method is an exam of the rectum and the last part of the colon. To see these areas, your provider will gently insert a device with a tiny camera through your anus and into the large bowel.

If they find any polyps or lesions, they will remove them using polypectomy or take a tissue sample (a biopsy). Afterward, a pathologist will examine the removed polyps and tissues under a microscope to look for cancer cells.

No polyps found

If no polyps are found during flexible sigmoidoscopy, screening is recommended again in 5 years using any method.

Small hyperplastic polyp(s) found

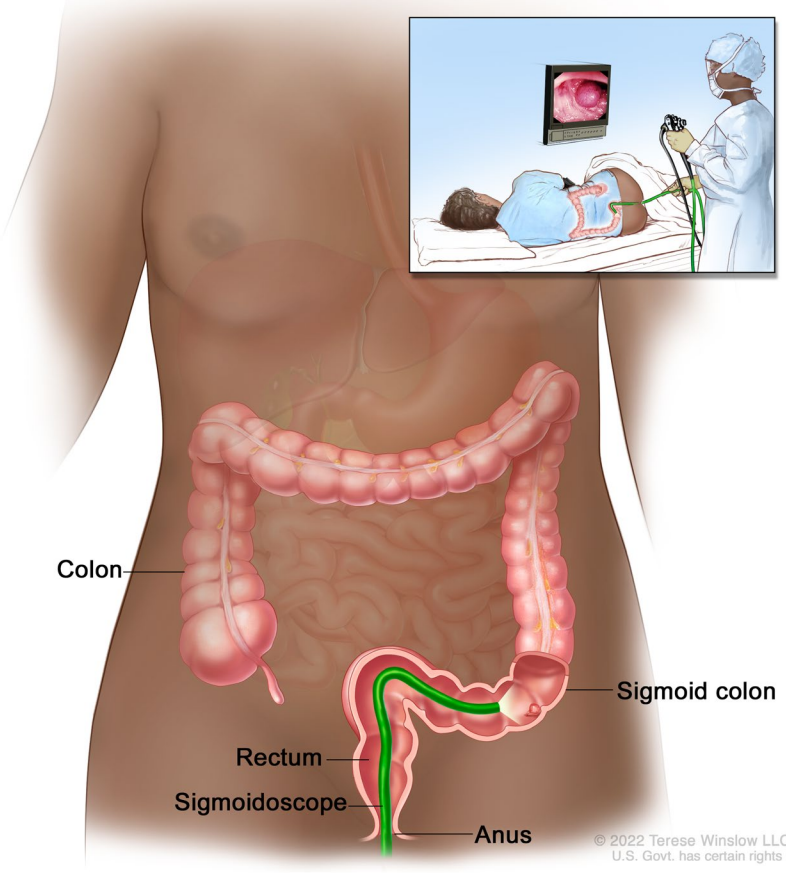
If the only polyps found during flexible sigmoidoscopy are hyperplastic and smaller than 1 cm, screening is recommended again in 5 years using any method.

If an adenoma, SSP/SSL, or large hyperplastic polyp is found

If any of these types of polyps are found, you should have a colonoscopy very soon. See pages 13 and 14 for recommended care based on the colonoscopy findings.

Sigmoidoscopy

Flexible sigmoidoscopy allows a health care provider to view your rectum and the last part of your colon. If no polyps are found, screening is recommended again in 5 years (using any method).



Stool-based screening

Another option for screening in people at average risk is stool-based screening. This method involves collecting a sample of your stool at home and sending it to a lab for testing.

If results of a stool-based test are abnormal, having a colonoscopy as soon as possible is recommended.

Multi-target stool DNA or RNA testing

In addition to occult (hidden) blood in stool, multi-target stool tests can detect DNA or RNA released by a colorectal cancer and by some precancerous polyps.

If the results of a multi-target stool test are normal, screening (using any method) in **3 years** is recommended.

If the results are abnormal, make it a priority to schedule a colonoscopy.

