

CONTENTS

Bacterial Vaginosis in Pregnancy 4

Chemoprevention for Breast Cancer..... 4

Breast Cancer Screening for Women Veterans..... 4

Chlamydial Infection 5

Screening for Colorectal Cancer (CRC) 6

Depression Screening 8

Diabetes..... 8

Hormone Replacement Therapy for Primary Prevention of Chronic Conditions..... 9

Influenza Vaccine..... 10

Lipid Disorders in Adults..... 10

Screening for Osteoporosis in Postmenopausal Women 11

Behavioral Counseling for Physical Activity... 11

Physical Fitness 12

Skin Cancer..... 12

VA NCHPDP New or Updated Prevention Recommendations April 2001 - November 2002

(Supplement to VHA Handbook 1120.2, May 3, 1999)

The VA National Center for Health Promotion/Disease Prevention (NCHPDP) represents the VA on two national expert groups that make recommendations about preventive services — the U.S. Preventive Services Task Force and the Community Preventive Services Task Force. The Center also utilizes other recommendations from federal agencies.

The U.S. Preventive Services Task Force (USPSTF), sponsored by the Agency for Healthcare Research and Quality (AHRQ), is widely regarded as a premier source of information on the effectiveness of a broad range of clinical preventive services. The work of the USPSTF documenting the strong evidence supporting many preventive services has helped further the steady progress over the past decade in awareness, delivery, and coverage of preventive care as an integral part of quality primary health care. Based both on strength of evidence and potential net benefit, its findings support efforts to increase the use of effective services and also to reduce use of ineffective services, thus further closing the gap between evidence-based and opinion-based practice. The VHA closely follows the recommendations of the USPSTF, which can be found at <http://www.ahrq.gov/clinic/prevenix.htm>.

The current USPSTF has modified its standard recommendation language from previous reports. Recommendations are now lettered A, B, C, D, or I. “A” recommendations are for services that are strongly recommended, based on good evidence that the service improves important health outcomes and that benefits substantially outweigh risks. “B” recommendations are for services that are recommended, based on at least fair evidence that the service improves important health outcomes and the benefits outweigh harms. “C” recommendations are for those situations in which the Task Force makes no recommendation for or against routinely providing the service. At least fair evidence may exist to show that the service can improve health outcomes, but the balance between benefits and harms is too close to justify a general recommendation. “D” recommendations are for services which are not recommended for routine use, based on at least fair evidence that the service is ineffective or that harms outweigh benefits. An “I” indicates that the Task Force has found insufficient evidence for or against routinely providing the service, based on a lack of studies, studies of poor quality or conflicting results, or the balance between benefits and harms cannot be determined.

The Community Preventive Services Task Force, sponsored by the CDC, develops recommendations for population-based, system-wide interventions to implement preventive services. These recommendations will be used by those responsible for planning and implementing population-based services and policies. Topics addressed by the Community Task Force include risky behaviors (tobacco use, alcohol misuse, other addictive drug use, physical inactivity, poor nutrition, and risky sexual behavior), specific diseases and injuries (mental impairment, cancer, diabetes, complicated pregnancy/infant health,

Continued on page 2

motor vehicle occupant injuries, vaccine-preventable diseases, oral health, and violent and abusive behavior), and sociocultural environmental factors on health. Potential interventions are rated as strongly recommended, insufficient information, or discouraged. The recommendations can be found in The Community Guide at <http://www.thecommunityguide.org>.

Included in this supplement is a graph summarizing clinical preventive services recommended by the USPSTF for normal risk adults, followed by selected alphabetized recommendations with their respective links. These recommendations and documents are new or updated from previous recommendations found in the VHA Handbook 1120.2 (May 3, 1999). Official VHA guidelines are available through the NCHPDP and the Office of Quality and Performance.

