



USPSTF round-up

The Task Force now recommends that physicians take steps to prevent perinatal depression and has modified its recommendation on lead screening.

Doug Campos-Outcalt, MD, MPA
University of Arizona,
Phoenix

 dougco@email.arizona.edu

In 2019, the US Preventive Services Task Force published 19 recommendation statements on 11 topics. Two of the topics are new; 9 are topics the Task Force had previously reviewed and has updated (TABLE 1). Three of these topics have been covered in Practice Alert podcasts (mdedge.com/familymedicine) and will not be discussed here: risk assessment, genetic counseling, and genetic testing for breast cancer susceptibility gene mutations (October 2019); medications to reduce the risk of breast cancer (December 2019); and preexposure prophylaxis to prevent HIV infections (January 2020).

Of the 19 recommendation statements made in 2019 (TABLE 2), 5 were rated “A” and 5 were “B,” meaning the evidence shows that benefits outweigh harms and these interventions should be offered in primary care practice. There were 5 “D” recommendations for interventions that should not be offered because they are either ineffective or harms exceed benefits. There were 3 “I” statements on interventions having insufficient evidence on benefits or harms to warrant a recommendation. Only 1 recommendation was rated “C” (selectively offer based on individual factors); this assessment is the hardest one to interpret and implement. Keep in mind that all “A” and “B” recommendations must be covered by commercial health plans with no out-of-pocket cost to the patient (ie, no co-pay or deductible).

New recommendation on preventing perinatal depression

One of 2 new topics reviewed in 2019 was the prevention of perinatal depression. (As noted,

the other on preexposure prophylaxis to prevent HIV infection has already been covered in a Practice Alert podcast.) The Task Force found that the prevalence of depression is estimated at 8.9% among pregnant women and 37% at any point in the first year postpartum.¹

Depression during pregnancy and the postpartum period is associated with adverse effects on the mother and infant, including higher rates of suicide and suicidal ideation and thoughts of harming the infant.¹ Women with perinatal depression are also more likely to exhibit significantly lower levels of positive maternal behaviors, such as praising and playing with their child,² and higher rates of negative maternal behaviors.² Perinatal depression is also associated with increased rates of preterm birth and low birth weight.³

Mothers with postpartum depression have higher rates of early termination of breast feeding and lower adherence for recommended child preventive services including vaccination.¹ Children of mothers with perinatal depression develop more behavior problems, have lower cognitive functioning, and have an increased risk of psychiatric disorders than do children of mothers without this condition.^{4,5}

A number of risk factors are associated with perinatal depression, but no screening tool was found to have enough predictive value to be recommended. In deciding who should receive an offer or referral for counseling, the Task Force recommends as a practical approach providing “counseling interventions to women with 1 or more of the following: a history of depression, current depressive symptoms (that do not reach a diagnostic threshold), certain socioeconomic risk factors

TABLE 1
Topics addressed by the USPSTF in 2019

Updates of previous topics
• Screening for abdominal aortic aneurism in older adults
• Screening for asymptomatic bacteriuria in adults
• Risk assessment, genetic counseling, and genetic testing for breast cancer susceptibility gene mutations
• Medications to reduce the risk of breast cancer
• Screening for elevated lead levels in children and pregnant women
• Screening for hepatitis B infection in pregnant women
• Screening for human immunodeficiency virus (HIV) infection
• Ocular prophylaxis to prevent gonococcal ophthalmia neonatorum
• Screening for pancreatic cancer
New topics
• Counseling to prevent perinatal depression
• Preexposure prophylaxis to prevent HIV infection

USPSTF, US Preventive Services Task Force.

such as low income or adolescent or single parenthood, recent intimate partner violence, or mental health-related factors such as elevated anxiety symptoms or a history of significant negative life events.”¹

There is no conclusive evidence to guide timing of counseling interventions, but most studies reviewed started them in the second trimester. These studies included cognitive behavioral therapy and interpersonal therapy and involved counseling sessions that ranged from 4 to 20 sessions and lasted for 4 to 70 weeks. They involved group and individual sessions, mostly in-person visits, and were provided by a variety of health professionals.⁶

The studies reviewed showed that counseling interventions reduced the likelihood of developing depression symptoms by 39%, with a number needed to treat of 13.5.⁶ Studies that looked at pregnancy and maternal and infant clinical outcomes were mixed but usually found little to no difference with counseling.⁶ Even so, the Task Force felt that a reduction in depression itself was enough to warrant a “B” recommendation.

