

1. **Current releases- What they are and where to find them**
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1. Current releases of the US Preventive Services Task Force

The hallmark hardcopy publication of the USPSTF is the annual pocket sized Clinical Guide. You can find a pdf version of the 2009 Clinical Guide to Preventive Services here: <http://www.ahrq.gov/clinic/pocketgd.htm>

Print Version: A free copy of the pocket guide (AHRQ Publication No. 09-IP006) is available from the AHRQ Publications Clearinghouse, on a single copy basis.

- **Online:** Select for [AHRQ Publications Online Store](#)
- **Phone:** 800-358-9295
- **E-mail:** ahrqpubs@ahrq.hhs.gov

Please note: Charges may apply for bulk copies and for delivery to addresses outside of the United States.

While the printed Guide has persistent adherents, many have moved to online and mobile electronic sources for medical reference. Furthermore, the AHRQ staff and the USPSTF recognize that the website and PDA program are kept updated in an ongoing manner and thus represent more current information than the printed Guide can.

**All information on the USPSTF can be accessed at the site:
www.preventiveservices.ahrq.gov**

PDA Program: Another online option for accessing USPSTF recommendations is its PDA program, the Electronic Preventive Services Selector. The program lets users search USPSTF recommendations by age, sex, and selected behavioral risk factors. The tool, updated as new recommendations are released, can be downloaded to a PDA or used on the Web. Go to <http://www.epss.ahrq.gov>.

List of 2009- 2010 USPSTF Releases

Skin Cancer Screening

<http://www.ahrq.gov/clinic/uspstf/uspsskca.htm>

Aspirin to prevent Cardiovascular disease

<http://www.ahrq.gov/clinic/uspstf/uspssami.htm>

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| Child Depression | http://www.ahrq.gov/clinic/uspstf/uspstfdepr.htm |
| Tobacco Use in Adults | http://www.ahrq.gov/clinic/uspstf/uspstfbac2.htm |
| Folic Acid supplementation | http://www.ahrq.gov/clinic/uspstf/uspstfnfol.htm |
| Screening Syphilis in pregnancy | http://www.ahrq.gov/clinic/uspstf/uspstfssyphpg.htm |
| Hepatitis B in pregnancy | http://www.ahrq.gov/clinic/uspstf/uspstfshpbpg.htm |
| Vision in Older Adults | http://www.ahrq.gov/clinic/uspstf/uspstfviseld.htm |
| Non Traditional Risk Factors in Coronary Heart Disease Risk Assessment | http://www.ahrq.gov/clinic/uspstf/uspstfcoronaryhd.htm |
| Breast Cancer, screening | http://www.ahrq.gov/clinic/uspstf/uspstfbrca.htm |
| Depression in Adults | http://www.ahrq.gov/clinic/uspstf/uspstfsaddepr.htm |
| Childhood Overweight and Obesity | http://www.ahrq.gov/clinic/uspstf/uspstfobes.htm |

2. Methods papers from the USPSTF

Petitti, D., Teutsch, S.M., Barton, M.B., et al. *Update on the Methods of the U.S. Preventive Services Task Force: Insufficient Evidence*. published in *Ann Intern Med* 2009;150:199-205.

Available in html at the following location

<http://www.ahrq.gov/clinic/uspstf09/methods/inevidup.htm>

Barton MB, Miller T, Wolff T, Petitti D, LeFevre M, Sawaya G, Yawn B, Guirguis-Blake J, Calonge N, Harris R. How to read the new recommendation statement: methods update from the U.S. Preventive Services Task Force. *Ann Intern Med* 2007;147:123-127.

Available in html at the following location:

<http://www.ahrq.gov/clinic/uspstf07/methods/methupd.htm>

Sawaya, G.F., Guirguis-Blake, J., LeFevre, M., et al. Update on the methods of the U.S. Preventive Services Task Force: estimating certainty and magnitude of net benefit. *Ann Intern Med* 2007;147: 871-875.

Available in html at the following location:

<http://www.ahrq.gov/clinic/uspstf07/methods/benefit.htm>

Guirguis-Blake J, Calonge E, Miller T, Siu A, Teutsch S, Whitlock E. Current processes of the U.S. Preventive Services Task Force: refining evidence-based recommendation development. *Ann Intern Med* 2007;147:117-22.