- Screening for **Bacterial Vaginosis in Pregnancy**
- Chemoprevention of **Breast Cancer**
- Screening for **Breast Cancer**
- Screening for **Chlamydial Infection**
- Screening for **Colorectal Cancer (CRC)**
- Screening for **Depression**
- Interventions for **Diabetes**
- **Hormone Replacement Therapy** for Primary Prevention of Chronic Conditions
- **Influenza** Vaccine
- Screening for **Lipid Disorders**
- Screening for **Osteoporosis** in Postmenopausal Women
- Behavioral Counseling for **Physical Activity**
- Recommendations for **Physical Fitness**
- Screening for **Skin Cancer**

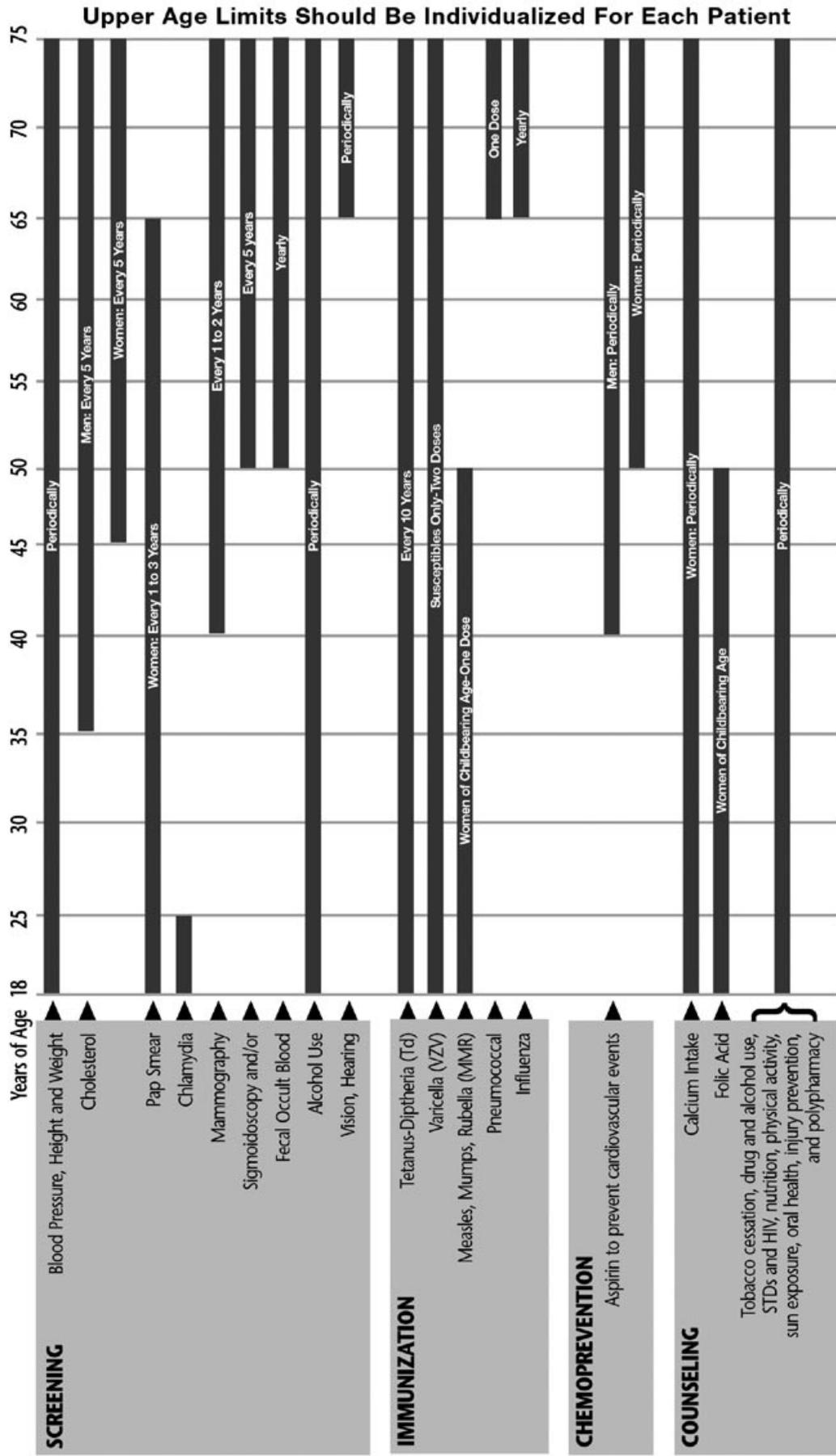
The VHA Office of Patient Care Services subscribes to recommendations of the U.S. Preventive Services Task Force (USPSTF). As the VA representative at the USPSTF, the VA National Center for Health Promotion and Disease Prevention (NCHPDP) has participated in the decision process and endorses the Task Force's recommendations. For questions related to these or other USPSTF recommendations, or the construct for decision-making that is used by the USPSTF, contact the VA NCHPDP.

