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# USPSTF recommendations you may have missed amid the breast cancer controversy

The USPSTF recommends aspirin for the prevention of stroke and heart attack for those at risk, and screening for major depression and childhood obesity.

**L**ate in 2009, a change in the recommendations of the US Preventive Services Task Force (USPSTF) brought more public attention to this panel than it had ever experienced before. This publicity centered on revised recommendations on breast cancer screening that pointed out that mammograms benefit a few women under 50, but are also associated with some harms. The Task Force recommended that patients and physicians discuss these potential benefits and harms and make an individual decision about whether to have a mammogram.<sup>1</sup>

Even though the criticism was loud—and harsh—from some sectors, many professional organizations, including the American Academy of Family Physicians, the American College of Physicians, and the American College of Preventive Medicine, came to the defense of the Task Force and its rigorous, evidence-based methodology.<sup>2-4</sup> Both the *Journal of the American Medical Association* and the *Annals of Internal Medicine* have since published a series of articles and opinions on the controversy, most of them favorable to the Task Force and its methods.<sup>2-9</sup>

**TABLE 1**  
**US Preventive Services Task Force recommendation categories**

Grade	Definition
A	The USPSTF recommends the service. There is high certainty that the net benefit is substantial.
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.
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.
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.
I	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.

Source: Agency for Healthcare Research and Quality. US Preventive Services Task Force (USPSTF) ratings. Available at: [www.ahrq.gov/clinic/uspstf07/ratingsv2.htm](http://www.ahrq.gov/clinic/uspstf07/ratingsv2.htm). Accessed March 22, 2010.

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Screening for major depressive disorder in adolescents is recommended when systems are in place to ensure accurate diagnosis, psychotherapy, and follow-up.

**TABLE 2**  
**USPSTF recommends FOR**

CARDIOVASCULAR DISEASE PREVENTION
<ul style="list-style-type: none"> <li>Using aspirin for men 45 to 79 years of age, when the potential benefit due to a reduction in myocardial infarctions (MIs) outweighs the potential harm due to an increase in gastrointestinal (GI) hemorrhage (A).</li> <li>Using aspirin for women 55 to 79 years of age when the potential benefit of a reduction in ischemic strokes outweighs the potential harm of an increase in GI hemorrhage (A).</li> <li>Asking all adults about tobacco use and providing tobacco cessation interventions for those who use tobacco products (A).</li> </ul>
PREGNANCY
<ul style="list-style-type: none"> <li>Asking all pregnant women about tobacco use and providing augmented, pregnancy-tailored counseling for those who smoke (A).</li> <li>Using a daily supplement containing 0.4 to 0.8 mg (400-800 mcg) folic acid for all women planning or capable of pregnancy (A).</li> <li>Screening pregnant women for hepatitis B virus (HBV) infection at their first prenatal visit (A).</li> <li>Screening all pregnant women for syphilis infection (A).</li> </ul>
CANCER SCREENING
<ul style="list-style-type: none"> <li>Using biennial screening mammography for women who are 50 to 74 years of age (B).</li> </ul>
DEPRESSION
<ul style="list-style-type: none"> <li>Screening adults for depression when staff-assisted depression care supports are in place to assure accurate diagnosis, effective treatment, and follow-up (B).</li> <li>Screening adolescents (12-18 years of age) for major depressive disorder when systems are in place to ensure accurate diagnosis, psychotherapy (cognitive-behavioral or interpersonal), and follow-up (B).</li> </ul>
OBESITY
<ul style="list-style-type: none"> <li>Screening children who are ≥6 years for obesity and offering or referring for comprehensive, intensive behavioral interventions to promote improvement in weight status (B).</li> </ul>

Lost in all the brouhaha were a number of other, less controversial recommendations that the Task Force made in 2009 (and early 2010). You can find them at [www.ahrq.gov/clinic/uspstfix.htm](http://www.ahrq.gov/clinic/uspstfix.htm). They are categorized by strength of recommendation (TABLE 1) and listed in TABLES 2 and 3. Family physicians should review the A and B recommendations and try to incorporate those into practice. At the same time, we should avoid services in the D category, as the evidence is strong that they are not effective or cause more harm than benefit. The C and I recommendations leave more discretion for physicians and patients to decide on these interventions based on personal values and risks. A C recommendation means

the service can benefit some individuals, but the totality of benefit is small. An I recommendation means that evidence is insufficient to evaluate benefits vs harms.

### The A and B recommendations you may have missed

The major additions to the A and B recommendations pertained to the use of aspirin to prevent cardiovascular disease, routine screening for depression in adults and adolescents, and screening for obesity in children ages 6 and older. The other recommendations in these categories were reaffirmations of previous recommendations (asking about

TABLE 3

**USPSTF recommends AGAINST *routinely***

- Screening women <50 years with biennial mammography. This should be an individual decision that takes patient context into account, including the patient's values regarding specific benefits and harms.
- Screening adults for depression when staff-assisted depression care supports are not in place. There may be considerations that support screening for depression in an individual patient.

**USPSTF recommends AGAINST**

- Using aspirin for stroke prevention in women <55 years and for MI prevention in men <45 years.
- Teaching women breast self-examination.