Available in html at the following location:

<http://www.ahrq.gov/clinic/uspstf07/methods/currprocess.htm>

3. Standard Tables

What the Grades Mean and Suggestions for Practice

| Grade | Definition | Suggestions for Practice |
|--------------------|--|---|
| A | The USPSTF recommends the service. There is high certainty that the net benefit is substantial. | Offer/provide this service. |
| B | The USPSTF recommends the service. There is high certainty that the net benefit is moderate or there is moderate certainty that the net benefit is moderate to substantial. | Offer/provide this service. |
| C | The USPSTF recommends against routinely providing the service. There may be considerations that support providing the service in an individual patient. There is at least moderate certainty that the net benefit is small. | Offer/provide this service only if other considerations support the offering or providing the service in an individual patient. |
| D | The USPSTF recommends against the service. There is moderate or high certainty that the service has no net benefit or that the harms outweigh the benefits. | Discourage the use of this service. |
| I Statement | The USPSTF concludes that the current evidence is insufficient to assess the balance of benefits and harms of the service. Evidence is lacking, of poor quality, or conflicting, and the balance of benefits and harms cannot be determined. | Read the clinical considerations section of USPSTF Recommendation Statement. If the service is offered, patients should understand the uncertainty about the balance of benefits and harms. |
| | | |
| | | |

| Levels of Certainty Regarding Net Benefit | |
|--|--|
| Level of Certainty* | Description |
| High | <p>The available evidence usually includes consistent results from well-designed, well-conducted studies in representative primary care populations. These studies assess the effects of the preventive service on health outcomes. This conclusion is therefore unlikely to be strongly affected by the results of future studies.</p> |
| Moderate | <p>The available evidence is sufficient to determine the effects of the preventive service on health outcomes, but confidence in the estimate is constrained by such factors as:</p> <ul style="list-style-type: none"> • The number, size, or quality of individual studies. • Inconsistency of findings across individual studies. • Limited generalizability of findings to routine primary care practice. • Lack of coherence in the chain of evidence. <p>As more information becomes available, the magnitude or direction of the observed effect could change, and this change may be large enough to alter the conclusion.</p> |
| Low | <p>The available evidence is insufficient to assess effects on health outcomes. Evidence is insufficient because of:</p> <ul style="list-style-type: none"> • The limited number or size of studies. • Important flaws in study design or methods. • Inconsistency of findings across individual studies. • Gaps in the chain of evidence. • Findings not generalizable to routine primary care practice. • Lack of information on important health outcomes. <p>More information may allow estimation of effects on health outcomes.</p> |

* The USPSTF defines *certainty* as "likelihood that the USPSTF assessment of the net benefit of a preventive service is correct." The net benefit is defined as benefit minus harm of the preventive service as implemented in a general, primary care population. The USPSTF assigns a certainty level based on the nature of the overall evidence available to assess the net benefit of a preventive service.



SCREENING FOR DEPRESSION IN ADULTS CLINICAL SUMMARY OF U.S. PREVENTIVE SERVICES TASK FORCE RECOMMENDATION

| | | |
|-----------------------|---|---|
| Population | Nonpregnant adults 18 years or older | |
| Recommendation | Screen when staff-assisted depression care supports* are in place to assure accurate diagnosis, effective treatment, and follow-up. Grade: B | Do not routinely screen when staff-assisted depression care supports* are not in place. Grade: C |

| | | |
|---------------------------------|--|---|
| Risk Assessment | <p>Persons at increased risk for depression are considered at risk throughout their lifetime. Groups at increased risk include persons with other psychiatric disorders, including substance misuse; persons with a family history of depression; persons with chronic medical diseases; and persons who are unemployed or of lower socioeconomic status. Also, women are at increased risk compared with men. However, the presence of risk factors alone cannot distinguish depressed patients from nondepressed patients.</p> | |
| Screening Tests | <p>Simple screening questions may perform as well as more complex instruments. Any positive screening test result should trigger a full diagnostic interview using standard diagnostic criteria.</p> | |
| Timing of Screening | <p>The optimal interval for screening is unknown. In older adults, significant depressive symptoms are associated with common life events, including medical illness, cognitive decline, bereavement, and institutional placement in residential or inpatient settings.</p> | |
| Balance of Harms and Benefits | | <p>Limited evidence suggests that screening for depression in the absence of staff-assisted depression care does not improve depression outcomes.</p> |
| Suggestions for Practice | <p>“Staff-assisted depression care supports” refers to clinical staff that assists the primary care clinician by providing some direct depression care and/or coordination, case management, or mental health treatment.</p> | |
| Relevant USPSTF Recommendations | <p>Related USPSTF recommendations on screening for suicidality and screening children and adolescents for depression are available at www.preventiveservices.ahrq.gov.</p> | |

For a summary of the evidence systematically reviewed in making these recommendations, the full recommendation statement, and supporting documents, please go to <http://www.preventiveservices.ahrq.gov>.

