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ACG Statement on the Inclusion of Blood-Based Tests in the American Cancer Society's Colorectal Cancer Screening Guideline

North Bethesda, MD (June 1, 2026)—Last Wednesday, the American Cancer Society released its updated colorectal cancer (CRC) screening guideline, reaffirming the recommendation that average-risk adults initiate CRC screening at age 45 and continue through age 75, as well as including multiple screening options to improve participation.

One notable change is that the ACS guideline now recommends blood-based tests as a "not preferred" screening option for a limited group of patients who decline or do not complete a preferred test (e.g., direct visualization like colonoscopy or stool-based tests). ACG is concerned that clinicians and patients may not fully understand this nuanced recommendation, leading some to select a lower-performing CRC screening test.

ACG recognizes that the guideline recommends blood-based tests in the hopes that it will increase CRC screening uptake for those who have yet to be screened and improve adherence among those who are not up to date. ACG supports improving adherence to CRC screening among unscreened individuals. However, we want to be certain that the unscreened individuals are given genuine opportunity to complete a "preferred" test first, before being offered a blood test. The substitution of a "preferred" test for a blood test poses serious risks to patients due to its low sensitivity for detecting precancerous polyps and early-stage cancers.

The accompanying editorial in *CA: A Cancer Journal for Clinicians* from Dr. Gloria Coronado and Dr. David Lieberman echoes this concern: "Because blood tests are less likely to find advanced adenomas than other available tests, the use of these tests in place of more effective screening tests could result in net harm (i.e., increased deaths from colorectal cancer)."

We must follow the science of the screening tests: a one-time Shield™ test may fail to detect one in three early-stage cancers and one in six total cancers. By comparison, studies have estimated that colonoscopy detects over 95% of colorectal cancers. In completing a colonoscopy, gastroenterologists not only detect but prevent CRC by removing precancerous polyps. When compared with stool-based tests, the guideline notes that the blood tests "demonstrated lower sensitivity for both advanced precancerous lesions and stage I cancers, with modelling studies predicting less effectiveness in reducing CRC incidence and mortality."

The implementation of the new guideline is likely to be substantially more wide-reaching than the narrow and qualified recommendation implies. Between preconceived notions about blood tests, overly simplistic headlines, and commercial advertising, the "not preferred" distinction will be buried in clinical language that patients should not be expected to parse in the first place. In fact, as Coronado and Lieberman suggest, patients may incorrectly believe blood-based screening is more accurate than high-sensitive stool-based tests (to say nothing of the gold standard of

colonoscopy). How reasonable is it to expect all patients to understand the limitations of these tests?

The same is true for clinicians. As time with patients is increasingly compressed, and a broader pool of healthcare professionals likely begins to advise patients on CRC screening in response to this recommendation, it is impractical to assume that every conversation about the blood test with a patient will:

- cover the limitations of the tests and the recommendation;
- address the required nuances each time;
- confirm that "preferred" tests have been declined before offering a blood-based test; and
- ensure that every patient understands a positive result requires a follow-up colonoscopy.

In the world of cancer, CRC screening is one of the few opportunities to provide patients with peace of mind. Despite this new recommendation, the current blood-based CRC screening tests cannot give patients surefire peace of mind. And by still recommending the blood-based tests after the preferred options have been exhausted, the new guideline has effectively lowered the bar on what qualifies as a 'recommended' test—undermining the very notion that the best test is the one that gets done.

ACG and the Multi-Society Task Force on Colorectal Cancer (MSTF) currently recommend colonoscopy every 10 years or annual FIT testing for CRC in average risk individuals starting at age 45. Learn more by visiting gi.org/colorectal-cancer.

About the American College of Gastroenterology
Founded in 1932, the American College of Gastroenterology (ACG) is an organization with an international membership of over 21,000 individuals from 86 countries. The College's vision is to be the preeminent organization supporting health care professionals who provide compassionate, equitable, high-quality, state-of-the-art, and personalized care to promote digestive health. The mission of the College is to provide tools, services, and accelerate advances in patient care, education, research, advocacy, practice management, professional development and clinician wellness, enabling our members to improve patients' digestive health and to build personally fulfilling careers that foster well-being, meaning and purpose. Learn more at www.gi.org.