Steven J. Yevich, MD, MPH, MS
Director

Mary Burdick, PhD, RN
Chief of Staff, NCHPDP
Prevention Consultant to Office of Nursing Service

VA National Center for Health Promotion & Disease Prevention
3000 Croasdaile Dr.
Durham, NC 27705
(919) 383-7874, ext. 224 or 227
FAX: (919) 383-7598

Clinical Preventive Services for Normal-Risk Adults Recommended by the U.S. Preventive Services Task Force



PUT PREVENTION INTO PRACTICE
 U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES • PUBLIC HEALTH SERVICE
 June 2002
 AppIP02-0022

For more information visit www.preventiveservices.ahrq.gov

Bacterial Vaginosis in Pregnancy

U.S. Preventive Services Task Force
New Topic, 2001 Release

Recommendations

Insufficient evidence to recommend for or against routinely screening women at high risk for pre-term delivery for bacterial vaginosis (I recommendation).

Recommends against routinely screening asymptomatic pregnant women at average risk for pre-term delivery for bacterial vaginosis (D recommendation).

Guide to Clinical Preventive Services, 3rd Edition: Periodic Updates (available Fall 2002)

Bacterial Vaginosis in Pregnancy: Screening, 2001

Recommendations and Rationale

<http://www.ahrq.gov/clinic/ajpmsuppl/bvrr.htm>

<http://www.ahrq.gov/clinic/ajpmsuppl/bvrr.pdf> (PDF 64KB)

Summary of Evidence

<http://www.ahrq.gov/clinic/ajpmsuppl/guis1.htm>

<http://www.ahrq.gov/clinic/ajpmsuppl/bvsum.pdf> (PDF 116KB)

Systematic Evidence Review

<http://hstat.nlm.nih.gov/hq/Hquest/screen/DirectAccess/db/3600>

<http://www.ahrq.gov/clinic/serfiles.htm#bv> (File Download 150KB)

Prevention Program Fact Sheets

<http://www.ahrq.gov/clinic/ppipix.htm#factsheets>

Screening for Bacterial Vaginosis in Pregnancy: What's New

<http://www.ahrq.gov/clinic/prev/bvwh.htm>

Chemoprevention for Breast Cancer

Tamoxifen (the only FDA-approved breast cancer chemopreventive drug) and Raloxifene (used off-label by some physicians) were determined to have "fair evidence" supporting their effectiveness in preventing breast cancer in women considered at **HIGH RISK** for developing the disease. Those considered at "High Risk for Breast Cancer" are defined as: 1) over 40 years of age; **and** 2) having a family history of breast cancer in a mother, sister, or daughter **OR** with a history of atypical cells on a breast biopsy.

In women who are NOT at high risk for breast cancer, the harms due to the increased risk for developing uterine cancer and thromboses due to use of Tamoxifen outweigh the benefits. The

Task Force recommended **against the use of this drug** by women at low or average risk for breast cancer.

The USPSTF recommended that clinicians discuss the potential benefits and risks of taking chemoprevention medicines to reduce the risk of breast cancer with their female patients who are at high risk for the disease. High Risk Women for whom the **benefits outweigh the harms** include: 1) women aged 40 to 49 who do not have a predisposition to develop blood clots; and 2) women aged 50 to 59 who do not have a predisposition to develop blood clots and do not have a uterus.

The complete announcement of the recommendation can be found at <http://www.ahrq.gov/clinic/3rduspstf/breastchemo>.

