Mammograms at 40: What the New 2026 Breast Cancer Screening Guidelines Mean for You

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If you have wondered when to begin mammograms or how often to have one, you are not alone. Several respected medical organizations offer recommendations, and they do not all say exactly the same thing. That can leave women confused about whether screening should begin at 40, 45, or 50 - and whether mammograms should be performed annually or every other year.

The newest guidance adds another important voice to that conversation. In April 2026, the American College of Physicians (ACP) released updated guidance for breast cancer screening in asymptomatic women at average risk. Understanding what the guidance says - and who it does not apply to - can help you make a more informed decision with your healthcare professional.

What does the new ACP guidance recommend?

The April 2026 ACP guidance applies to women who have no breast symptoms and are considered at average risk for breast cancer.

- Ages 40-49: ACP recommends a conversation with a clinician about personal risk, values, preferences, and the potential benefits and harms of screening. If a woman chooses screening after shared decision-making, ACP recommends mammography every two years.
- Ages 50-74: ACP recommends screening mammography every two years.
- Age 75 and older, or limited life expectancy: ACP recommends discussing whether screening should be discontinued, based on health, risk, preferences, and the uncertainty surrounding benefits and harms.
- Dense breasts: For average-risk women with BI-RADS category C or D density, ACP advises considering digital breast tomosynthesis, often called 3D mammography. ACP does not recommend supplemental screening MRI or ultrasound solely because an otherwise average-risk woman has dense breasts.

ACP favors biennial screening partly because annual screening can lead to more false-positive findings, callbacks, biopsies, anxiety, radiation exposure, overdiagnosis, and overtreatment. Those are legitimate concerns and should be explained honestly.

Why do breast cancer screening recommendations differ?

Guideline organizations examine many of the same studies but may weigh the benefits and harms differently.

- The U.S. Preventive Services Task Force recommends mammography every two years from ages 40 through 74 for women at average risk.
- The American College of Obstetricians and Gynecologists recommends beginning at age 40 and screening every one to two years after informed shared decision-making.
- The American Cancer Society says women ages 40-44 should have the option of annual mammography, women ages 45-54 should undergo annual mammography, and women 55 and older may transition to every two years or continue annually.
- The American College of Physicians now advises shared decision-making for average-risk women ages 40-49 and biennial screening when screening is chosen, followed by biennial screening for ages 50-74.

These differences do not mean that one organization cares more about early detection than another. They reflect different interpretations of how to balance lives saved and cancers detected against callbacks, biopsies, anxiety, cost, and overdiagnosis.

My recommendation as a breast cancer surgeon

For women at average risk, I recommend a screening mammogram every year beginning at age 40.

This is my clinical recommendation, not the ACP recommendation. I respect the evidence review behind the ACP guidance, but my perspective is shaped by more than 20 years of caring for women with breast cancer and seeing what early detection can mean for treatment choices and outcomes.

Annual screening creates more opportunities to identify a cancer before it becomes clinically apparent. Although it may also increase the chance of a callback or benign biopsy, I believe that tradeoff should be discussed with each woman rather than decided by age alone.

The American Cancer Society estimates that breast cancer incidence has been rising by about 1% per year, with a somewhat faster increase among women younger than 50. It also reports that Black women have the highest breast cancer death rate and are more likely to die of breast cancer at every stage than women in other racial and ethnic groups. Those realities make timely risk assessment, access to quality mammography, and prompt follow-up especially important.

Average risk is not the same as your personal risk

The ACP guidance is not intended for women who have breast symptoms or who are at increased risk. You may need earlier, more frequent, or supplemental screening if you have:

- A personal history of breast cancer
- A prior high-risk breast lesion, such as atypical ductal hyperplasia, atypical lobular hyperplasia, or lobular carcinoma in situ
- A BRCA1, BRCA2, PALB2, TP53, or other cancer-associated genetic variant
- A strong family history of breast, ovarian, pancreatic, or certain prostate cancers
- Prior high-dose radiation to the chest at a young age
- A calculated lifetime breast cancer risk of approximately 20% or greater
- Other clinical factors that substantially increase risk

Women with a new lump, nipple discharge, skin dimpling, nipple inversion, persistent focal breast pain, redness, swelling, or another concerning change do not need a "screening" recommendation. They need prompt clinical evaluation and, when appropriate, diagnostic imaging.

What should women with dense breasts know?

Dense breast tissue matters for two reasons: it can make cancer more difficult to see on a mammogram, and it is independently associated with increased breast cancer risk. Federal mammography standards require facilities to notify patients about breast density.

Density alone does not automatically determine whether you need MRI or ultrasound. The decision should include your complete risk profile, the type and quality of mammography available, prior imaging, family history, and personal preferences. Three-dimensional mammography may improve evaluation for some women, but additional imaging can also produce more false-positive results.

Do not stop at the sentence, "You have dense breasts." Ask what your density means when combined with the rest of your risk factors.

The most important next step: know your risk before 40

Age 40 is an important screening milestone, but breast health should begin before the first mammogram. By age 25-30, women should begin discussing family history and personal risk factors with a qualified healthcare professional. A formal risk assessment may identify someone who should begin imaging earlier, add annual MRI, or consider genetic counseling and testing.

If you are 40 or older and have not scheduled your mammogram, now is the time to discuss screening with your clinician. If you are already being screened every two years, ask whether annual screening is appropriate for you.

Most importantly, do not allow differing guidelines to become a reason to do nothing.

Move beyond awareness and into action

Beyond October™ exists because breast health education must continue all year. Continue learning with April Spencer, M.D., through the Beyond October™ breast health video series and community on YouTube:

https://youtube.com/@draprilspencer?si=h78bGbUb_crPJiu6

Bring your questions, learn your risk, schedule the screening that is right for you, and encourage another woman to do the same.

From Breast Health to Best Health™

Medical note

This article provides general education and does not replace individualized medical advice. Screening decisions should be made with a qualified healthcare professional who understands your health history and breast cancer risk.

References

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