Complete Summary

Take the Fifth Annual Customer Satisfaction Survey

GUIDELINE TITLE

Screening for lipid disorders in adults: recommendations and rationale.

BIBLIOGRAPHIC SOURCE(S)

Berg AO. Screening adults for lipid disorders. Recommendations and rationale. Am J Prev Med 2001 Apr;20(3 Suppl):73-6. [12 references]

COMPLETE SUMMARY CONTENT

SCOPE
METHODOLOGY - including Rating Scheme and Cost Analysis
RECOMMENDATIONS
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IMPLEMENTATION OF THE GUIDELINE
INSTITUTE OF MEDICINE (IOM) NATIONAL HEALTHCARE QUALITY REPORT CATEGORIES
IDENTIFYING INFORMATION AND AVAILABILITY

SCOPE

DISEASE/CONDITION(S)

- Lipid disorders
- Coronary heart disease

GUIDELINE CATEGORY

Prevention
Screening

CLINICAL SPECIALTY

Family Practice
Internal Medicine

INTENDED USERS

Advanced Practice Nurses
Allied Health Personnel
Health Care Providers
Nurses
Physician Assistants
Physicians

GUIDELINE OBJECTIVE(S)

- To present recommendations for screening for lipid disorders.
- To update the 1995 recommendations contained in the Guide to Clinical Preventive Services, second edition.

TARGET POPULATION

- All men aged 35 years and older and women aged 45 years and older
- Men aged 20 to 35 years and women aged 30 to 45 years with risk factors for coronary heart disease

INTERVENTIONS AND PRACTICES CONSIDERED

Laboratory measurement of total cholesterol and high-density lipoprotein cholesterol on nonfasting or fasting blood samples.

Note: measurement of low-density lipoprotein cholesterol and triglycerides are considered

MAJOR OUTCOMES CONSIDERED

- Risk of coronary heart disease events
- Incidence of coronary heart disease
- Adverse effects of lipid-lowering drug therapy

METHODOLOGY

METHODS USED TO COLLECT/SELECT EVIDENCE

Hand-searches of Published Literature (Primary Sources)
Hand-searches of Published Literature (Secondary Sources)
Searches of Electronic Databases

DESCRIPTION OF METHODS USED TO COLLECT/SELECT THE EVIDENCE

To identify articles relevant to the questions of screening and treatment of lipid disorders, the Evidence-based Practice Center staff searched the MEDLINE database from 1994 to December 1999. The searches focused on four main areas: drug therapy for lipid disorders, diet and exercise therapy for lipid disorders, screening, and harms and adverse events. Searches were supplemented with a check of the Cochrane database of controlled trials to identify important articles not included in MEDLINE. The second edition of the US Preventive Services Task

Force Guide to Clinical Preventive Services - as well as systematic reviews, meta-analyses, and evidence-based practice guidelines that addressed screening and treatment of lipid disorders - were used to identify key articles that were published before 1994. Several large, prospective observational studies were identified and used to answer contextual questions about screening. Finally, bibliographies of included articles were hand-searched to detect any important articles that may have been missed in the other steps.

Two members of the Evidence-based Practice Center team reviewed abstracts of all articles. If either reviewer believed that the abstract met the inclusion criteria, the Evidence-based Practice Center retrieved the full text of the article.

NUMBER OF SOURCE DOCUMENTS

1,521 abstracts were reviewed; 317 full articles were reviewed; 153 articles were included in the systematic review; 39 studies were included in the evidence tables

METHODS USED TO ASSESS THE QUALITY AND STRENGTH OF THE EVIDENCE

Weighting According to a Rating Scheme (Scheme Given)

RATING SCHEME FOR THE STRENGTH OF THE EVIDENCE

The U.S. Preventive Services Task Force (USPSTF) grades the quality of the overall evidence on a 3-point scale (good, fair, or poor).

Good

Evidence includes consistent results from well-designed, well-conducted studies in representative populations that directly assess effects on health outcomes.