USPSTF recommendations can be viewed at <http://www.ahrq.gov/clinic/3rduspstf/breastchemo>.

The recommendations, which include information to help women assess their breast cancer risk as well as compare the benefits and risks of tamoxifen and raloxifene, appear in the 2 JUL 02 issue of the *Annals of Internal Medicine*.

Breast Cancer Screening for Women Veterans

Recommendations

- 1) The third USPSTF recommends mammography screening, with or without clinical breast examination (CBE), every 1 to 2 years for women aged 40 and older. This is a grade B recommendation.

(This is a change from the 1996 second USPSTF recommendation: Screening for breast cancer every 1-2 years, with mammography alone or mammography and annual CBE, is recommended for women aged 50-69, grade A recommendation).

- The USPSTF found fair evidence that mammography screening every 12 to 33 months significantly reduces mortality from breast cancer. Evidence is strongest for women aged 50 to 69 and the evidence that screening mammography reduces mortality from breast cancer is weaker for women aged 40 to 49. The evidence is also generalizable to women aged 70 and older (who face a higher absolute risk of breast cancer) if their life expectancy is not compromised by co-morbid disease.
- The absolute probability of benefits of regular mammography increases along a continuum with age, whereas the likelihood of harms from screening diminishes from ages 40 to 70.

- The balance of benefits and potential harms, therefore, grows more favorable as women age. The USPSTF did not find sufficient evidence to specify the optimal screening interval for women aged 40 to 49.
- 2) The USPSTF concludes that the evidence is insufficient to recommend for or against routine CBE alone to screen for breast cancer.
- The USPSTF could not determine the benefits of CBE alone or the incremental benefit of adding CBE to mammography.
- 3) The USPSTF concludes that the evidence is insufficient to recommend for or against teaching or performing routine breast self-examination (BSE).
- The USPSTF could not determine the balance of benefits and potential harms of BSE.

Clinical Considerations

Clinicians should inform women veterans of the following in regard to breast cancer screening:

- the potential benefits of mammography (reduced chance of dying from breast cancer);
- the potential harms of mammography (false-positive results and unnecessary anxiety, biopsies, and cost);
- the limitations of mammography that apply to their specific age group;
- that the benefits of mammography increase and potential harms decrease with increasing age for women between the ages of 40 and 70;
- that women who are at increased risk for breast cancer (because of a family history of breast cancer in a mother or sister, previous abnormal breast biopsy, or first childbirth after age 30) are more likely to benefit from regular mammography than women at lower risk;
- that the recommendation for women to begin routine screening in their 40's is strengthened by a family history of breast cancer having been diagnosed before menopause;
- that for women aged 50 and older, there is little evidence to suggest that annual mammography is more effective than mammography done every other year;
- that for women aged 40 to 49, available trials also have not reported a clear advantage of annual mammography over biennial mammography; however some experts recommend annual mammography based on the lower sensitivity of the test and on evidence that tumors grow more rapidly in this age group;
- that the precise age at which to discontinue screening mammography is uncertain;
- that mammograms should be done at screening centers with proper accreditation and quality assurance standards, and that provide timely and adequate follow-up of abnormal results;

- that women who perform BSE or receive CBE by clinicians should understand that there is currently insufficient evidence to determine whether these practices affect breast cancer mortality and that they are likely to increase the incidence of clinical assessments and biopsies; and
- that decisions about breast cancer screening should take into account patient preferences.

The USPSTF did not examine whether women should be screened for genetic mutations (BRCA1 and BRCA2) that increase the risk of developing breast cancer, or whether women with genetic mutations might benefit from earlier or more frequent screening for breast cancer.

For Further Information

The complete recommendations and rationale can be found at www.preventiveservices.ahrq.gov

These recommendations appeared in the 3 September 2002 *Annals of Internal Medicine*. Any or all USPSTF recommendations, summaries of the evidence, easy-to-read fact sheets explaining the recommendations, and related materials are available from the AHRQ Publications Clearinghouse by calling (800) 358-9295 or sending email requests to ahrqpubs@ahrq.gov.