**USPSTF indicates the evidence is INSUFFICIENT to assess the balance of benefits and harms of**

- Screening asymptomatic men and women with no history of coronary heart disease (CHD) using nontraditional risk factors to prevent CHD events. Nontraditional risk factors are high-sensitivity C-reactive protein, ankle-brachial index, leukocyte count, fasting blood glucose level, periodontal disease, carotid intima-media thickness, coronary artery calcification score on electron-beam computed tomography, homocysteine level, and lipoprotein(a) level.
- Using aspirin for cardiovascular disease prevention in men and women who are ≥80 years.
- Using screening mammography in women ≥75 years.
- Performing clinical breast examination in addition to screening mammography in women ≥40 years.
- Using either digital mammography or magnetic resonance imaging instead of film mammography as screening modalities for breast cancer.
- Screening children (7-11 years of age) for depression.
- Screening infants for hyperbilirubinemia to prevent chronic bilirubin encephalopathy.
- Screening for visual acuity for the improvement of functional outcomes in older adults.
- Using whole-body skin examination by a primary care clinician, or patient skin self-examination for the early detection of cutaneous melanoma, basal cell cancer, or squamous cell skin cancer in the adult general population.

Source: Agency for Healthcare Research and Quality. Available at: [www.ahrq.gov/clinic/uspstfix.htm](http://www.ahrq.gov/clinic/uspstfix.htm). Accessed April 2, 2010.

smoking and providing smoking cessation guidance to adults and pregnant women, advising folic acid supplementation for women planning or capable of pregnancy, and screening pregnant women for syphilis and hepatitis B virus) and the more controversial recommendation for biennial rather than annual mammography for women ages 50 to 74.

■ **The use of aspirin to prevent myocardial infarction** in men ages 45 to 79 and ischemic strokes in women ages 55 to 79 was endorsed if a patient's risk of these cardiovascular events exceeds the risk of bleeding from regular aspirin use. The Task Force recom-

mendation statement is available at <http://www.ahrq.gov/clinic/uspstf09/aspirincvd/aspcvdrs.htm> and provides links to tools for calculating the risk of a myocardial infarction (MI) and ischemic stroke, as well as 2 tables to compare the risks and benefits of aspirin therapy for prevention.

■ **Screening adults for depression** is endorsed if "staff-assisted depression care supports" are in place to assure accurate diagnosis, effective treatment, and follow-up. Such support includes the presence of clinical staff members who can assist the primary care provider with care support or coordination, case

➤ **Weight loss programs that include less than 25 hours of contact with the child and family over a 6-month period do not result in sustained improvement.**

management, or mental health treatment. The definition can be accessed at <http://www.ahrq.gov/clinic/uspstf09/adultdepression/addepr.htm>.

One example in the statement describes “a successful study designed for practices without ready access to mental health specialty care, (in which) office staff recruited, screened, and enrolled participants who screened positive for depression before a clinic visit. If the physician confirmed the depression diagnosis, the participant was scheduled for a return visit with the physician and to meet with the nurse specialist in 1 week. The nurse specialist reassessed the patient’s level of depression, discussed treatment options and preferences, and asked the participant to complete a homework assignment. Participants completed up to 8 additional sessions that followed the same pattern, either by phone or in person.”

■ **Screening for major depressive disorder (MDD) in adolescents 12 to 18 years of age** is recommended when systems are in place to ensure accurate diagnosis, psychotherapy (cognitive-behavioral or interpersonal), and follow-up. The Task Force addressed screening for MDD only—not for less severe depression. The instruments the group recommended using included the Patient Health Questionnaire for Adolescents (PHQ-A) and the Beck Depression Inventory-Primary Care Version (BDI-PC).

■ **The recommendation for screening for obesity** in children ages 6 and older reflects the difficulty in achieving long-term, sustainable weight loss in this group. Effective comprehensive weight-management programs include counseling and other interventions that target both diet and physical

activity. Behavioral interventions and parental involvement are also encouraged. Moderate-to high-intensity programs include more than 25 hours of contact with the child and/or the family over a 6-month period; less than this does not result in sustained improvement.

### What about the D and I categories?

■ **Two interventions received a D recommendation:** Use of aspirin for stroke prevention in women <55 years and for MI prevention in men <45 years, and teaching breast self-examination (BSE) to women. The BSE recommendation has been misinterpreted as recommending against women performing self-breast exams. The recommendation is against formalized teaching of the procedure by physicians, as this leads to increased false positives and no improvement in outcomes when compared to women performing exams on their own.

■ **The list of interventions receiving an I recommendation include** some services that are commonly offered in the belief that they are effective. The Task Force is attempting to develop methodologies to decrease the number of interventions that receive an I recommendation. Currently, about 40% of all recommendations end up in this category, and physicians and patients alike could use more guidance on them. This plethora of recommendations made with insufficient evidence reflects the “ready, shoot, aim” philosophy of American medicine. We tend to accept and adopt new interventions before they are proven effective. The I recommendations are valuable reminders that, while many interventions are in common use, we often do not know as much as we should about their benefits and harms.

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The plethora of recommendations made with insufficient evidence reflects the “ready, shoot, aim” philosophy of American medicine.

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