Fair

Evidence is sufficient to determine effects on health outcomes, but the strength of the evidence is limited by the number, quality, or consistency of the individual studies; generalizability to routine practice; or indirect nature of evidence on health outcomes.

Poor

Evidence is insufficient to assess the effects on health outcomes because of limited number or power of studies, important flaws in their design or conduct, gaps in the chain of evidence, or lack of information on important health outcomes.

Note: See the companion document titled "Current Methods of the U.S. Preventive Services Task Force: a Review of the Process" (Am J Prev Med 2001 Apr;20[3S]:21-35) for a more detailed description of the methods used to assess the quality and strength of the evidence for the three strata at which the evidence was reviewed.

METHODS USED TO ANALYZE THE EVIDENCE

Meta-Analysis
Review of Published Meta-Analyses
Systematic Review with Evidence Tables

DESCRIPTION OF THE METHODS USED TO ANALYZE THE EVIDENCE

Note from the National Guideline Clearinghouse (NGC): A systematic evidence review was prepared by the Research Triangle Institute-University of North Carolina at Chapel Hill (RTI-UNC) Evidence-based Practice Center (EPC) for the Agency for Healthcare Research and Quality (AHRQ) for use by the U.S. Preventive Services Task Force (USPSTF) (see the "Companion Documents" field).

EPC staff entered study design and outcomes data from the articles on drug and diet treatment into an electronic database and constructed evidence tables.

To characterize the quality of the included studies, EPC staff rated the internal and external validity for each article in the evidence tables using criteria developed by the USPSTF Methods Work Group. They then rated the aggregate internal validity and external validity as well as the coherence (agreement of the results of the individual studies) for each of the Key Questions defined in the analytic framework.

To better estimate the effects of drug therapy, EPC staff performed a quantitative meta-analysis under both random and fixed effects models using RevMan software. EPC staff examined the effect of drug therapy on the incidence of coronary heart disease events (nonfatal myocardial infarction and coronary heart disease deaths combined), on the incidence of coronary heart disease deaths alone, and on total mortality. The EPC staff represented the results as summary odds ratios with 95% confidence intervals and examined the results for heterogeneity visually and using tests of homogeneity. The EPC staff also performed sub-analyses that measured the effect of the statin drugs alone, which included four studies that could not be clearly included or excluded based on the their prospective eligibility criteria.

METHODS USED TO FORMULATE THE RECOMMENDATIONS

Balance Sheets
Expert Consensus

DESCRIPTION OF METHODS USED TO FORMULATE THE RECOMMENDATIONS

When the overall quality of the evidence is judged to be good or fair, the U.S. Preventive Services Task Force (USPSTF) proceeds to consider the magnitude of net benefit to be expected from implementation of the preventive service. Determining net benefit requires assessing both the magnitude of benefits and the magnitude of harms and weighing the two.

The USPSTF classifies benefits, harms, and net benefits on a 4-point scale: "substantial," "moderate," "small," and "zero/negative."

"Outcomes tables" (similar to 'balance sheets') are the USPSTF's standard resource for estimating the magnitude of benefit. These tables, prepared by the topic teams for use at USPSTF meetings, compare the condition specific outcomes expected for a hypothetical primary care population with and without use of the preventive service. These comparisons may be extended to consider only people of specified age or risk groups or other aspects of implementation. Thus, outcomes tables allow the USPSTF to examine directly how the preventive services affects benefits for various groups.

When evidence on harms is available, the topic teams assess its quality in a manner like that for benefits and include adverse events in the outcomes tables. When few harms data are available, the USPSTF does not assume that harms are small or nonexistent. It recognizes a responsibility to consider which harms are likely and judge their potential frequency and the severity that might ensue from implementing the service. It uses whatever evidence exists to construct a general confidence interval on the 4-point scale (e.g., substantial, moderate, small, and zero/negative).