Chlamydial Infection

*U.S. Preventive Services Task Force
Update, 2001 Release*

Recommendations

Strongly recommends routine screening for:

- All sexually active women ages 25 and younger.
- Other asymptomatic women at increased risk for infection (A recommendation).

Makes no recommendation for or against routine screening for asymptomatic women ages 26 and older at low risk for infection (C recommendation).

Recommends routine screening for:

- All asymptomatic pregnant women ages 25 and younger.
- Other pregnant women at increased risk for infection (B recommendation).

Makes no recommendation for or against routine screening of asymptomatic, low-risk pregnant women age 26 and older (C recommendation).

Insufficient evidence to recommend for or against routinely screening asymptomatic men (I recommendation).

Continued on page 6

Age 25 and younger is the strongest risk factor for chlamydial infection. Other risk factors include:

- Having more than one sexual partner.
- Having had a sexually-transmitted disease in the past.
- Not using condoms consistently and correctly.

Guide to Clinical Preventive Services, 3rd Edition: Periodic Updates (available Fall 2002)

Chlamydial Infection: Screening, 2001

Recommendations and Rationale

<http://www.ahrq.gov/clinic/ajpmsuppl/chlarr.htm>

<http://www.ahrq.gov/clinic/ajpmsuppl/chlarr.pdf> (PDF 68KB)

Summary of Evidence

<http://www.ahrq.gov/clinic/ajpmsuppl/nelson1.htm>

<http://www.ahrq.gov/clinic/ajpmsuppl/chlasum.pdf> (PDF 137KB)

Systematic Evidence Review

<http://hstat.nlm.nih.gov/hq/Hquest/screen/DirectAccess/db/3602>

<http://www.ahrq.gov/clinic/serfiles.htm#chlamyd> (File Download 490 KB)

Prevention Program Fact Sheets

<http://www.ahrq.gov/clinic/ppipix.htm#factsheets>

Screening for Chlamydial Infection: What's New

<http://www.ahrq.gov/clinic/prev/chlamwh.htm>

Guide to Clinical Preventive Services, 2nd Edition

<http://hstat.nlm.nih.gov/hq/Hquest/screen/DirectAccess/db>

Screening for Chlamydial Infection, 1996

<http://hstat.nlm.nih.gov/hq/Hquest/screen/DirectAccess/db/local.gcps.cps/IHR/CH29>

Screening for Colorectal Cancer (CRC)

Synopsis

The U.S. Preventive Services Task Force strongly recommends that clinicians screen for colorectal cancer in all adults 50 years of age or older who are at average risk for colorectal cancer. For higher-risk patients, it is reasonable to begin screening at a younger age. Various screening tests are available, making it possible for patients and their clinicians to decide which test is most appropriate for each individual, based on patient preferences, medical contraindications, patient adherence, and available resources for testing and follow-up. (See below for Screening Options.)

Background: Risk of Colorectal Cancer

Colorectal cancer is the fourth most common cancer in the United States and the second leading cause of cancer death. 57,000 patients die each year from CRC. A person at age 50 has about a 5 percent lifetime risk of being diagnosed with colorectal cancer and a 2.5 percent chance of dying from it; the average patient dying of colorectal cancer loses 13 years of life.

Screening Options

The USPSTF reviewed evidence of the effectiveness of the following screening tests for colorectal cancer: DRE, FOBT, sigmoidoscopy, colonoscopy, DCBE, and CT colography, singly and in various combinations. The VA continues to support the use of FOBT X 3, sigmoidoscopy, or colonoscopy as the three options for screening for CRC.

Screening Option Evidence

The USPSTF found **good evidence** that periodic **fecal occult blood testing** (FOBT) reduces mortality from colorectal cancer and **fair evidence** that **sigmoidoscopy alone or in combination with FOBT** reduces mortality. The USPSTF **did not find direct evidence** that **screening colonoscopy** is effective in reducing colorectal cancer mortality; efficacy of colonoscopy is supported by its integral role in trials of FOBT, extrapolation from sigmoidoscopy studies, limited case-control evidence, and the ability of colonoscopy to inspect the proximal colon. **Double-contrast barium enema** offers an **alternative** means of whole-bowel examination, but it is less sensitive than colonoscopy, and there is **no direct evidence that it is effective in reducing mortality rates**. The USPSTF found **insufficient evidence** that newer screening technologies (for example, **computed tomographic colography**) are effective in improving health outcomes.

