Screening by age

grey = screening; yellow = prescribe

	Screening
Obesity	**USPSTF (2012):** - screen all adults (B rec) **USPSTF (2010):** - screen children ≥6yo (B rec) **USPSTF (2014):** - intensive behavioral counseling interventions for adults who are overweight or obese and have additional cardiovascular disease (CVD) risk factors (to promote a healthful diet and physical activity for CVD prevention)
Fluoride and dental caries	**USPSTF (2014)**: - oral fluoride supplementation for children ≥6mo whose water supply is deficient in fluoride (B rec) - flouride varnish to primary teeth at age of primary tooth eruption (B rec)
Depression	**USPSTF (2016/2016)**: - screen general adult population (B rec) - screen 12-18yo (B rec)*
HIV	**USPSTF (2013):** - screen all people 15-65yo (A rec) - screen all pregnant women (A rec)
Syphilis	**USPSTF (2016):** - screen all people at inc risk (A rec) **USPSTF (2009):** - screen all pregnant women (A rec)
Hypertension	**USPSTF (2015):** - screen all adults >18yo, and recommends measurement outside clinical setting for dx confirmation before tx (A rec)
Cervical cancer	**USPSTF (2012)**: - ages <21: no screen (D rec) - ages <30: no screening with HPV testing (D rec) - ages 21-65: Pap smear (cytology) q3y (A rec) - ages 30-65: Pap smear q3y or Pap + HPV testing q5y (A rec) - ages >65 w/ adeq. prior screening & not high risk: no screen (D rec) - Hysterectomy w/ removal of cervix + no h/o CIN2/3: no screen (D rec) **ACS/ASCCP/ASCP/ACOG (2012)**: - agrees with above
Chlamydia & Gonorrhea	**USPSTF (2014):** - screen for chlamydia & gonorrhea in sexually active women ≤24yo AND in >24yo who are at increased risk (B rec) - insufficient evidence to screen men (I rec) **USPSTF screening intervals (2007):** - first prenatal visit - third trimester if new risk factor or sexual partner - unknown interval for nonpregnant women **CDC screening interval (2006):** - annually for women at risk

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Lipid disorders	**ACC/AHA (2013):** - for adults 20-79yo who are free from CVD it is "reasonable" to assess risk factors (smoking, HTN, DM, lipids) q4-6y to calculate 10y CVD risk - for adults 20-59yo with 10y CVD risk <7.5% consider assessing 30y or lifetime CVD risk **Uptodate (2016)** - start screening men 20-30yo and women 30-34yo who are at high-risk for CV disease (HTN, Fhx premature CAD, smoke) - start screening men 35yo and women 45yo who are at low-risk for CV disease **USPSTF (2008) *old and without new guideline as of 2017*:** - screen men >35yo (A rec) - screen men 20-35yo if at inc risk for CHD (B rec) - screen women >45yo if at inc risk for CHD (A rec) - screen women 20-45yo if at inc risk for CHD (B rec) - no recomm. for men 20-35yo or women >20yo w/o inc risk for CHD (C rec) **ATP III - NCEP (2001):** - fasting lipoprotein profile every 5y starting at 20yo
Diabetes	**USPSTF (2015)**: - Screen adults 40-70yo who are overweight or obese (B rec) **ADA (2013):** - Test adults with BMI >25 with risk factors, q3y - Test pts without risk factors when >45yo* **CDC** - Screen pts >45yo or pts with risk factors (overwt, FH, high-risk ethnic groups, h/o gDM, sedentary lifestyle) - **CTFPHC (Canadian) (2012):** - Use validated risk calculator and screen high risk pts - Do not routinely screen low to mod risk pts - Repeat q3-5y for high risk pts - Repeat q1y for very high risk pts
Statin	**USPSTF (2016):** - low to mod statin for those without a h/o CVD if they have all the following: 1) 40-75yo; 2) ≥1 CVD risk factor; 3) 10y CVD event risk **≥10%** (B rec) - low to mod statin for those without a h/o CVD if they have all the following: 1) 40-75yo; 2) ≥1 CVD risk factor; 3) 10y CVD event risk **7.5-10%** (C rec) - insufficient evidence for adults ≥76yo with no hx of CVD (I rec) **ACC/AHA (2013)**: 1. Patients with any form of clinical ASCVD 2. Patients with primary LDL-C levels of ≥190 3. Patients with diabetes mellitus, 40-75yo, with LDL-C levels of 70 to 189 mg per dL 4. Patients without diabetes, 40 to 75 years of age, with an estimated 10-year ASCVD risk ≥ 7.5%