*See the Suggestions for Practice section of this figure for further explanation.



SCREENING FOR IMPAIRED VISUAL ACUITY IN OLDER ADULTS* CLINICAL SUMMARY OF U.S. PREVENTIVE TASK FORCE RECOMMENDATION

| | |
|-----------------------|---------------------------------------|
| Population | Adults Age 65 and Older |
| Recommendation | Grade I: Insufficient Evidence |

| | |
|---------------------------------------|--|
| Risk Assessment | <p style="text-align: center;">Older age is an important risk factor for most types of visual impairment.</p> <p style="text-align: center;">Additional risk factors include:</p> <ul style="list-style-type: none"> • Smoking, alcohol use, exposure to ultraviolet light, diabetes, corticosteroids, and black race (for cataracts) • Smoking, family history, and white race (for age-related macular degeneration) |
| Screening Tests | <p style="text-align: center;">Visual acuity testing (for example, the Snellen eye chart) is the usual method for screening for impairment of visual acuity in the primary care setting.</p> <p style="text-align: center;">Screening questions are not as accurate as a visual acuity test.</p> |
| Balance of Harms and Benefits | <p style="text-align: center;">There is no direct evidence that screening for vision impairment in older adults in primary care settings is associated with improved clinical outcomes.</p> <p style="text-align: center;">There is evidence that early treatment of refractive error, cataracts, and age-related macular degeneration may lead to harms that are small.</p> <p style="text-align: center;">The magnitude of net benefit for screening cannot be calculated because of a lack of evidence.</p> |
| Other Relevant USPSTF Recommendations | <p style="text-align: center;">Recommendations on screening for glaucoma and on screening for hearing loss in older adults can be accessed at http://www.preventiveservices.ahrq.gov.</p> |

For a summary of the evidence systematically reviewed in making these recommendations, the full recommendation statement, and supporting documents please go to <http://www.preventiveservices.ahrq.gov>.

*This recommendation does not cover screening for glaucoma.

This summary was first published in *Annals of Internal Medicine* on July 7, 2009. (*Ann Intern Med.* 151:41).

AHRQ Publication No. 09-05135-EF-3. Current as of July 2009.



**COUNSELING AND INTERVENTIONS TO PREVENT TOBACCO USE AND
TOBACCO-CAUSED DISEASE IN ADULTS AND PREGNANT WOMEN
CLINICAL SUMMARY OF U.S. PREVENTIVE SERVICES TASK FORCE RECOMMENDATION**

| Population | Adults 18 years or older | Pregnant Women of any age |
|----------------|--|--|
| Recommendation | <p align="center">Ask about tobacco use. Provide tobacco cessation interventions to those who use tobacco products.</p> <p align="center">Grade: A</p> | <p align="center">Ask about tobacco use. Provide augmented pregnancy-tailored counseling for women who smoke.</p> <p align="center">Grade: A</p> |

| | | |
|---------------------------------|--|---|
| Counseling | <p>The "5-A" framework provides a useful counseling strategy:</p> <ol style="list-style-type: none"> 1. Ask about tobacco use 2. Advice to quit through clear personalized messages 3. Assess willingness to quit 4. Assist to quit 5. Arrange follow-up and support <p>Intensity of counseling matters: brief one-time counseling works; however, longer sessions or multiple sessions are more effective. Telephone counseling "quit lines" also improve cessation rates.</p> | |
| Pharmacotherapy | <p>Combination therapy with counseling and medications is more effective than either component alone. FDA-approved pharmacotherapy includes nicotine replacement therapy, sustained release bupropion, and varenicline.</p> | <p>The USPSTF found inadequate evidence to evaluate the safety or efficacy of pharmacotherapy during pregnancy.</p> |
| Implementation | <p>Successful implementation strategies for primary care practice include:</p> <ul style="list-style-type: none"> • Instituting a tobacco user identification system • Promoting clinician intervention through education, resources, and feedback • Dedicating staff to provide treatment, and assessing the delivery of treatment in staff performance evaluations | |
| Relevant USPSTF Recommendations | <p>Recommendations on other behavioral counseling topics are available at http://www.preventiveservices.ahrq.gov.</p> | |

For a summary of the [evidence](#) systematically reviewed in making these recommendations, the full [recommendation statement](#), and [supporting documents](#) please go to <http://www.preventiveservices.ahrq.gov>.