Specific Comments on Screening Modalities

Fecal Occult Blood Testing (FOBT). Proven methods of FOBT screening use guaiac-based test cards prepared at home by patients from **three consecutive stool samples** and forwarded to the clinician. Whether patients need to restrict their diet and avoid certain medications is not established. **Note:** See below regarding digital rectal examination (DRE).

Sigmoidoscopy. First-time sigmoidoscopic screening detects approximately 7 cancers and about 60 large or high-risk polyps per 1,000 examinations. Although sigmoidoscopy can only visualize the lower half of the colon, it has been estimated to identify 80 percent of all patients with significant findings in the colon, but this is because findings on sigmoidoscopy will trigger examination of the entire colon.

FOBT and Sigmoidoscopy. Combining FOBT and periodic sigmoidoscopy has been advocated to improve the sensitivity of screening. The combination may detect more cancers and more large polyps than either test alone, but the additional benefits and potential harms of combining the two tests are **uncertain**.

Colonoscopy. Colonoscopy recently has been advocated for screening, usually at 10-year intervals or as a once-in-a-lifetime examination at age 55-65. The accuracy of colonoscopy is difficult to evaluate because it is usually considered the “Gold standard”. Many patients will have polyps detected or removed on colonoscopy, **but only a minority of those would have developed cancer**. While C-scope is the most sensitive and specific test for detecting cancer and large polyps but is **associated with higher risks** than other screening tests for colorectal cancer. **RISKS:** Include a small risk for bleeding and risk for perforation, primarily associated with removal of polyps or biopsies performed during screening (1 to 2 per 10,000 examinations). Because it is a more invasive procedure than FOBT or sigmoidoscopy, and because generally it is used with conscious sedation, it is more vulnerable to complications. **Inconvenience:** C-scope requires more highly trained personnel, overnight bowel preparation, sedation, and longer recovery time, which may necessitate transportation for the patient. It is NOT CERTAIN whether the increased accuracy of colonoscopy compared with alternative screening methods (for example, the identification of lesions that FOBT and flexible sigmoidoscopy would not detect) offsets the procedure’s additional complications, inconvenience, and costs.

Double-Contrast Barium Enema. Most studies of DCBE have **important limitations** for determining accuracy **in an asymptomatic** screening population. Previous studies have reported high sensitivity (up to 90%) of DCBE for colorectal cancer and polyps, and high specificity (95%). In the National Polyp Study, however, DCBE detected only 48 percent of polyps greater than 1 cm.

Digital Rectal Examination/Office FOBT. Fewer than 10 percent of colorectal cancers arise within reach of the examining finger, and some of these lesions will already be symptomatic. Samples collected by DRE may be affected by other limitations, including inadequate amount of stool or trauma from the exam.

Computed Tomography (CT) Colography. CT colography, or “virtual colonoscopy,” is a noninvasive procedure that requires a preparation similar to colonoscopy, followed by instillation of air through a rectal tube. Although CT colography can be relatively sensitive and specific in research settings (up to 90%), recent reports have suggested lower accuracy when performed by less experienced examiners. Small and flat polyps are less well visualized

on CT colography than are cancers and large polyps. Studies have not yet examined clinical outcomes with CT colography screening.

Screening Interval

The optimal interval for screening depends on the test. **Annual FOBT** offers greater reductions in mortality rates than biennial screening but produces more false-positive results. A **10-year interval** has been recommended **for colonoscopy** on the basis of evidence regarding the natural history of adenomatous polyps. Shorter intervals (**5 years**) have been recommended for **flexible sigmoidoscopy and double-contrast barium enema** because of their lower sensitivity, but there is no direct evidence with which to determine the optimal interval for tests other than FOBT.