Screening for abdominal aortic aneurisms
Ultrasound is underused in screening for abdominal aortic aneurisms (AAA) and preventing death from their rupture. (See “Whom

should you screen for abdominal aortic aneurysm?” on page 188.) The prevalence of AAA in the United States is unknown; in other western countries it varies from 1.2% to 3.3% in men and is declining due to decreased rates of smoking, the primary risk factor.⁷

The risk of AAA rupture is related to the size of the aneurism, and surgical repair (either endovascular or open repair) is usually reserved for lesions > 5.5 cm in diameter or for smaller ones that are rapidly increasing in size. The standard of care for most aneurysms < 5.5 cm is to periodically monitor growth using ultrasound.

The 2019 recommendations on AAA screening are essentially the same as those made in 2004; evaluation of new evidence supported the previous recommendations. The Task Force recommends one-time screening for men ages 65 to 75 years who have ever smoked (**B** recommendation). Selective screening is recommended for men in this age group who have never smoked, based mainly on personal factors such as a family history of AAA, the presence of other arterial aneurisms, and the number of risk factors for cardiovascular disease (**C** recommendation).

The Task Force recommends against screening women ages 65 to 75 years with no history of smoking or family history of AAA, while the evidence was felt to be insufficient to make a recommendation for women in this age range who have either risk factor. This is problematic for family physicians since women with these risk factors are at increased risk of AAA compared with women without risk factors.⁸ And aneurisms in women appear to rupture more frequently at smaller sizes, although at a later age than in men.⁸ Operative mortality is also higher in women than in men⁸ and there is no direct evidence that screening improves outcomes for women.

Screening for asymptomatic bacteriuria
The Task Force re-examined and reconfirmed its previous recommendations on screening for asymptomatic bacteriuria in adults. It recommends in favor of it for pregnant women, using a urine culture to screen, and against it for all other adults. There is good evidence that treating screen-detected asymptomatic bacteriuria in pregnant women reduces the

TABLE 2

2019 USPSTF recommendation statements

A recommendations
<ul style="list-style-type: none"> • Screen for hepatitis B virus (HBV) infection in pregnant women at their first prenatal visit. • Screen for human immunodeficiency virus (HIV) infection in adolescents and adults ages 15 to 65 years. Also screen younger adolescents and older adults who are at increased risk of infection. • Screen for HIV infection in all pregnant women, including those in labor or at delivery whose HIV status is unknown. • Prescribe prophylactic ocular topical medication for all newborns to prevent gonococcal ophthalmia neonatorum. • Offer preexposure prophylaxis with effective antiretroviral therapy to individuals at high risk of HIV acquisition.
B recommendations
<ul style="list-style-type: none"> • Screen once for abdominal aortic aneurysm (AAA) with ultrasonography in men ages 65 to 75 years who have ever smoked. • Screen for asymptomatic bacteriuria using urine culture in pregnant women. • Use an appropriate brief familial risk assessment tool to assess women who have a personal or family history of breast, ovarian, tubal, or peritoneal cancer, or who have an ancestry associated with breast cancer susceptibility 1 and 2 (BRCA1/2) gene mutations. Women with a positive result on the risk assessment tool should receive genetic counseling and, if indicated after counseling, genetic testing. • Offer to prescribe risk-reducing medications, such as tamoxifen, raloxifene, or aromatase inhibitors, to women who are at increased risk for breast cancer and at low risk for adverse medication effects. • Provide, or refer for, counseling interventions to pregnant and postpartum women who are at increased risk of perinatal depression.
C recommendations
<ul style="list-style-type: none"> • Selectively offer screening for AAA with ultrasonography in men ages 65 to 75 years who have never smoked, rather than routinely screening all men in this group.
D recommendations
<ul style="list-style-type: none"> • Do not screen for AAA with ultrasonography in women who have never smoked and have no family history of AAA. • Do not screen for asymptomatic bacteriuria in nonpregnant adults. • Do not conduct risk assessment, genetic counseling, or genetic testing for women whose personal or family history or ancestry is not associated with potentially harmful BRCA1/2 gene mutations. • Do not offer to prescribe risk-reducing medications, such as tamoxifen, raloxifene, or aromatase inhibitors, for women who are not at increased risk for breast cancer. • Do not screen for pancreatic cancer in asymptomatic adults.
I statements
<ul style="list-style-type: none"> • Screening for AAA with ultrasonography in women ages 65 to 75 years who have ever smoked or have a family history of AAA. • Screening for elevated blood lead levels in asymptomatic children. • Screening for elevated blood lead levels in asymptomatic pregnant women.