FIT

The fecal immunochemical test (FIT) is a type of fecal occult blood test (FOBT). A sample of stool is placed in a collection tube or on a card for testing. FIT uses an antibody that binds to a blood protein called hemoglobin to detect blood.

The FIT doesn't require changing your diet, and many brands require only 1 stool sample per year.

If the results of FIT are normal, screening (using any method) in **1 year** is recommended. If the results are abnormal, make it a priority to schedule a colonoscopy.

Guaiac-based testing

A common type of FOBT uses guaiac, a substance used to coat the stool sample cards. If there's blood in the sample, the guaiac will cause it to change color rapidly.

Guaiac-based testing requires that you collect 3 stool samples in a row and follow a special diet.

If the results of guaiac-based testing are normal, screening (with any method) in **1 year** is recommended. If the results are abnormal, make it a priority to schedule a colonoscopy.

Blood-based screening

Colorectal tumors release microscopic pieces of DNA into the bloodstream, called circulating tumor DNA (ctDNA).

Blood-based ctDNA (bb-ctDNA) testing is less likely to detect polyps and cancer than other screening methods. For this reason, it's currently only recommended for people at average risk **who can't or won't use other methods**.

If testing is performed and the results are normal, rescreening in **3 years** with any testing method is recommended.

If the results are abnormal for cancer cells, you'll be scheduled for a colonoscopy very soon.

share with us.

Take our survey and help make the NCCN Guidelines for Patients better for everyone!

NCCN.org/patients/comments

Who is most affected?

In the United States, American Indians/Alaska Natives and Black individuals are more likely to develop colorectal cancer and to die of it than any other racial or ethnic group. These individuals also often face barriers to colorectal cancer screening.



CT colonography

Computed tomography colonography (CTC), also called virtual colonoscopy, is another screening option for people at average risk.

This test uses a CT scanner and a small amount of radiation to get a close look at the large bowel. It also shows nearby organs in the abdomen.

CT colonography is non-invasive and doesn't require sedation. A disadvantage is that bowel cleaning is needed, just like for a colonoscopy.

No polyps found

If no polyps or lesions are found, screening in **5 years** using any method is recommended. Talk to your doctor about the benefits and risks of each method.

Large polyp(s) or several smaller polyps found

If any polyps larger than 1 cm are found, or if 3 or more small polyps are found, you should have a colonoscopy very soon. See pages 13 and 14 for recommended care based on the colonoscopy findings.

If only 1 or 2 small polyps are found, you will likely have 2 options:

- Colonoscopy soon after to have a closer look at the bowel wall
- Screening again in 3 years with CT colonography

Be proactive about screening

- Before age 45, discuss your risk of colorectal cancer with your health care provider.
- Be prepared to share your family history of colorectal cancer and advanced polyps.
- Learn about the methods currently used to screen for colorectal cancer.
- Start screening on time and stay on schedule for follow-up screening.

What else can I do to lower my risk?

Screening is the best way to prevent colorectal cancer. Other steps you can take to lower your risk are described below.

Fruits and vegetables should make up a large portion of the foods you eat. The best way to get nutrients is from real foods, not supplements. Limit red meat and processed meats. Dairy products may help prevent colorectal cancer.

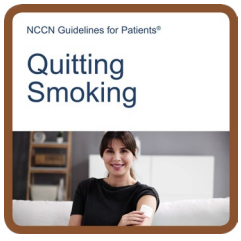
Get your vitamin D from foods like salmon, tuna, mackerel, and egg yolks. Your skin can also make vitamin D when exposed to the sun, but remember to wear sunscreen when outside for a long time.

Drink little to no alcohol.

Move more, rest less.

Maintain a healthy weight. Tracking your foods, calorie intake, and activity levels may help you meet your goals.

Stop using tobacco. Ask your care team about options to help you quit. Counseling and medication are often options.