Value judgments are involved in using the information in an outcomes table to rate either benefits or harms on the USPSTF's 4-point scale. Value judgments are also needed to weigh benefits against harms to arrive a rating of net benefit.

In making its determinations of net benefit, the USPSTF strives to consider what it believes are the general values of most people. It does this with greater confidence for certain outcomes (e.g., death) about which there is little disagreement about undesirability, but it recognizes that the degree of risk people are willing to accept to avert other outcomes (e.g., cataracts) can vary considerably. When the USPSTF perceives that preferences among individuals vary greatly, and that these variations are sufficient to make trade-off of benefits and harms a 'close-call', then it will often assign a C recommendation (see the "Recommendation Rating Scheme" field). This recommendation indicates the decision is likely to be sensitive to individual patient preferences.

The USPSTF uses its assessment of the evidence and magnitude of net benefit to make recommendations. The general principles the USPSTF follows in making recommendations are outlined in Table 5 of the companion document cited below. The USPSTF liaisons on the topic team compose the first drafts of the recommendations and rationale statements, which the full panel then reviews and edits. Recommendations are based on formal voting procedures that include explicit rules for determining the views of the majority.

From: Harris RP, Helfand M, Woolf SH, Lohr KN, Mulrow, CD, Teutsch SM, Atkins D. Current methods of the U.S. Preventive Services Task Force: a review of the process. Methods Work Group, Third U.S. Preventive Services Task Force. Am J Prev Med 2001 Apr;20(3S):21-35.

RATING SCHEME FOR THE STRENGTH OF THE RECOMMENDATIONS

The U.S. Preventive Services Task Force (USPSTF) grades its recommendations according to one of five classifications (A, B, C, D, or I), reflecting the strength of evidence and magnitude of net benefit (benefits minus harms).

A

The U.S. Preventive Services Task Force (USPSTF) strongly recommends that clinicians provide [the service] to eligible patients. (The USPSTF found good evidence that [the service] improves important health outcomes and concludes that benefits substantially outweigh harms.)

B

The U.S. Preventive Services Task Force (USPSTF) recommends that clinicians provide [the service] to eligible patients. (The USPSTF found at least fair evidence that [the service] improves health outcomes and concludes that benefits outweigh harms.)

C

The U.S. Preventive Services Task Force (USPSTF) makes no recommendation for or against routine provision of [the service]. (The USPSTF found at least fair evidence that [the service] can improve health outcomes but concludes that the balance of benefits and harms it too close to justify a general recommendation.)

D

The U.S. Preventive Services Task Force (USPSTF) recommends against routinely providing [the service] to asymptomatic patients. (The USPSTF found at least fair evidence that [the service] is ineffective or that harms outweigh benefits.)

I

The U.S. Preventive Services Task Force (USPSTF) concludes that the evidence is insufficient to recommend for or against routinely providing [the service]. (Evidence that [the service] is effective is lacking, of poor quality, or conflicting and the balance of benefits and harms cannot be determined.)

COST ANALYSIS

A formal cost analysis was not performed and published cost analyses were not reviewed.

METHOD OF GUIDELINE VALIDATION

Comparison with Guidelines from Other Groups
External Peer Review
Internal Peer Review

DESCRIPTION OF METHOD OF GUIDELINE VALIDATION

Peer Review . Before the U.S. Preventive Services Task Force makes its final determinations about recommendations on a given preventive service, the Evidence-based Practice Center and the Agency for Healthcare Research and Quality send a draft systematic evidence review to 4 to 6 external experts and to federal agencies and professional and disease-based health organizations with interests in the topic. They ask the experts to examine the review critically for accuracy and completeness and to respond to a series of specific questions about the document. After assembling these external review comments and documenting the proposed response to key comments, the topic team presents this information to the Task Force in memo form. In this way, the Task Force can consider these external comments and a final version of the systematic review before it votes on its recommendations about the service. Draft recommendations are then circulated for comment from reviewers representing professional societies, voluntary organizations and Federal agencies. These comments are discussed before the whole U.S. Preventive Services Task Force before final recommendations are confirmed.

