These USPSTF recommendations should be on your radar

The US Preventive Services Task Force made 24 recommendations last year. But the ones highlighted here are most likely to affect your daily practice.

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The US Preventive Services Task Force (USPSTF) had a productive year in 2022. In total, the USPSTF

- reviewed and made recommendations on 4 new topics
- re-assessed 19 previous recommendations on 11 topics
- made 24 separate recommendations, including 1 "A," 3 "B," 3 "C," and 5 "D" recommendations and 12 "I" statements (see **TABLE 1**[1]).

A note about grading. **TABLE 2**[2] outlines the USPSTF's grade definitions and suggestions for practice. The importance of an "A" or "B" recommendation rests historically with the requirement in the Affordable Care Act (ACA) that all USPSTF-recommended services with either of these grades have to be provided by commercial health insurance plans with no co-pay or deductible applied. (The legal challenge in Texas to the ACA's preventive care provision may change that.)

What's new?

The USPSTF's review of 4 new topics exceeds the entity's output in each of the prior 4 years, when the Task Force was able to add only 1 or 2 topics annually. However, 3 of the 4 new topics in 2022 resulted in an insufficient evidence or "I" statement, which means there was not enough evidence to judge the relative benefits and harms of the intervention.

These 3 included screening for type 2 diabetes in children and adolescents younger than 18 years; screening for obstructive sleep apnea in the general adult population (ages ≥ 18 years); and screening for eating disorders in adolescents and adults. The fourth new topic, screening for anxiety in children and adolescents, resulted in a "B" recommendation and was described in a recent Practice Alert.[3]

Major revision to 1 prior recommendation

Only 1 of the 19 revisited recommendations resulted in a major revision: the use of daily aspirin for primary prevention of cardiovascular disease (CVD). Note that it does not apply to those who have established CVD, in whom the use of aspirin would be considered tertiary prevention or harm reduction.

In 2016, the USPSTF recommended (with a "B" grade) the use of daily low-dose aspirin for those ages 50 to 59 years who had a 10-year risk for a CVD event > 10%; no increased risk for bleeding; at least a 10-year life expectancy; and a willingness to take aspirin for 10 years. For those ages 60 to 69 years with a 10-year risk for a CVD event > 10%, the recommendation was a "C." For those younger than 50 and older than 70, an "I" statement was issued.

In 2022, the USPSTF was much less enthusiastic about daily aspirin as a primary preventative.[4] The recommendation is now a "C" for those ages 40 to 59 years who have a 10-year CVD risk ≥ 10%. Those most likely to benefit have a 10-year CVD risk > 15%.

The recommendation pertains to the initiation of aspirin, not the continuation or discontinuation for those who have been using aspirin without complications. The USPSTF

BREAKING NEWS

At press time, the USPSTF issued a draft recommendation statement that women begin receiving biennial mammograms starting at age 40 years (through age 74 years). For more, see: www.uspreventiveservicestaskforce.org/uspstf/draft-recommendation/breast-cancer-screening-adults#fullrecommendationstart

TABLE 1

US Preventive Services Task Force recommendations in 2022[1]

"A" and "B" recommendations
• Screen for syphilis infection in individuals who are at increased risk for infection. (**A**)
• Prescribe a statin for the primary prevention of cardiovascular disease (CVD) for adults ages 40 to 75 years who have ≥ 1 CVD risk factors (dyslipidemia, diabetes, hypertension, or smoking) and an estimated 10-year risk for a CV event ≥ 10%. (**B**)
• Screen for major depressive disorder (MDD) in adolescents ages 12 to 18 years. (**B**)
• Screen for anxiety in children and adolescents ages 8 to 18 years. (**B**)
"C" recommendations
• Initiate low-dose aspirin use for the primary prevention of CVD in adults ages 40 to 59 years who have a 10-year CVD risk ≥ 10%.
• Offer or refer adults without CVD risk factors to behavioral counseling interventions to promote a healthy diet and physical activity.
• Offer a statin for the primary prevention of CVD for adults ages 40 to 75 years who have ≥ 1 CVD risk factors (dyslipidemia, diabetes, hypertension, or smoking) and an estimated 10-year risk for a CV event of 7.5% to < 10%.
"I" statements
• Screening for eating disorders in adolescents and adults.
• Screening for atrial fibrillation in adults older than 50 years.
• Screening for impaired visual acuity in adults older than 65 years.
• Screening for primary open-angle glaucoma in adults older than 40 years.
• Use of multivitamin supplements for the prevention of CVD or cancer.
• Use of single or paired nutrient supplements (other than beta-carotene and vitamin E) for the prevention of CVD or cancer.
• Initiating a statin for the primary prevention of CVD events and mortality in adults ages 76 years or older.
• Screening for type 2 diabetes in children and adolescents younger than 18 years.
• Screening for obstructive sleep apnea in the general adult population (≥ 18 years).
• Screening for MDD in children ages 11 years or younger.
• Screening for suicide risk in children and adolescents.
• Screening for anxiety in children ages 7 years or younger.
"D" recommendations
• Initiating low-dose aspirin use for the primary prevention of CVD in adults ages 60 years or older.
• Screening adults for chronic obstructive pulmonary disease.
• The use of beta-carotene or vitamin E supplements for the prevention of CVD or cancer.
• The use of combined estrogen and progestin for the primary prevention of chronic conditions in postmenopausal individuals.
• The use of estrogen alone for the primary prevention of chronic conditions in postmenopausal people who have had a hysterectomy.