Key points

- People at average risk and in good health should start screening at age 45 and continue until age 75. Screening for people between the ages of 76 and 85 is a personal decision.
- Discuss the benefits and risks of each screening method with your doctor. The length of time until your next screening depends on the testing method and your results.
- Colonoscopy is the most thorough screening test for colorectal cancer. It allows a health care provider to examine the entire large bowel and remove any polyps or abnormal growths.
- Flexible sigmoidoscopy allows a health care provider to examine the rectum and the last part of the colon and to remove any polyps or abnormal growths.
- The fecal immunochemical test (FIT) and guaiac-based testing check for occult (hidden) blood in stool. In addition to occult blood, multi-target stool testing can detect tumor DNA or RNA in stool.
- Blood-based screening is a non-invasive method that can detect circulating tumor DNA in blood. It's currently only recommended for people at average risk who can't or won't use other methods.
- CT colonography is a non-invasive method that uses CT imaging to view the large bowel and nearby organs.
- If you have abnormal results using a noninvasive method (stool, blood, or imaging), a colonoscopy is needed to complete the screening process.



We want your feedback!

Our goal is to provide helpful and easy-to-understand information on cancer. Take our survey to let us know what we got right and what we could do better.
NCCN.org/patients/feedback

Questions to ask

- Which screening method do you recommend for me?
- If I have an abnormal result on a blood or stool test, how soon should I have a colonoscopy?
- How do I prepare for a colonoscopy?

3
Screening in people at increased risk

22 Inflammatory bowel disease

24 Cystic fibrosis

24 Family history of colorectal cancer

26 History of cancer treatment

27 Key points

27 Questions to ask

Colonoscopy is the preferred screening method for everyone at increased risk of colorectal cancer.

Inflammatory bowel disease

Inflammatory bowel disease (IBD) is a group of health problems that cause long-term swelling and damage in the digestive tract. The damage can lead to the growth of abnormal cells, which can become cancer over time.

Ulcerative colitis and Crohn's colitis are types of IBD that affect the colon and rectum. These conditions often start before age 30, or much later in life. Having either increases your risk of colorectal cancer.

Your risk is further increased if colorectal cancer runs in your family, or if you have primary sclerosing cholangitis, a health condition that causes damage and narrowing of the bile ducts.

When to start screening

Most people with IBD (affecting the colon) should start screening for colorectal cancer 8 years after their IBD symptoms started. Starting earlier than 8 years is recommended if you have a family history of colorectal cancer.

Screening should ideally be performed when IBD is inactive. It helps your doctor spot dysplasia in flat and normal-looking sections of the bowel wall.

People with primary sclerosing cholangitis (PSC) should start screening when they are diagnosed with PSC, regardless of when their IBD symptoms started.

IBD increases colorectal cancer risk

Ulcerative colitis and Crohn's disease are types of inflammatory bowel disease (IBD). People with IBD are at increased risk of colorectal cancer and should always screen using colonoscopy.



Screening with colonoscopy

Colonoscopy should always be used to screen for colorectal cancer in people with IBD. See page 11 for more information on this method.

Colonoscopy is often paired with newer methods to see the bowel wall better. These include:

- High-definition white light endoscopy (HD-WLE)
- Chromoendoscopy

HD-WLE is procedure to look inside the colon with a device guided through the anus that creates very clear images.

Chromoendoscopy involves applying a stain to the inner lining of the bowel. The stain makes it easier to see abnormal areas and perform targeted biopsies.

Your provider will biopsy (remove samples from) any areas that look abnormal. They will also take random samples from every section of the large bowel.

Resectable polyps or lesions

Polyps and lesions that can be safely removed are called resectable. If any are found, they will be removed endoscopically (if possible). The timing of your next colonoscopy depends on the features of the removed polyps.

For lower-risk polyps that are completely removed, having your next colonoscopy in 1 to 3 years is recommended.

For higher-risk polyps that are completely removed, rescreening in 1 year is recommended, but may be needed as soon as 3 months afterward.

If a polyp wasn't fully removed, you may be referred to an endoscopist trained in advanced resection techniques, or to a surgeon who specializes in IBD.