Recommendations of Others. Recommendations for screening for lipid disorders from the following groups were discussed: National Cholesterol Education Program's Adult Treatment Panel II, sponsored by the National Institutes of Health and endorsed by the American Heart Association and the American College of Obstetricians and Gynecologists; the American College of Physicians; the American Academy of Family Physicians; and the Canadian Task Force on Preventive Health Care.

RECOMMENDATIONS

MAJOR RECOMMENDATIONS

The US Preventive Services Task Force grades its recommendations (A, B, C, D, or I) and the quality of the overall evidence for a service (good, fair, poor). The definitions of these grades can be found at the end of the "Major Recommendations" field.

- The US Preventive Services Task Force strongly recommends that clinicians routinely screen men aged 35 years and older and women aged 45 years and older for lipid disorders and treat abnormal lipids in persons who are at increased risk of coronary heart disease. A recommendation.

The US Preventive Services Task Force found good evidence that lipid measurement can identify asymptomatic middle-aged persons at increased risk of coronary heart disease and good evidence that lipid-lowering drug therapy substantially decreases the incidence of coronary heart disease in such persons with abnormal lipids, and causes few major harms. The US Preventive Services Task Force concludes that the benefits of screening for and treating lipid disorders in middle-aged and older persons substantially outweigh harms.

- The US Preventive Services Task Force recommends that clinicians routinely screen younger adults (men aged 20 to 35 years and women aged 20 to 45 years) for lipid disorders if they have other risk factors for coronary heart

disease. (See â œClinical Considerationsâ for a discussion of risk factors.) B recommendation.

The US Preventive Services Task Force found good evidence that lipid measurement can identify younger people at increased risk for coronary heart disease, that risk is highest in those with other risk factors, and that the absolute benefits of lipid-lowering treatment depend on a person's underlying risk of coronary heart disease. The US Preventive Services Task Force concludes that benefits of screening for and treating high-risk young adults outweigh harms.

- The US Preventive Services Task Force makes no recommendation for or against routine screening for lipid disorders in younger adults (men aged 20 to 35 years or women aged 20 to 45 years) in the absence of known risk factors for coronary heart disease. C recommendation.

The US Preventive Services Task Force found good evidence that lipid measurement in low-risk young adults can detect some individuals at increased long-term risk of heart disease, but the absolute reduction in risk as a result of treating dyslipidemia in most persons is small before middle-age. Fair evidence suggests that a substantial proportion of the benefits of treatment may be realized within 5 years of initiating therapy. The USPSTF concludes the net benefits of screening for lipid disorders in low-risk young persons are not sufficient to make a general recommendation.

- The US Preventive Services Task Force recommends that screening for lipid disorders include measurement of total cholesterol and high-density lipoprotein cholesterol. B recommendation.

The US Preventive Services Task Force found good evidence that measurement of high-density lipoprotein cholesterol along with total cholesterol improves the identification of persons at increased risk of cardiovascular disease. Good evidence from randomized trials demonstrates that persons with low high-density lipoprotein cholesterol without high total cholesterol benefit from treatment.

- The US Preventive Services Task Force concludes that the evidence is insufficient to recommend for or against triglyceride measurement as a part of routine screening for lipid disorders. I recommendation.

Evidence that elevated triglyceride level is an independent risk factor for heart disease is conflicting, and prospective data are lacking to determine whether including triglyceride is more effective for screening than simply measuring total cholesterol and high-density lipoprotein cholesterol.