Grade A: There is high certainty that the net benefit is substantial.

Grade B: There is high certainty that the net benefit is moderate, or there is moderate certainty that the net benefit is moderate to substantial.

Grade C: There is at least moderate certainty that the net benefit is small. Offer selectively.

Grade D: There is moderate or high certainty that the service has no net benefit or that the harms outweigh the benefits.

I statement: Current evidence is insufficient to assess the balance of benefits and harms of the service.

incidence of pyelonephritis in pregnancy.

The Task Force made this a “B” recommendation based on a lower prevalence of pyelonephritis found in more recent studies, making the overall magnitude of benefits moderate. There is also good evidence that treating asymptomatic bacteriuria in nonpregnant adults offers no benefits.⁹ The Task

Force has re-examined this topic 5 times since 1996 with essentially the same results.

Screening for elevated lead levels in children and pregnant women

In 2019 the Task Force changed its 2006 recommendation on screening for elevated lead levels. The earlier recommendation advised

➤ Perinatal counseling of women with known risks of depression reduces the likelihood of depressive symptoms by 39%.

against screening both children ages 1 to 5 years and pregnant women at average risk for elevated blood lead levels. In 2006 the Task Force also felt that evidence was insufficient to make a recommendation regarding children ages 1 to 5 years at elevated risk.

The Task Force now believes the evidence is insufficient to make a recommendation for all children ages 1 to 5 years and for pregnant women, thus moving from a “D” to an “I” recommendation for children and pregnant women with average risk. Even though there is little evidence to support screening for elevated lead levels in children ages 1 to 5 years and in pregnant women, the Task Force apparently did not feel comfortable recommending against testing, given that the cutoff for elevated blood lead levels has been lowered from 10 to 5 mcg/dL and that other sources of lead may now be more prevalent than in 2006.¹⁰

Remember that the Medicaid Early and Periodic Screening, Diagnostic, and Treatment program requires that all children receive a blood lead test twice, at ages 12 and 24 months, and that previously unscreened children ages 36 to 72 months must be tested once.

Additional updates with no recommendation changes

Four other topics were re-examined by the Task Force in 2019, resulting in no significant changes to recommendations (TABLE 2):

- Screen for hepatitis B infection in pregnant women at the first prenatal visit (A recommendation; updated from 2009).
- Screen for HIV infection in adolescents and adults ages 15 to 65 years, and in those younger and older who are at high risk, and during pregnancy (A recommendation; updated from 2013).
- Provide topical medication for all newborns to prevent gonococcal ophthal-

mia neonatorum (A recommendation; first recommendation in 1996, updated in 2005 and 2011).

- Avoid screening for pancreatic cancer in asymptomatic adults (D recommendation; updated from 2004).

Affirmation of USPSTF's value

In only 1 out of 9 reassessments of past topics did the Task Force modify its previous recommendations in any significant way. This demonstrates that recommendations will usually stand the test of time if they are made using robust, evidence-based methods (that consider both benefits and harms) and they are not made when evidence is insufficient. That only 2 new topics could be addressed in 2019 may reflect a need for more resources for the Task Force.

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