Invisible dysplasia

Testing may find dysplasia (abnormal tissue) in samples that looked normal during endoscopy. This is called invisible dysplasia. It can't be seen with an endoscope.

If dysplasia is confirmed, chromoendoscopy is the next step (if not already performed). Your provider may perform this, or refer you to an endoscopist with expertise in chromoendoscopy. Your provider may also refer you to a surgeon who specializes in IBD to discuss surveillance versus surgery.

No dysplasia found

If no dysplasia is found, colonoscopy is recommended in 1 year for people at high risk. High-risk features include primary sclerosing cholangitis, active inflammation, and a family history of colorectal cancer diagnosis before age 50.

For all others without active inflammation, the next colonoscopy should take place in 2 to 5 years.

Colon stricture

Over time, IBD can cause scar tissue to form in the lining of the bowel. This causes narrowings in certain areas of the bowel, called strictures.

Colon strictures can have underlying cancer, especially in people with long-term IBD. If surveillance screening detects a stricture, you should be seen by an expert in IBD.

The next step of care may be surgery to remove all or part of your colon. This is called colectomy. If surgery isn't planned, rescreening in 1 year is recommended.

Cystic fibrosis

People with cystic fibrosis are at increased risk of colorectal cancer. It often develops earlier in people with this condition than in those at average risk.

People who have had an organ transplant for managing cystic fibrosis have an even higher risk. For those people, colonoscopy is recommended starting at age 30, or within 2 years of the transplant. For people who haven't had an organ transplant, screening should start at age 40.

A more thorough bowel cleanout process is needed before colonoscopy for people with cystic fibrosis. Your care team will instruct you on the bowel prep.

If the colonoscopy results are normal, the next will take place in 5 years. If the colonoscopy finds pre-cancerous polyps, the next is recommended 3 years.

Family history of colorectal cancer

Your provider will ask about the health history of your biological (related by blood) family members. You may be at increased risk of colorectal cancer based on your family history.

In most families with a history of colorectal cancer, the cause isn't clear. It may be caused by shared genes, shared experiences, or both.

In some families, the cause is a hereditary colorectal syndrome, such as Lynch syndrome or familial adenomatous polyposis (FAP). Lynch syndrome greatly increases the risk of developing colorectal, endometrial, ovarian, and other cancers. FAP is a polyposis syndrome that causes many (potentially hundreds to thousands) of polyps to form in the large bowel.

The following recommendations **don't** apply to families with Lynch or polyposis syndromes. If your doctor suspects you have an inherited syndrome, they will refer you to a genetic counselor for possible genetic testing. To be tested, you must provide a sample of blood or saliva. The sample is tested for inherited gene differences that cause these syndromes.

Compared to average-risk screening, screening based on family history often starts earlier and is more frequent. The time between screenings might be lengthened if 2 screenings in a row are normal.

Share your screening results with your family so that they can make informed decisions. Screening recommendations for family members may be included in your colonoscopy

report. Some providers will give you a letter to share with your first-degree relatives.

First-degree relative(s) with an advanced pre-cancerous polyp

If one (or more) of your first-degree relatives had an advanced adenoma or an advanced serrated polyp or lesion, you should start screening with colonoscopy beginning at age 40, or at the age the advanced polyp was found (if earlier than age 40).

Screening is recommended every 5 to 10 years, but may be needed more often depending on the results of each colonoscopy.

What is an advanced pre-cancerous polyp?
Adenomas and serrated polyps and lesions are considered advanced if they are larger than 1 centimeter (cm) or have certain features, like fast-growing dysplasia or, in adenomas, a non-tubular growth pattern.

A comprehensive family history includes first-, second-, and third-degree relatives.



You

First-degree relatives	Birth parents, full siblings, biological children
Second-degree relatives	Grandparents, aunts and uncles, half siblings, nieces and nephews, grandchildren
Third-degree relatives	Great grandparents, great aunts and uncles, half aunts and uncles, cousins, half nieces and nephews, grand nieces and nephews, great grandchildren

First-degree relative(s) with CRC

If you have any first-degree relatives diagnosed with colorectal cancer (CRC) at any age, colonoscopy is recommended beginning at age 40, or 10 years before the earliest diagnosis in your family. For example, if your first-degree relative was diagnosed at age 44, you should start screening at age 34.