Clinical Considerations

- Total cholesterol and high-density lipoprotein cholesterol can be measured on non-fasting or fasting samples.
  Abnormal results should be confirmed by a repeated sample on a separate occasion, and the average of both results used for risk assessment. Although measuring both total cholesterol and high-density lipoprotein cholesterol is more sensitive and specific for assessing coronary heart disease risk, total

cholesterol alone is an acceptable screening test if available laboratory services cannot provide reliable measurements of high-density lipoprotein. In conjunction with high-density lipoprotein cholesterol, low-density lipoprotein cholesterol and total cholesterol provide comparable information, but measuring low-density lipoprotein cholesterol requires a fasting sample and is more expensive. In patients with elevated risk on screening results, lipoprotein analysis, including fasting triglycerides, may provide information that is useful in choosing optimal treatments.

- Screening is recommended for men aged 20 to 35 years and women aged 20 to 45 years in the presence of any of the following:
    - Diabetes
    - A family history of cardiovascular disease before age 50 years in male relatives or age 60 years in female relatives
    - A family history suggestive of familial hyperlipidemia
    - Multiple coronary heart disease risk factors (e.g., tobacco use, hypertension)
- The optimal interval for screening is uncertain.
  On the basis of other guidelines and expert opinion, reasonable options include every 5 years, shorter intervals for people who have lipid levels close to those warranting therapy, and longer intervals for low-risk people who have had low or repeatedly normal lipid levels.
- An age to stop screening is not established.
  Screening may be appropriate in older persons who have never been screened, but repeated screening is less important in older persons because lipid levels are less likely to increase after age 65.
- Treatment decisions should take into account overall risk of heart disease rather than lipid levels alone.
  Overall risk assessment should include the presence and severity of the following risk factors: age, gender, diabetes, elevated blood pressure, family history (in younger adults), and smoking. Tools that incorporate specific information on multiple risk factors provide more accurate estimation of cardiovascular risk than categorizations based on counting the numbers of risk factors.
- Treatment choices should take into account costs and patient preferences.
  Drug therapy is usually more effective than diet alone, but choice of treatment should consider overall risk, costs of treatment, and patient preferences. Guidelines for treating high cholesterol are available from the National Cholesterol Education Program of the National Institutes of Health. Although diet therapy is an appropriate initial therapy for most patients, a minority achieve substantial reductions in lipid levels from diet alone; drugs are frequently needed to achieve therapeutic goals, especially for high-risk persons. Lipid-lowering treatments should be accompanied by interventions addressing all modifiable risk factors for heart disease, including smoking cessation, treatment of blood pressure, diabetes, and obesity, and promotion of a healthy diet and regular physical activity. Long-term adherence to therapies should be emphasized.
- All patients, regardless of lipid levels, should be offered counseling about the benefits of a diet low in saturated fat and high in fruits and vegetables, regular physical activity, avoiding tobacco use, and maintaining a healthy weight.

Definitions:

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Fair

Evidence is sufficient to determine effects on health outcomes, but the strength of the evidence is limited by the number, quality, or consistency of the individual

studies; generalizability to routine practice; or indirect nature of evidence on health outcomes.

Poor

Evidence is insufficient to assess the effects on health outcomes because of limited number or power of studies, important flaws in their design or conduct, gaps in the chain of evidence, or lack of information on important health outcomes.

CLINICAL ALGORITHM(S)

None provided

EVIDENCE SUPPORTING THE RECOMMENDATIONS

TYPE OF EVIDENCE SUPPORTING THE RECOMMENDATIONS

The type of evidence supporting each recommendation is identified in the "Major Recommendations" field.

BENEFITS/HARMS OF IMPLEMENTING THE GUIDELINE RECOMMENDATIONS

POTENTIAL BENEFITS

Effectiveness of Early Intervention

In four large primary prevention trials, cholesterol-lowering drug treatment for 5 to 7 years decreased risk of coronary heart disease events approximately 30% in persons with high total cholesterol or average cholesterol and low high-density lipoprotein cholesterol. In the one trial that included women, treatment appeared to be as effective in postmenopausal women as in men. The average benefit of treating abnormal lipids in women, however, may be smaller than in men of similar ages because of their lower rates of heart disease. Although trials have enrolled few persons younger than age 45 years or older than age 65 years, the US Preventive Services Task Force concluded that the benefits of treatment could be generalized to older and younger people whose underlying risk of coronary heart disease is comparable to or greater than that of subjects in the existing trials (annual incidence of coronary heart disease 0.6% to 1.5% per year).