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ASA for the prevention of cardiovascular disease (CVD) and colorectal cancer (CRC) **&** **B-carotene, Vit E**	**USPSTF (2016):** - aspirin for adults 50-59yo with ≥10% 10y CVD risk, are not at inc risk for GI bleeding, have a life expectancy ≥10y, and willing to take ASA daily for 10y (B rec) - **individual decision** is made for aspirin for adults 60-69yo with ≥10% 10y CVD risk, are not at inc risk for GI bleeding, have a life expectancy ≥10y, and willing to take ASA daily for 10y (C rec) - insufficient evidence for aspirin in men and women <50yo (I rec) - insufficient evidence for aspirin in men and women ≥70yo (I rec) **AHA:** - no aspirin for women <65yo to prevent MI - aspirin 81-100mg/dL every other day for women >65yo - aspirin 75-375mg/dL for high risk pts (ie DM) **ACP:** - same as USPSTF **ACCP:** - select individuals ≥50yo (75-100mg qD) for primary prevention of MI and stroke **USPSTF (2014):** - recs against use of B-carotene or vitamin E to prevent CV disease or cancer (D rec)*
Breast cancer	**USPSTF (2016)**: - screen women 50-74yo q2y (B rec) - individual decision to screen women 40-49yo (most benefits for average risk women will be screening >50yo; women with 1st deg relative w/ breast CA may benefit more screening in their 40s) (C rec) - insufficient evidence about screening mammography in >75yo (I rec) **ACS (2015)**: - women can choose to start yearly mammograms ≥40yo - yearly mammograms ≥45yo - mammograms every other year or yearly ≥55yo - continue screening as long as life expectance is ≥10y **ACOG (2016):** - breast self-awareness - clinical breast exam yearly for ≥19yo - yearly mammograms ≥40yo
Colorectal cancer	**USPSTF (2016):** - screen adults 50-75yo using FOBT, sigmoidoscopy, or colonoscopy (A rec) - individual decision to screen adults 76-85yo (C rec) **American Cancer Society (2013)**: - FOBT: q1y - Flexible Sigmoidoscopy: q5y - DCBE: q5y - Colonoscopy: q10y - CT Colonography: q5y For average risk: - colonoscopy q10y For increased risk: - colonoscopy at age 40yo or 10y before age of cancer dx in relative (**whichever comes first**) q5y***

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Prostate cancer	**USPSTF (2012):** - recommends against PSA-based screening (D rec) ***USPSTF (DRAFT 2016):*** - *individual decision for men 55-69yo (C rec)* - *recommends against screening men ≥70 (D rec)* **ACS (2012):** - discussion about screening at 50yo - discussion about screening at 45yo for AA with first-degree relatives with prostate cancer before age 65yo **ACP (2013)**: - recommends informing men 50-69yo about limited benefits and substantial harms of screening - does not recommend screening using PSA for average-risk men <50yo, men >69yo, or men with life expectancy <10-15y **AAFP (2012):** - agrees with USPSTF **AUA (2013):** - recommends against screening men <40yo - does not recommend screening men 40-54yo at average risk - strongly recommends shared decision-making for men 55-69yo after weighing benefits and harms - routine screening interval of 2y or more may be preferred over annual screening - does not recommend screening men >70yo or men with <10-15y life expectancy
Lung cancer	**USPSTF (2013):** - annual* screening with low-dose CT scan for adults 55-80yo who have a ≥30 pack-year smoking history (only pts who currently smoke or have quit within 15y) (B rec)***
Abdominal aortic aneurysm	**USPSTF (2014):** - one-time screening by U/S in men 65-75yo who have ever smoked (>100 cig) (B rec) - selective screening for men 65-75yo who have never smoked (C rec) - insufficient evid. to screen women who have smoked (I rec) - rec against screening women who never smoked (D rec)
Osteoporosis	**USPSTF (2011)**: - screen women ≥65yo (B rec) - screen younger women whose fracture risk is ≥ to a 65yo white woman who has no additional risk factors (B rec) - insufficient evidence to screen men (I rec) **WHO**: - dual energy xray absorptiometry (DEXA) is choice test - osteoperosis at or below -2.5 SD - ostepoenia between -1.0 and -2.5 SD **NOF:** - Woman > 65yo - Man > 70yo - Man 50-69yo with risk factors - If you break a bone after 50yo - Menopausal women with risk factors - Postmenopausal women < 65yo with risk factors **AAFP:** - women >65yo (A rec) - postmenopausal women, men 50-69yo with fracture risk (C rec) - men >70yo (C rec)
Vitamin D	**USPSTF (2013)**: - vit D supplementation for adults ≥65yo who are at inc risk for falls (h/o recent fall or Vit D def) (B rec)

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USPSTF grade definitions (2012):

Grade	Definition	Suggestions for Practice
A	The USPSTF recommends the service. There is high certainty that the net benefit is substantial.	Offer or 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 or provide this service.
C	The USPSTF recommends selectively offering or providing this service to individual patients based on professional judgment and patient preferences. There is at least moderate certainty that the net benefit is small.	Offer or provide this service for selected patients depending on individual circumstances.
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.

AAFP Strength-of-Recommendation Taxonomy (SORT):

Table 1. Strength-of-Recommendation Grades

Strength of recommendation	*Basis for recommendation*
A	Consistent, good-quality patient-oriented evidence*
B	Inconsistent or limited-quality patient-oriented evidence*
C	Consensus, disease-oriented evidence,* usual practice, expert opinion, or case series for studies of diagnosis, treatment, prevention, or screening

**—Patient-oriented evidence measures outcomes that matter to patients: morbidity, mortality, symptom improvement, cost reduction, and quality of life. Disease-oriented evidence measures intermediate, physiologic, or surrogate end points that may or may not reflect improvements in patient outcomes (e.g., blood pressure, blood chemistry, physiologic function, pathologic findings).*

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