Repeating colonoscopy every 5 years is generally recommended. But you and your doctor may decide to screen more often, based on the following factors:

- The size, number, and features of the polyps removed at each colonoscopy
- Your age and preferences
- Your family history of CRC

Second- or third-degree relatives with CRC

If any of your second- or third-degree (but not first-degree) relatives have been diagnosed with colorectal cancer, you should start screening at age 45 (the same age as people at average risk).

While your risk of colorectal cancer might be higher than someone at average risk, studies haven't found enough data to support screening before age 45.

Repeating colonoscopy every 10 years is recommended, as long as results continue to be normal.

History of cancer treatment

Some cancer treatments increase your risk of developing another cancer years later. If you had treatment with any of the following as a child, adolescent, or young adult, you are at increased risk of colorectal cancer:

- Chemotherapy
- Radiation therapy (especially to the abdomen, pelvis, or spine)
- Total body irradiation (regardless of dose, with or without chemotherapy)

Past treatment with chemotherapy

If you've received chemotherapy only (not radiation therapy), colonoscopy is recommended starting at age 35, or 10 years after the age you were when you had chemotherapy. For example, if you had chemotherapy at age 28, screening starts at age 38. Screening should always start by age 45, and should be repeated every 5 years.

Past treatment with radiation therapy

For people who had radiation therapy as described above, colonoscopy is recommended starting at age 30, or 5 years after treatment (whichever occurred last). Screening should always start by age 45, and should be repeated every 5 years.

Polyposis caused by treatment

If you've had 10 or more polyps (of any type) anywhere in your GI tract, the cause could be your prior cancer treatment. This is more likely if comprehensive genetic testing didn't find any inherited gene differences linked

with colorectal cancer or hereditary polyp syndromes.

In this case, your provider may suggest an upper endoscopy (in addition to the colonoscopy surveillance). This gives them a baseline (starting) look at your GI tract that can be compared to future GI exams.

Key points

- People with cystic fibrosis are at increased risk of colorectal cancer. For people with cystic fibrosis who have had an organ transplant, colonoscopy is recommended starting at age 30, or within 2 years of the transplant. Otherwise, screening starts at age 40.
- People with inflammatory bowel disease (IBD) affecting the colon have an increased risk of colorectal cancer. Screening should start 8 years after IBD symptoms begin, or earlier if you have a family history or primary sclerosing cholangitis.
- If you have a family history of colorectal cancer or pre-cancerous polyps, screening often starts at or before age 40. You may be rescreened in as soon as 5 years, even if no polyps are found.
- Treatment with chemotherapy or radiation therapy as a child, adolescent, or young adult increases your risk of colorectal cancer later in life. Starting screening earlier than average is recommended. The exact starting age depends on the treatment(s) received.

"Colorectal cancer has always been thought of as an 'old person's disease.' Now, studies have shown that a person born on or after 1990 is 2 to 4 times more likely to develop colorectal cancer compared to a person born in 1950. Because of this, it is very important to get screened at 45 years old."

Questions to ask

- I'm very anxious about my risk of colorectal cancer. Who can help?
- Several of my second- and third-degree relatives have or had CRC. Should I start screening earlier than 45?
- Can you give me a document with my results to share with my family?

4
Other resources

29 What else to know

29 What else to do

29 Where to get help

29 Questions to ask

Want to learn more? Here's how you can get additional help.

What else to know

This guide helps you know your options so you can make informed decisions and improve your cancer care. But it's not the only resource that you have.

Ask for as much information and help as you need. Many people are interested in learning more about:

- The details of their screening results
- Being a part of a care team
- Getting financial help
- Finding a cancer care professional who's an expert in their field
- Coping with other health problems

What else to do

Your health care center can help you with next steps. It often has on-site resources to help meet your needs and find answers to your questions. Health care centers can also inform you of resources in your community.