The only trials examining diet with coronary heart disease outcomes have modified diet in conjunction with interventions on other risk factors, in patients with heart disease, or using atypical institutional diets. Reducing dietary saturated fat and weight loss can lower total and low-density lipoprotein cholesterol as much as 10 to 20% in some individuals, but the average effect of diet interventions in outpatients is relatively modest (2 to 6% reduction in total cholesterol). Lipid screening does not clearly improve the effectiveness of routine diet interventions.

POTENTIAL HARMS

Potential Adverse Effects of Screening

Studies of adverse effects of screening are limited but have not found adverse psychological effects (i.e. labeling) in patients identified with abnormal lipids. Screening could subject some low-risk persons to the inconvenience and expense of treatments that may offer only minimal benefits.

QUALIFYING STATEMENTS

QUALIFYING STATEMENTS

The primary goal of screening younger persons is to promote lifestyle changes, which may provide long-term benefits later in life. The average effect of diet interventions is small, however, and screening is not necessary to advise young adults about the benefits of a healthy diet and regular exercise. Although universal screening may detect some patients with familial hyperlipidemia earlier than selective screening, whether this will lead to important reductions in coronary events is not known.

IMPLEMENTATION OF THE GUIDELINE

DESCRIPTION OF IMPLEMENTATION STRATEGY

The experiences of the first and second U.S. Preventive Services Task Force (USPSTF), as well as that of other evidence-based guideline efforts, have highlighted the importance of identifying effective ways to implement clinical recommendations. Practice guidelines are relatively weak tools for changing clinical practice when used in isolation. To effect change, guidelines must be coupled with strategies to improve their acceptance and feasibility. Such strategies include enlisting the support of local opinion leaders, using reminder systems for clinicians and patients, adopting standing orders, and audit and feedback of information to clinicians about their compliance with recommended practice.

In the case of preventive services guidelines, implementation needs to go beyond traditional dissemination and promotion efforts to recognize the added patient and clinician barriers that affect preventive care. These include clinicians' ambivalence about whether preventive medicine is part of their job, the psychological and practical challenges that patients face in changing behaviors, lack of access to health care or of insurance coverage for preventive services for some patients, competing pressures within the context of shorter office visits, and the lack of organized systems in most practices to ensure the delivery of recommended preventive care.

Neither the resources nor the composition of the U.S. Preventive Services Task Force (USPSTF) equip it to address these numerous implementation challenges, but a number of related efforts seek to increase the impact of future U.S. Preventive Services Task Force (USPSTF) reports. The U.S. Preventive Services Task Force (USPSTF) convened representatives from the various audiences for the Guide - clinicians, consumers and policy makers from health plans, national organizations and Congressional staff - about how to modify the content and

format of its products to address their needs. With funding from the Robert Wood Johnson Foundation, the U.S. Preventive Services Task Force (USPSTF) and Community Guide effort have conducted an audience analysis to further explore implementation needs. The Put Prevention into Practice initiative at the Agency for Healthcare Research and Quality (AHRQ) has developed office tools such as patient booklets, posters, and handheld patient mini-records, and a new implementation guide for state health departments.

Dissemination strategies have changed dramatically in this age of electronic information. While recognizing the continuing value of journals and other print formats for dissemination, the Agency for Healthcare Research and Quality will make all U.S. Preventive Services Task Force (USPSTF) products available through its Web site. The combination of electronic access and extensive material in the public domain should make it easier for a broad audience of users to access U.S. Preventive Services Task Force (USPSTF) materials and adapt them for their local needs. Online access to U.S. Preventive Services Task Force (USPSTF) products also opens up new possibilities for the appearance of the third edition of the Guide to Clinical Preventive Services. Freed from having to serve as primary repository for all of U.S. Preventive Services Task Force work, the next Guide may be much slimmer than the almost 1000 pages of the second edition.