This summary was first published in *Annals of Internal Medicine* in April 2009. (*Ann Intern Med.* 2009;150:553. <http://www.annals.org>).

AHRQ Publication No. 09-05131-EF-2.



SCREENING FOR SYPHILIS INFECTION IN PREGNANCY CLINICAL SUMMARY OF U.S. PREVENTIVE SERVICES TASK FORCE RECOMMENDATION

| | |
|-----------------------|--|
| Population | All Pregnant Women |
| Recommendation | Screen for syphilis infection. Grade: A |

| | |
|---------------------------------|--|
| Screening Tests | <p>Nontreponemal tests commonly used for initial screening include:</p> <ul style="list-style-type: none"> • Venereal Disease Research Laboratory (VDRL) • Rapid Plasma Reagin (RPR) <p>Confirmatory tests include:</p> <ul style="list-style-type: none"> • Fluorescent treponemal antibody absorbed (FTA-ABS) • Treponema pallidum particle agglutination (TPPA) |
| Timing of Screening | Test all pregnant women at the first prenatal visit. |
| Other Clinical Considerations | <p>Most organizations recommend testing high-risk women again during the third trimester and at delivery. Groups at increased risk include:</p> <ul style="list-style-type: none"> • uninsured women • women living in poverty • sex workers • illicit drug users • those diagnosed with other sexually transmitted diseases (STDs) • other women living in communities with high syphilis morbidity. <p style="text-align: center;">Prevalence is higher in southern U.S. and in metropolitan areas and in Hispanic and African American populations.</p> |
| Interventions | <p style="text-align: center;">The Centers for Disease Control and Prevention (CDC) recommends treatment with parenteral benzathine penicillin G. Women with penicillin allergies should be desensitized and treated with penicillin. Consult the CDC for the most up-to-date recommendations: http://www.cdc.gov/std/treatment/</p> |
| Relevant USPSTF Recommendations | Recommendations on screening for other STDs, and on counseling for STDs, can be found at www.preventiveservices.ahrq.gov . |

For a summary of the evidence systematically reviewed in making these recommendations, the full recommendation statement, and supporting documents please go to <http://www.preventiveservices.ahrq.gov>.

This document is a summary of the 2009 recommendation of the U.S. Preventive Services Task Force (USPSTF) on screening for syphilis infection in pregnant women. This summary is intended for use by primary care clinicians. This summary was first published in Annals of Internal Medicine in May 2009 (Ann Intern Med. 2009;150:707. <http://www.annals.org>). AHRQ Publication No. 09-05133-EF-2. Current as of May 2009.



Screening for Skin Cancer Clinical Summary of U.S. Preventive Services Task Force Recommendation

| | |
|---|--|
| Population | Adult General Population¹ |
| “I” Statement: Insufficient Evidence | No recommendation due to insufficient evidence |

| | |
|---|--|
| Risk Assessment | <p style="text-align: center;">Skin cancer risks: family history of skin cancer, considerable history of sun exposure and sunburn</p> <p style="text-align: center;">Groups at increased risk for melanoma:</p> <ul style="list-style-type: none"> ▪ fair-skinned men and women over the age of 65 years ▪ patients with atypical moles ▪ patients with more than 50 moles |
| Screening Tests | There is insufficient evidence to assess the balance of benefits and harms of whole body skin examination by a clinician or patient skin self-examination for the early detection of skin cancer. |
| Screening Intervals | Not applicable. |
| Suggestions for Practice | Clinicians should remain alert for skin lesions with malignant features that are noted while performing physical examinations for other purposes. Features associated with increased risk for malignancy include: asymmetry, border irregularity, color variability, diameter >6mm (“A,” “B,” “C,” “D”), or rapidly changing lesions. Suspicious lesions should be biopsied. |
| Other Relevant Recommendations from the USPSTF and the U.S. Task Force on Community Preventive Services | <p style="text-align: center;">The USPSTF has reviewed the evidence for counseling to prevent skin cancer. The recommendation statement and supporting documents can be accessed at http://www.preventiveservices.ahrq.gov.</p> <p style="text-align: center;">The U.S. Task Force on Community Preventive Services has reviewed the evidence on interventions to reduce skin cancer. The recommendations can be accessed at http://www.thecommunityguide.org.</p> |

For a summary of the [evidence](#) systematically reviewed in making these recommendations, the full [recommendation statement](#), and [supporting documents](#) please go to <http://www.preventiveservices.ahrq.gov>.

¹ **Note:** The USPSTF does not examine outcomes related to surveillance of patients with familial syndromes, such as familial atypical mole and melanoma (FAM-M) syndrome.