In addition to help from your providers, the resources listed in the next section provide support for many people like yourself.

Where to get help

Look through the list below and visit the provided websites to learn more about these organizations.

CanCare, Inc.
cancare.org

Cancer*Care*
cancercare.org

Colorectal Cancer Alliance
ccalliance.org

Fight Colorectal Cancer
fightcolorectalcancer.org

GI Cancers Alliance
gicancersalliance.org

Global Colon Cancer Association
globalcca.org

GRACE
cancergrace.org

Imerman Angels
imermanangels.org

Triage Cancer
triagecancer.org

Questions to ask

- Who can I talk to about help with housing, food, and other basic needs?
- What help is available for transportation, childcare, and home care?
- Are there other services available to me and my caregivers?



Words to know

adenoma
The most common type of colorectal polyp. Also called an adenomatous polyp, traditional polyp, and conventional polyp.

biopsy
Removal of part or all of a polyp or lesion for testing. A pathologist examines the tissue under a microscope to check for cancer or pre-cancer cells.

blood-based circulating tumor DNA (bb-ctDNA)
A non-invasive screening method that can detect microscopic pieces of tumor DNA in the bloodstream. Currently only an option for people at average risk who can't or won't use other methods.

colon
The longest section of the large bowel. Where digested food becomes stool.

colonoscopy
A procedure to look inside the colon with a device guided through the anus. An option for screening for colorectal cancer in people at average or increased risk.

computed tomography colonography (CTC)
A non-invasive screening method that uses a CT scanner to view the large bowel and nearby areas. Also called virtual colonoscopy.

Crohn's colitis
A type of inflammatory bowel disease (IBD) that increases the risk of colorectal cancer.

dysplasia
A pattern of abnormal cell growth.

fecal immunochemical test (FIT)
A lab test that looks for tiny amounts of blood in stool. A type of fecal occult blood test (FOBT).

flexible sigmoidoscopy
An option for colorectal cancer screening in people at average risk. Involves viewing the rectum and last section of the colon to look for abnormal areas.

high-definition white light endoscopy (HD-WLE)
A procedure to look inside the colon with a device guided through the anus that creates very clear images.

hyperplastic polyp
A type of serrated polyp. Large hyperplastic polyps may increase the risk of colorectal cancer.

inflammatory bowel disease (IBD)
A group of health conditions that cause long-term swelling in the digestive tract and increase colorectal cancer risk. Includes Crohn's colitis and ulcerative colitis.

multi-target stool DNA test (mt-sDNA)
A non-invasive screening method that looks for both occult (hidden) blood and tumor DNA in a sample of stool.

multi-target stool RNA test (mt-sRNA)
A non-invasive screening method that looks for both occult (hidden) blood and tumor RNA in a sample of stool.

pathologist
A doctor who's an expert in testing cells and tissue to find disease.

pedunculated polyp
A polyp that sticks out from the bowel wall on a stalk.

polyp
A non-cancerous growth on the inner lining of the large bowel. Over time, certain types can form cancer.

polypectomy
A minor surgical procedure to remove polyps, usually during a colonoscopy.

polyposis syndromes
A group of cancer syndromes that cause colorectal polyps. The most common is familial adenomatous polyposis (FAP).

primary sclerosing cholangitis (PSC)
A rare, long-term disease that causes damage to the bile ducts. Increases the risk of colorectal cancer.

rectum
The last section of the large bowel. Stool is held here until it leaves the body through the anus.

sessile polyp
A polyp that lies flat against the bowel wall.

sessile serrated polyp (SSP)
A flat polyp that has a high risk of forming cancer. Has a sawtooth cell pattern when viewed under a microscope. Also called a sessile serrated lesion or sessile serrated adenoma.

traditional serrated adenoma (TSA)
A rare polyp that has a high risk of forming cancer. Has a sawtooth cell pattern when viewed under a microscope.

ulcerative colitis
A type of inflammatory bowel disease (IBD) that increases the risk of colorectal cancer.