To be successful, approaches for implementing prevention have to be tailored to the local level and deal with the specific barriers at a given site, typically requiring the redesign of systems of care. Such a systems approach to prevention has had notable success in established staff-model health maintenance organizations, by addressing organization of care, emphasizing a philosophy of prevention, and altering the training and incentives for clinicians. Staff-model plans also benefit from integrated information systems that can track the use of needed services and generate automatic reminders aimed at patients and clinicians, some of the most consistently successful interventions. Information systems remain a major challenge for individual clinicians' offices, however, as well as for looser affiliations of practices in network-model managed care and independent practice associations, where data on patient visits, referrals and test results are not always centralized.

RELATED QUALITY TOOLS

- Pocket Guide to Good Health for Adults

- A Step-by-Step Guide to Delivering Clinical Preventive Services: A Systems Approach

- Screening Adults for Lipid Disorders. What's New from the USPSTF.

INSTITUTE OF MEDICINE (IOM) NATIONAL HEALTHCARE QUALITY REPORT CATEGORIES

IOM CARE NEED

Staying Healthy

IOM DOMAIN

Effectiveness

IDENTIFYING INFORMATION AND AVAILABILITY

BIBLIOGRAPHIC SOURCE(S)

Berg AO. Screening adults for lipid disorders. Recommendations and rationale. Am J Prev Med 2001 Apr;20(3 Suppl):73-6. [12 references]

ADAPTATION

Not applicable: The guideline was not adapted from another source.

DATE RELEASED

1996 (revised 2001 Apr)

GUIDELINE DEVELOPER(S)

United States Preventive Services Task Force - Independent Expert Panel

GUIDELINE DEVELOPER COMMENT

The U.S. Preventive Services Task Force (USPSTF) is a Federally-appointed panel of independent experts. Conclusions of the USPSTF do not necessarily reflect policy of the U.S. Department of Health and Human Services (DHHS) or DHHS agencies.

SOURCE(S) OF FUNDING

United States Government

GUIDELINE COMMITTEE

U.S. Preventive Services Task Force (USPSTF)

COMPOSITION OF GROUP THAT AUTHORED THE GUIDELINE

The U.S. Preventive Services Task Force (USPSTF) consists of 13 experts from the specialties of family medicine, pediatrics, internal medicine, obstetrics and

gynecology, geriatrics, preventive medicine, public health, behavioral medicine, and nursing. Members of the Task Force were selected from more than 80 nominees, based on recognized expertise in prevention, evidence-based medicine, and primary care.

Names of members: Alfred O. Berg, MD, MPH (Chair); Janet D. Alan, PhD, RN, CS, FAAN (Vice-Chair); Paul Frame, MD; Charles J. Homer, MD, MPH; Tracy A. Lieu, MD, MPH; Cynthia D. Mulrow, MD, MSc; Carole Tracy Orleans, PhD; Jeffrey F. Peipert, MD, MPH; Nola J Pender, PhD, RN, FAAN; Harold C Sox, Jr., MD; Steven M. Teutsch, MD, MPH; Carolyn Westhoff, MD, MSc; Steven H Woolf, MD, MPH

FINANCIAL DISCLOSURES/CONFLICTS OF INTEREST

The U.S. Preventive Services Task force has an explicit policy concerning conflict of interest. All members and evidence-based practice center (EPC) staff disclose at each meeting if they have an important financial conflict for each topic being discussed. Task Force members and EPC staff with conflicts can participate in discussions about evidence, but members abstain from voting on recommendations about the topic in question.