High-Risk Patients

The high-risk patient group includes those with a family history of colorectal cancer in a first-degree relative, those with a personal history of ulcerative colitis, previously diagnosed large adenomatous polyps or colorectal cancer, genetic syndromes such as familial adenomatous polyposis [FAP] or hereditary nonpolyposis colorectal cancer [HNPCC]. It is reasonable to begin screening at a younger age in this high risk group.

Upper Age Limit

The upper age limit to discontinue colorectal cancer screening is not known -- research data is generally restricted to patients younger than 80 years of age. With increasing age, benefits of CRC screening may be limited due to other causes of death. Discontinuing screening is therefore reasonable in patients whose age or comorbid conditions limit life expectancy.

Costs

Studies reviewed by the USPSTF indicate that colorectal cancer screening is likely to be cost-effective regardless of which screening method is used. Initial costs of colonoscopy are higher than the costs of other tests. Estimates of cost-effectiveness, however, suggest that, from a societal perspective, compared with no screening, all methods of colorectal cancer screening are likely to be as cost-effective as many other clinical preventive services -- less than \$30,000 per additional year of life gained.

For Further Information

The complete recommendations and rationale can be found at: <http://www.ahrq.gov/clinic/3rduspstf/colorectal/colorr.htm>

USPSTF recommendations can be viewed at <http://www.ahrq.gov/clinic/3rduspstf/colorectal>.

The recommendations appear in the 16 JUL 02 issue of the Annals of Internal Medicine.

Any or all USPSTF recommendations, summaries of the evidence, easy-to-read fact sheets explaining the recommendations, and related materials are available from the AHRQ Publications Clearinghouse by calling (800) 358-9295 or sending an e-mail to ahrqpubs@ahrq.gov.

Depression Screening

The U.S. Preventive Services Task Force (USPSTF) recently reviewed the scientific evidence regarding depression screening for adults in the primary care setting. The USPSTF finds sufficient evidence to encourage primary care clinicians to screen their adult patients for depression. The USPSTF noted that clinicians should have systems in place to assure accurate diagnosis, effective treatment, and follow-up of patients.

In addition, the USPSTF concluded that the evidence is insufficient to recommend for or against routine screening of children or adolescents for depression.

To view the complete announcement of the recommendation released today, visit the AHRQ Web site at: <http://www.ahrq.gov/clinic/3rduspstf/depression>.

The recommendations and accompanying article appeared in the "Annals of Internal Medicine" on Tuesday, May 21, 2002.

Diabetes

Published findings

The most recent publication from the Community Preventive Services Task Force (on diabetes) was released this month in a special supplement to the American Journal of Preventive Medicine. The articles (listed below) are available for download at <http://www.thecommunityguide.org> in the "publications" section.

Special recognition is given to our VA representatives on the Diabetes Team of the Task Force:

- Dr. Len Pogach, Chief, Endocrine Service at NJHCS, East Orange, New Jersey
- Dr. Jeffrey Robbins, Director, Podiatric Services at the VA Medical Center, Cleveland, Ohio

Contact either one with your questions about diabetes care in the VA (both are on Outlook).

Highlights (excerpts from CDC Dissemination Coordinator)

- A lot has been published recently about the fact that Americans are becoming heavier (one out of every five Americans is obese, a 61% increase since 1991), and sicker (one out of every sixteen has diabetes, an increase of 49% since 1990). We have also heard a lot about the fact that physical inactivity is a major risk factor for both obesity and type 2 diabetes, and about the toll of diabetes on health.
- What's been missing has been scientifically sound evidence on effective community-level strategies to increase physical

activity or evidence on ways to improve the care of persons with diabetes.

- The Task Force's findings demonstrate the value of several strategies for increasing physical activity, including informational approaches such as community-wide campaigns, behavioral and social approaches such as school-based physical education and environmental and policy approaches such as creation of or enhanced access to places for physical activity.
- This supplement also provides information on effective care strategies for persons with diabetes. Teaching people how to manage their disease can improve their health, and this education can effectively occur in community settings such as the home and community centers. Health care organizations can use strategies such as case management that focus on the individual patient, and population strategies such as disease management to improve the health of persons with diabetes.