Let us know what you think!

Please take a moment to complete an online survey about the NCCN Guidelines for Patients.
NCCN.org/patients/response

NCCN Contributors

This patient guide is based on the NCCN Clinical Practice Guidelines in Oncology (NCCN Guidelines®) for Colorectal Cancer Screening, Version 2.2026. It was adapted, reviewed, and published with help from the following people:

Dorothy A. Shead, MS
Assistant Vice President
Patient Information Operations

Erin Vidic, MA
Senior Medical Writer, Patient Information

Lisa Diehl
Production Layout Artist

The NCCN Clinical Practice Guidelines in Oncology (NCCN Guidelines®) for Colorectal Cancer Screening, Version 2.2026, were developed by the following NCCN Panel Members:

Reid M. Ness, MD, MPH/Chair
Vanderbilt-Ingram Cancer Center

Xavier Llor, MD, PhD/Vice Chair
Yale Cancer Center/ Smilow Cancer Hospital

Leonard Baidoo, MD
St. Jude Children's Research Hospital/ The University of Tennessee Health Science Center

Shrinivas Bishu, MD
University of Michigan Rogel Cancer Center

*Christine Boumitri, MD
Robert H. Lurie Comprehensive Cancer Center of Northwestern University

*Gregory Cooper, MD
Case Comprehensive Cancer Center/ University Hospitals Seidman Cancer Center and Cleveland Clinic Taussig Cancer Institute

Dayna S. Early, MD
Siteman Cancer Center at Barnes-Jewish Hospital and WashU Medicine

Mark Friedman, MD
Moffitt Cancer Center

David Fudman, MD
UT Southwestern Simmons Comprehensive Cancer Center

Kathryn Glaser, PhD, MA
Roswell Park Comprehensive Cancer Center

Suryakanth Gurudu, MD
Mayo Clinic Comprehensive Cancer Center

Michael Hall, MD, MS
Fox Chase Cancer Center

*Lyen C. Huang, MD, MPH
Huntsman Cancer Institute at the University of Utah

*Rachel B. Issaka, MD, MAS
Fred Hutchinson Cancer Center

Bryson Katona, MD, PhD
Abramson Cancer Center at the University of Pennsylvania

Trilokesh Kidambi, MD
City of Hope National Medical Center

Audrey J. Lazenby, MD
Fred & Pamela Buffett Cancer Center

Jennifer Maratt, MD, MS
Indiana University Melvin and Bren Simon Comprehensive Cancer Center

Arnold J. Markowitz, MD
Memorial Sloan Kettering Cancer Center

Joseph Marsano, MD
UC Davis Comprehensive Cancer Center

Folasade P. May, MD, PhD, MPhil
UCLA Jonsson Comprehensive Cancer Center

Robert J. Mayer, MD
Dana-Farber Cancer Institute

Kinga Olortegui, MD, MS
The UChicago Medicine Comprehensive Cancer Center

Swati Patel, MD, MS
University of Colorado Cancer Center

Shajan Peter, MD
O'Neal Comprehensive Cancer Center at UAB

*Laura D. Porter, MD
Independent Patient Advocate

Mehnaz Shafi, MD
The University of Texas MD Anderson Cancer Center

*Peter P. Stanich, MD
The Ohio State University Comprehensive Cancer Center - James Cancer Hospital and Solove Research Institute

Brian Sullivan, MD
Duke Cancer Institute

Jonathan Terdiman, MD
UCSF Helen Diller Family Comprehensive Cancer Center

Peter Vu, MD
UC San Diego Moores Cancer Center

Jennifer M. Weiss, MD, MS
University of Wisconsin Carbone Cancer Center

NCCN

Carly J. Cassara, MSc
Guidelines Layout Specialist

Vaishnavi Sambandam, PhD
Oncology Scientist/Medical Writer

* Reviewed this patient guide. For disclosures, visit NCCN.org/disclosures.

NCCN Cancer Centers

For contact information, visit NCCN.org/cancercenters.