From: Harris RP, Helfand M, Woolf SH, Lohr KN, Mulrow, CD, Teutsch SM, Atkins D. Current methods of the U.S. Preventive Services Task Force: a review of the process. Methods Work Group, Third U.S. Preventive Services Task Force. Am J Prev Med 2001 Apr;20(3S):21-35.

GUIDELINE STATUS

This is the current release of the guideline.

This release updates a previously published guideline: U.S. Preventive Services Task Force. Screening for high blood cholesterol and other lipid abnormalities. In: Guide to clinical preventive services. 2nd ed. Baltimore (MD): Williams & Wilkins; 1996.

GUIDELINE AVAILABILITY

Electronic copies: Available from AJPM (American Journal of Preventive Medicine) Online. Additional information is available from the U.S. Preventive Services Task Force (USPSTF) Web site and the National Library of Medicine's Health Services/Technology Assessment Text (HSTAT) Web site.

Print copies: Available from the Agency for Healthcare Research and Quality Publications Clearinghouse. For more information, go to http://www.ahrq.gov/news/pubsix.htm or call 1-800-358-9295 (U.S. only).

AVAILABILITY OF COMPANION DOCUMENTS

The following are available:

Evidence Reviews:

- Pignone MP, Phillips CJ, Atkins D, Teutsch SM, Mulrow CD, Lohr KN. Screening and treating adults for lipid disorders. Am J Prev Med 2001 Apr;20(3S):77-89. [62 references]
- Screening for lipid disorders. Rockville (MD): Agency for Healthcare Research and Quality (AHRQ), 2001. (Systematic evidence review; no. 4) [243 references] (Electronic copies are only available in a downloadable format from the USPSTF Web site.)

Background Articles:

- Woolf SH, Atkins D. The evolving role of prevention in health care: contributions of the U.S. Preventive Services Task Force. Am J Prev Med 2001 Apr;20(3S):13-20.
- Harris RP, Helfand M, Woolf SH, Lohr KN, Mulrow, CD, Teutsch SM, Atkins D. Current methods of the U.S. Preventive Services Task Force: a review of the process. Methods Work Group, Third U.S. Preventive Services Task Force. Am J Prev Med 2001 Apr;20(3S):21-35.
- Saha S, Hoerger TJ, Pignone MP, Teutsch SM, Helfand M, Mandelblatt. The art and science of incorporating cost effectiveness into evidence-based recommendations for clinical preventive services. Cost Work Group of the Third U.S. Preventive Services Task Force. Am J Prev Med 2001 Apr;20(3S):36-43.

Electronic copies: Available from the USPSTF Web site.

Additional Implementation Tools:

- A step-by-step guide to delivering clinical preventive services: a systems approach. Rockville (MD): Agency for Healthcare Research and Quality (AHRQ), 2001. 189 p. (Pub. No. APPIP01-0001). Electronic copies available from the AHRQ Web site.

  Print copies: Available from the Agency for Healthcare Research and Quality Publications Clearinghouse. For more information, go to http://www.ahrq.gov/news/pubsix.htm or call 1-800-358-9295 (U.S. only).

- The Preventive Services Selector, an application for Palm Pilots and other PDA's, is also available from the AHRQ Web site.
- Screening adults for lipid disorders. What's new from the USPSTF?. Rockville (MD): Agency for Healthcare Research and Quality; 2001 Mar. Electronic copies: Available from USPSTF Web site.

PATIENT RESOURCES

The following is available:

- The Pocket Guide to Good Health for Adults. Rockville (MD): Agency for Healthcare Research and Quality (AHRQ); 2003.

Electronic copies: Available from the U.S. Preventive Services Task Force (USPSTF) Web site. Copies also available in Spanish from the USPSTF Web site.

Print copies: Available from the Agency for Healthcare Research and Quality (AHRQ) Publications Clearinghouse. For more information, go to http://www.ahrq.gov/news/pubsix.htm or call 1-800-358-9295 (U.S. only).

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NGC STATUS

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