SCREENING FOR HEPATITIS B VIRUS (HBV) INFECTION IN PREGNANCY CLINICAL SUMMARY OF U.S. PREVENTIVE TASK FORCE RECOMMENDATION

| | |
|-----------------------|--|
| Population | All Pregnant Women |
| Recommendation | Screen at the first prenatal visit Grade: A |

| | |
|---------------------------------|--|
| Screening Tests | Serologic identification of hepatitis B surface antigen (HBsAg). Reported sensitivity and specificity are greater than 98%. |
| Timing of Screening | Order HBsAg testing at the first prenatal visit. Re-screen women with unknown HBsAg status or new or continuing risk factors at admission to hospital, birth center, or other delivery setting. |
| Interventions | Administer hepatitis B vaccine and hepatitis B immune globulin to HBV-exposed infants within 12 hours of birth. Refer women who test positive for counseling and medical management. Counseling should include information about how to prevent transmission to sexual partners and household contacts. Reassure patients that breastfeeding is safe for infants who receive appropriate prophylaxis. |
| Implementation | Establish systems for timely transfer of maternal HBsAg test results to the labor and delivery and newborn medical records. |
| Relevant USPSTF Recommendations | USPSTF recommendations on the screening of pregnant women for other infections, including asymptomatic bacteriuria, bacterial vaginosis, chlamydia, HIV, and syphilis, can be found at http://www.preventiveservices.ahrq.gov . |

For a summary of the [evidence](#) systematically reviewed in making these recommendations, the full [recommendation statement](#), and [supporting documents](#) please go to <http://www.preventiveservices.ahrq.gov>.

This document is a summary of the 2009 recommendation of the U.S. Preventive Services Task force on screening for Hepatitis B infection in pregnancy. It is intended for use by primary care clinicians. This summary was first published in *Annals of Internal Medicine* in June 2009 (*Ann Intern Med.* 2009;150:871 <http://www.annals.org>).

AHRQ Publication No. 09-05134-EF-2. Current as of June 2009.



FOLIC ACID FOR THE PREVENTION OF NEURAL TUBE DEFECTS CLINICAL SUMMARY OF U.S. PREVENTIVE SERVICES TASK FORCE RECOMMENDATION

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|----------------|---|
| Population | Women planning a pregnancy or capable of becoming pregnant |
| Recommendation | Take a daily vitamin supplement containing 0.4 to 0.8 mg (400 to 800 µg) of folic acid. Grade: A |

| | |
|---------------------------|--|
| Risk Assessment | <p>Risk factors include:</p> <ul style="list-style-type: none">• A personal or family history of a pregnancy affected by a neural tube defect (NTD)• The use of certain antiseizure medications• Mutations in folate-related enzymes• Maternal diabetes• Maternal obesity <p>Note: This recommendation does not apply to women who have had a prior pregnancy affected by neural tube defects, or women taking certain anti-seizure medicines. These women may be advised to take higher doses of folic acid.</p> |
| Timing of Medication | <p>Start supplementation at least 1 month before conception.</p> <p>Continue through first 2 to 3 months of pregnancy.</p> |
| Recommendations of Others | <p>ACOG, AAFP, and most other organizations recommend 4 mg per day for women with a history of a pregnancy affected by a neural tube defect.</p> |

For a summary of the evidence systematically reviewed in making these recommendations, the full recommendation statement, and supporting documents please go to <http://www.preventiveservices.ahrq.gov>.

ACOG: American College of Obstetricians and Gynecologists; AAFP: American Academy of Family Physicians.

This summary was first published in Annals of Internal Medicine in May 2009. (Ann Intern Med 2009;150:629; <http://www.annals.org>).

AHRQ Publication No. 09-05132-EF-3



USING NONTRADITIONAL RISK FACTORS IN CORONARY HEART DISEASE RISK ASSESSMENT CLINICAL SUMMARY OF U.S. PREVENTIVE SERVICES TASK FORCE RECOMMENDATION

| | |
|---|---|
| Population | Asymptomatic men and women with no history of coronary heart disease (CHD), diabetes, or any CHD risk equivalent |
| I statement: Insufficient Evidence | No recommendation because of insufficient evidence |