suggests that the dose of aspirin, if used, should be 81 mg and that it should not be continued past age 75 years. A more detailed discussion of this recommendation and some of its clinical considerations is contained in a recent Practice Alert.[5]

"D" is for "don't" (with a few caveats)

Avoiding unnecessary or harmful testing and treatments is just as important as offering preventive services of proven benefit. Those practices listed in **TABLE 1**[1] with a

TABLE 2

US Preventive Services Task Force grade definitions[2]

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	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.

"D" recommendation should be avoided in practice.

However, it is worth mentioning that, while postmenopausal hormone replacement therapy should not be prescribed for the prevention of chronic conditions, this does not mean it should not be used to alleviate postmenopausal vasomotor symptoms—albeit for a limited period of time.

Also, it is important to appreciate the difference between screening and diagnostic tests. When the USPSTF recommends for or against screening, they are referring to the practice in asymptomatic people. The recommendation does not pertain to diagnostic testing to confirm or rule out a condition in a person with symptoms suggestive of a condition. Thus, the recommendation against screening adults for chronic obstructive pulmonary disease applies only to those without symptoms.

Be selective with services graded "C" or "I"

The USPSTF recommendations that require the most clinical judgment and are the most difficult to implement are those with a "C." Few individuals will benefit from these interventions, and those most likely to benefit usually are described in the clinical considerations that accompany the recommendation. These interventions are time consuming and may be subject to insurance co-pays and deductibles. All 3 "C" recommendations made in 2022 (see **TABLE 1**[1]) pertained to the prevention of CVD, still the leading cause of death in the United States.

An "I" statement is not the same as a recommendation *against* the service—but if the service is offered, both the physician and the patient should understand the uncertainty involved. The services the USPSTF has determined lack sufficient evidence of benefits and/or harms are often recommended by other organizations—and in fact, the use of the "I" statement distinguishes the USPSTF from other clinical guideline groups.

If good evidence does not exist, the USPSTF will not make a recommendation. This is the main reason that, when the USPSTF reevaluates a topic (about every 6 to 7 years), they seldom make significant changes to their previous recommendations. Good evidence tends to survive the test of time.

However, adherence to this standard can cause the USPSTF to lag behind other guideline producers for some commonly used interventions. This delay can be considered a detriment if the intervention eventually proves to be effective, but it is a benefit if the intervention proves to be nonbeneficial or even harmful.

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Putting recommendations into best practice

Given the time constraints in primary care practice, the most efficient way of providing high-quality, clinical preventive services is by implementing USPSTF "A" and "B" recommendations, being very selective about who receives an intervention with a "C" recommendation or "I" statement, and avoiding interventions with a "D" recommendation. JFP

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using opioids for pain is no more effective than using other analgesics.[4-9] In addition to overdose deaths and addiction, these studies show significantly higher rates of opioid discontinuation due to adverse effects.

We certainly can manage most patients' pain effectively with other approaches. For some, though—patients whose pain is not adequately controlled and/or interferes with their ability to function, and those who are terminally ill—opioid nihilism has had unintended consequences. Recognizing these issues, the CDC updated its guideline for prescribing opioids in 2022.[10] Four areas were addressed: whether to initiate opioids; opioid selection and dosing; duration of therapy and need for follow-up; and assessing risk and addressing potential harms of opioid use. The CDC encourages clinicians to find a balance of the potential benefits and harms and to avoid inflexibility. Finally, the CDC encourages clinicians to identify and treat patients with opioid use disorders.

Clearly, opioid overuse and overdose result from complex medical, economic, and societal factors. Individual clinicians are well equipped to manage things "in their own backyards." However, what *we* do can be perceived as a bandage for a much larger problem. Our public health system has the potential for greater impact, but the "cure" will require multimodal solutions addressing many facets of society and government.[11] At the very least, we should keep some naloxone close by and vote for political candidates who see broader solutions for addressing this life-and-death crisis. JFP

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