Abramson Cancer Center
at the University of Pennsylvania
Philadelphia, Pennsylvania

Case Comprehensive Cancer Center/
University Hospitals Seidman Cancer Center and
Cleveland Clinic Taussig Cancer Institute
Cleveland, Ohio

City of Hope National Medical Center
Duarte, California

Dana-Farber Cancer Institute
Boston, Massachusetts

Duke Cancer Institute
Durham, North Carolina

Fox Chase Cancer Center
Philadelphia, Pennsylvania

Fred & Pamela Buffett Cancer Center
Omaha, Nebraska

Fred Hutchinson Cancer Center
Seattle, Washington

Huntsman Cancer Institute at the University of Utah
Salt Lake City, Utah

Indiana University Melvin and Bren Simon
Comprehensive Cancer Center
Indianapolis, Indiana

Johns Hopkins Kimmel Cancer Center
Baltimore, Maryland

Mass General Brigham Cancer Institute
Boston, Massachusetts

Mayo Clinic Comprehensive Cancer Center
Phoenix/Scottsdale, Arizona
Jacksonville, Florida
Rochester, Minnesota

Memorial Sloan Kettering Cancer Center
New York, New York

Moffitt Cancer Center
Tampa, Florida

O'Neal Comprehensive Cancer Center at UAB
Birmingham, Alabama

Robert H. Lurie Comprehensive Cancer Center
of Northwestern University
Chicago, Illinois

Roswell Park Comprehensive Cancer Center
Buffalo, New York

Siteman Cancer Center at Barnes-Jewish Hospital
and WashU Medicine
St. Louis, Missouri

St. Jude Children's Research Hospital/
The University of Tennessee Health Science Center
Memphis, Tennessee

Stanford Cancer Institute
Stanford, California

The Ohio State University Comprehensive Cancer Center -
James Cancer Hospital and Solove Research Institute
Columbus, Ohio

The UChicago Medicine Comprehensive Cancer Center
Chicago, Illinois

The University of Texas MD Anderson Cancer Center
Houston, Texas

UC Davis Comprehensive Cancer Center
Sacramento, California

UC San Diego Moores Cancer Center
La Jolla, California

UCLA Jonsson Comprehensive Cancer Center
Los Angeles, California

UCSF Helen Diller Family Comprehensive Cancer Center
San Francisco, California

University of Colorado Cancer Center
Aurora, Colorado

University of Michigan Rogel Cancer Center
Ann Arbor, Michigan

University of Wisconsin Carbone Cancer Center
Madison, Wisconsin

UT Southwestern Simmons
Comprehensive Cancer Center
Dallas, Texas

Vanderbilt-Ingram Cancer Center
Nashville, Tennessee

Yale Cancer Center/Smilow Cancer Hospital
New Haven, Connecticut

Notes

Index

adenoma 6, 8, 13–15, 25

blood-based ctDNA testing 17

computed tomography colonography (CTC) 18

Crohn's colitis 22

cystic fibrosis 8, 24

dysplasia 6, 13, 22–25

family history 8, 18, 24–26

fecal occult blood test (FOBT) 16

fecal immunochemical test (FIT) 16

flexible sigmoidoscopy 15

hereditary cancer syndrome 8, 14, 24

hyperplastic polyp 7, 13, 15

inflammatory bowel disease (IBD) 8, 22–24

multi-target stool DNA/RNA testing 16

sessile serrated polyp (SSP) 6, 7, 13–15

traditional serrated adenoma 6, 13

ulcerative colitis 22



NCCN Guidelines for Patients®

Cancer care recommendations from leading experts at the National Comprehensive Cancer Network® (NCCN®)

Colorectal Cancer Screening



The way forward starts here.

Give Now

National Comprehensive Cancer Network® Foundation

National Comprehensive Cancer Network®

3025 Chemical Road, Suite 100
Plymouth Meeting, PA 19462
215.690.0300

NCCN.org/patients – For Patients | NCCN.org – For Clinicians

PAT-N-2003-1226