| | |
|---------------------------------|--|
| Risk Assessment | This recommendation applies to adult men and women classified at intermediate 10-year risk for CHD (10% to 20%) by traditional risk factors. |
| Importance | <p>Coronary heart disease (CHD) is the most common cause of death in adults in the United States. Treatment to prevent CHD events by modifying risk factors is currently based on the Framingham risk model. If the classification of individuals at intermediate risk could be improved by using additional risk factors, treatment to prevent CHD might be targeted more effectively.</p> <p>Risk factors not currently part of the Framingham model (nontraditional risk factors) include high sensitivity C-reactive protein (hs-CRP), ankle-brachial index (ABI), leukocyte count, fasting blood glucose level, periodontal disease, carotid intima-media thickness,; electron beam computed tomography,; homocysteine level, and lipoprotein(a) level.</p> |
| Rationale for No Recommendation | There is insufficient evidence to determine the percentage of intermediate-risk individuals who would be reclassified by screening with nontraditional risk factors, other than hs-CRP and ABI. For individuals reclassified as high-risk on the basis of hs-CRP or ABI scores, data are not available to determine whether they benefit from additional treatments. Little evidence is available to determine the harms of using nontraditional risk factors in screening. Potential harms include lifelong use of medications without proven benefit and psychological and other harms from being misclassified in a higher risk category. |
| Considerations for Practice | Clinicians should continue to use the Framingham model to assess CHD risk and guide risk-based preventive therapy. Adding nontraditional risk factors to CHD assessment would require additional patient and clinical staff time and effort. Routinely screening with nontraditional risk factors could result in lost opportunities to provide other important health services of proven benefit. |
| Relevant USPSTF Recommendations | USPSTF recommendations on risk assessment for CHD, the use of aspirin to prevent cardiovascular disease, and screening for high blood pressure can be accessed at www.preventiveservices.ahrq.gov |

For a summary of the evidence systematically reviewed in making these recommendations, the full recommendation statement, and supporting documents please go to <http://www.preventiveservices.ahrq.gov>.

This summary was first published in *Annals of Internal Medicine* on October 6, 2009. AHRQ Publication No. 10-05141-EF-3.



SCREENING FOR BREAST CANCER USING FILM MAMMOGRAPHY CLINICAL SUMMARY OF U.S. PREVENTIVE SERVICES TASK FORCE RECOMMENDATION

| Population | Women Aged 40–49 Years | Women Aged 50–74 Years | Women Aged ≥75 Years |
|----------------|---|------------------------------|---|
| Recommendation | Do not screen routinely. Individualize decision to begin biennial screening according to the patient's context and values. | Screen every 2 years. | No recommendation. |
| | Grade: C | Grade: B | Grade: I (insufficient evidence) |

| | | |
|---|---|--|
| Risk Assessment | This recommendation applies to women aged ≥40 years who are not at increased risk by virtue of a known genetic mutation or history of chest radiation. Increasing age is the most important risk factor for most women. | |
| Screening Tests | Standardization of film mammography has led to improved quality. Refer patients to facilities certified under the Mammography Quality Standards Act (MQSA), listed at www.fda.gov/cdrh/mammography/certified.html . | |
| Timing of Screening | Evidence indicates that biennial screening is optimal. A biennial schedule preserves most of the benefit of annual screening and cuts the harms nearly in half. A longer interval may reduce the benefit. | |
| Balance of Harms and Benefits | <p>There is convincing evidence that screening with film mammography reduces breast cancer mortality, with a greater absolute reduction for women aged 50 to 74 years than for younger women.</p> <p>Harms of screening include psychological harms, additional medical visits, imaging, and biopsies in women without cancer, inconvenience due to false-positive screening results, harms of unnecessary treatment, and radiation exposure. Harms seem moderate for each age group.</p> <p>False-positive results are a greater concern for younger women; treatment of cancer that would not become clinically apparent during a woman's life (overdiagnosis) is an increasing problem as women age.</p> | |
| Rationale for No Recommendation (I Statement) | | Among women 75 years or older, evidence of benefit is lacking. |
| Relevant USPSTF Recommendations | USPSTF recommendations on screening for genetic susceptibility for breast cancer and chemoprevention of breast cancer are available at www.preventiveservices.ahrq.gov . | |

For a summary of the evidence systematically reviewed in making these recommendations, the full recommendation statement, and supporting documents, please go to <http://www.preventiveservices.ahrq.gov>.



SCREENING FOR BREAST CANCER USING METHODS OTHER THAN FILM MAMMOGRAPHY CLINICAL SUMMARY OF U.S. PREVENTIVE SERVICES TASK FORCE RECOMMENDATION

| | | | | |
|-------------------------|---|---|--|--------------------------------------|
| Population | Women Aged ≥40 Years | | | |
| Screening Method | Digital Mammography | Magnetic Resonance Imaging (MRI) | Clinical Breast Examination (CBE) | Breast Self-Examination (BSE) |
| Recommendation | Grade: I (insufficient evidence) | | | Grade: D |

| | | | |
|--|--|--|--|
| Rationale for No Recommendation or Negative Recommendation | Evidence is lacking for benefits of digital mammography and MRI of the breast as substitutes for film mammography. | Evidence of CBE's additional benefit, beyond mammography, is inadequate. | Adequate evidence suggests that BSE does not reduce breast cancer mortality. |
| Considerations for Practice | | | |
| Potential Preventable Burden | For younger women and women with dense breast tissue, overall detection is somewhat better with digital mammography. | Contrast-enhanced MRI has been shown to detect more cases of cancer in very high-risk populations than does mammography. | Indirect evidence suggests that when CBE is the only test available, it may detect a significant proportion of cancer cases. |
| Potential Harms | It is not certain whether overdiagnosis occurs more often with digital than with film mammography. | Contrast-enhanced MRI requires injection of contrast material. MRI yields many more false-positive results and potentially more overdiagnosis than mammography. | Harms of CBE include false-positive results, which lead to anxiety, unnecessary visits, imaging, and biopsies. |
| Costs | Digital mammography is more expensive than film. | MRI is much more expensive than mammography. | Costs of CBE are primarily opportunity costs to clinicians. |
| Current Practice | Some clinical practices are now switching to digital equipment. | MRI is not currently used to screen women of average risk. | No standard approach or reporting standards are in place. |
| | | | The number of clinicians who teach BSE to patients is unknown; it is likely that few clinicians teach BSE to all women. |

For a summary of the evidence systematically reviewed in making these recommendations, the full recommendation statement, and supporting documents, please go to <http://www.preventiveservices.ahrq.gov>.



SCREENING FOR OBESITY IN CHILDREN AND ADOLESCENTS: CLINICAL SUMMARY OF USPSTF RECOMMENDATION

| | |
|--|---|
| Population | Children and adolescents 6 to 18 y of age |
| Recommendation | Screen children aged 6 y and older for obesity. Offer or refer for intensive counseling and behavioral interventions. Grade: B |
| Screening tests | <p>BMI is calculated from the weight in kilograms divided by the square of the height in meters.</p> <p>Height and weight, from which BMI is calculated, are routinely measured during health maintenance visits. BMI percentile can be plotted on a chart or obtained from online calculators.</p> <p>Overweight = age- and gender-specific BMI at ≥85th to 94th percentile Obesity = age- and gender-specific BMI at ≥95th percentile</p> |
| Timing of screening | No evidence was found on appropriate screening intervals. |
| Interventions | Refer patients to comprehensive moderate- to high-intensity programs that include dietary, physical activity, and behavioral counseling components. |
| Balance of harms and benefits | <p>Moderate- to high-intensity programs were found to yield modest weight changes.</p> <p>Limited evidence suggests that these improvements can be sustained over the year after treatment.</p> <p>Harms of screening were judged to be minimal.</p> |
| Relevant recommendations from the USPSTF | Recommendations on other pediatric and behavioral counseling topics can be found at www.preventiveservices.ahrq.gov . |

For a summary of the evidence systematically reviewed in making these recommendations, the full recommendation statement, and supporting documents please go to www.preventiveservices.ahrq.gov.



ASPIRIN FOR THE PREVENTION OF CARDIOVASCULAR DISEASE CLINICAL SUMMARY OF U.S. PREVENTIVE SERVICES TASK FORCE RECOMMENDATION

| Population | Men Age 45-79 Years | Women Age 55-79 Years | Men Age < 45 Years | Women Age < 55 Years | Men & Women Age ≥ 80 Years |
|----------------|--|--|--|--|---|
| Recommendation | Encourage aspirin use when potential CVD benefit (MIs prevented) outweighs potential harm of GI hemorrhage | Encourage aspirin use when potential CVD benefit (strokes prevented) outweighs potential harm of GI hemorrhage | Do not encourage aspirin use for MI prevention | Do not encourage aspirin use for stroke prevention | No Recommendation |
| | GRADE: A | | GRADE: D | | GRADE: I (Insufficient Evidence) |

| How to Use This Recommendation | <p>Shared decision making is strongly encouraged with individuals whose risk is close to (either above or below) the estimates of 10-year risk levels indicated below. As the potential CVD benefit increases above harms, the recommendation to take aspirin should become stronger.</p> <p>To determine whether the potential benefit of MIs prevented (men) and strokes prevented (women) outweighs the potential harm of increased GI hemorrhage, both 10-year CVD risk and age must be considered.</p> <table border="1" style="margin-left: auto; margin-right: auto; border-collapse: collapse;"> <thead> <tr> <th colspan="4" style="text-align: center;">Risk level at which CVD events prevented (benefit) exceeds GI harms</th> </tr> <tr> <th colspan="2" style="text-align: center;">Men</th> <th colspan="2" style="text-align: center;">Women</th> </tr> <tr> <th colspan="2" style="text-align: center;">10-year CHD risk</th> <th colspan="2" style="text-align: center;">10-year stroke risk</th> </tr> </thead> <tbody> <tr> <td style="text-align: center;">Age 45 – 59 years</td> <td style="text-align: center;">≥ 4%</td> <td style="text-align: center;">Age 55 – 59 years</td> <td style="text-align: center;">≥ 3%</td> </tr> <tr> <td style="text-align: center;">Age 60 – 69 years</td> <td style="text-align: center;">≥ 9%</td> <td style="text-align: center;">Age 60 – 69 years</td> <td style="text-align: center;">≥ 8%</td> </tr> <tr> <td style="text-align: center;">Age 70 – 79 years</td> <td style="text-align: center;">≥ 12%</td> <td style="text-align: center;">Age 70 – 79 years</td> <td style="text-align: center;">≥ 11%</td> </tr> </tbody> </table> <p>The table above applies to adults who are not taking NSAIDs and who do not have upper GI pain or a history of GI ulcers.</p> <p>NSAID use and history of GI ulcers raise the risk of serious GI bleeding considerably and should be considered in determining the balance of benefits and harms. NSAID use combined with aspirin use approximately quadruples the risk of serious GI bleeding compared to the risk with aspirin use alone. The rate of serious bleeding in aspirin users is approximately 2 – 3 times higher in patients with a history of GI ulcers.</p> | Risk level at which CVD events prevented (benefit) exceeds GI harms | | | | Men | | Women | | 10-year CHD risk | | 10-year stroke risk | | Age 45 – 59 years | ≥ 4% | Age 55 – 59 years | ≥ 3% | Age 60 – 69 years | ≥ 9% | Age 60 – 69 years | ≥ 8% | Age 70 – 79 years | ≥ 12% | Age 70 – 79 years | ≥ 11% |
|---|---|---|-------|--|--|-----|--|-------|--|------------------|--|---------------------|--|-------------------|------|-------------------|------|-------------------|------|-------------------|------|-------------------|-------|-------------------|-------|
| Risk level at which CVD events prevented (benefit) exceeds GI harms | | | | | | | | | | | | | | | | | | | | | | | | | |
| Men | | Women | | | | | | | | | | | | | | | | | | | | | | | |
| 10-year CHD risk | | 10-year stroke risk | | | | | | | | | | | | | | | | | | | | | | | |
| Age 45 – 59 years | ≥ 4% | Age 55 – 59 years | ≥ 3% | | | | | | | | | | | | | | | | | | | | | | |
| Age 60 – 69 years | ≥ 9% | Age 60 – 69 years | ≥ 8% | | | | | | | | | | | | | | | | | | | | | | |
| Age 70 – 79 years | ≥ 12% | Age 70 – 79 years | ≥ 11% | | | | | | | | | | | | | | | | | | | | | | |
| Risk Assessment | <p>For MEN: Risk factors for CHD include age, diabetes, total cholesterol level, HDL level, blood pressure, and smoking. CHD risk estimation tool: http://healthlink.mcw.edu/article/923521437.html</p> <p>For WOMEN: Risk factors for ischemic stroke include age, high blood pressure, diabetes, smoking, history of CVD, atrial fibrillation, and left ventricular hypertrophy. Stroke risk estimation tool: http://www.westernstroke.org/PersonalStrokeRisk1.xls</p> | | | | | | | | | | | | | | | | | | | | | | | | |
| Relevant Recommendations from the USPSTF | <p>The USPSTF has made recommendations on screening for abdominal aortic aneurysm, carotid artery stenosis, coronary heart disease, high blood pressure, lipid disorders, and peripheral arterial disease. These recommendations are available at www.preventiveservices.ahrq.gov.</p> | | | | | | | | | | | | | | | | | | | | | | | | |

For the full recommendation statement and supporting documents, please go to: www.preventiveservices.ahrq.gov. Abbreviations: CHD = coronary heart disease, CVD = cardiovascular disease, GI = gastrointestinal, HDL = high-density lipoprotein, MI = myocardial infarction, NSAIDs = nonsteroidal anti-inflammatory drugs.