Articles

The 7 articles in the May, 2002, supplement include:

- 1) Diabetes and Physical Activity Translating Evidence into Practice
- 2) Working Toward the Next Generation of Diabetes Self-Management Education
- 3) Striving for a More Active Community - Lessons from the Diabetes Prevention Program and Beyond
- 4) Recommendations for Healthcare System and Self-Management Education Interventions to Reduce Morbidity and Mortality from Diabetes
- 5) The Effectiveness of Disease and Case Management for People with Diabetes - A Systematic Review
- 6) Increasing Diabetes Self-Management Education in Community Settings - A Systematic Review
- 7) The Effectiveness of Interventions to Increase Physical Activity - A Systematic Review (<http://www.thecommunityguide.org>)

Hormone Replacement Therapy for Primary Prevention of Chronic Conditions

Recommendations

After reviewing new clinical trial data that found more harms than benefits for chronic disease prevention for most women, the third U.S. Preventive Services Task Force recommended this week against the use of combined estrogen and progestin therapy for preventing cardiovascular disease and other chronic conditions in postmenopausal women.

The USPSTF found fair-to-good evidence that the combination of estrogen and progestin has both benefits and harms. Benefits include increased bone mineral density (good evidence), reduced risk for fracture (fair-to-good evidence), and reduced risk for colorectal cancer (fair evidence). Harms include increased risk for breast cancer (good evidence), venous thromboembolism (good evidence), coronary heart disease (CHD) (fair-to-good evidence), stroke (fair evidence), and cholecystitis (fair evidence). Evidence was insufficient to assess the effects of HRT on other important outcomes, such as dementia and cognitive function, ovarian cancer, mortality from breast cancer or cardiovascular disease, or all-cause mortality.

The USPSTF concluded that the harmful effects of estrogen and progestin are likely to exceed the chronic disease prevention benefits in most women. The USPSTF did not evaluate the use of HRT to treat symptoms of menopause, such as vasomotor symptoms (hot flashes) or urogenital symptoms. The balance of benefits and harms for an individual woman will be influenced by her personal preferences, individual risks for specific chronic diseases, and the presence of menopausal symptoms.

The Task Force found insufficient evidence to recommend for or against the use of unopposed estrogen for the prevention of chronic conditions in postmenopausal women who have had a hysterectomy.

The USPSTF found fair-to-good evidence that the use of unopposed estrogen has both benefits and harms. Although most current data come from observational studies, likely benefits include increased bone mineral density, reduced fracture risk, and reduced risk for colorectal cancer. Likely harms include increased risk for venous thromboembolism, cholecystitis, and stroke; in women who have not had a hysterectomy, unopposed estrogen increases the risk for endometrial cancer. Evidence is insufficient to determine the effects of unopposed estrogen on the risk for breast and ovarian cancer, CHD, dementia and cognitive function, or mortality. As a result, the USPSTF could not determine whether the benefits of unopposed estrogen outweigh the harms for women who have had a hysterectomy.

Better data on benefits and harms are expected from ongoing randomized trials, including the Women's Health Initiative

(WHI) study of unopposed estrogen in women who have had a hysterectomy.

Benefits

A number of studies have found that estrogen increases bone mineral density and decreases fracture rates. Several studies have also found that hormone therapy reduces the risk of colorectal cancer, although the results have not all been statistically significant.

Harms

The effect of hormone therapy on breast cancer has been controversial, with studies showing mixed results. Two recent randomized clinical trials found an increase in breast cancer incidence; no effect on breast cancer mortality has been observed. Recent randomized clinical trials have found increased rates of cardiovascular disease, especially in the first year or two of therapy. Small increases in stroke incidence and increases of 2 to 3 times for venous thromboembolic diseases have been found in several studies. An increased risk of endometrial cancer with unopposed estrogen has been well established; no increased risk is seen with combination hormone therapy. Many, but not all, studies have reported an association between hormone therapy and gallbladder disease.

Discussion

Although the potential harms may be greater than the benefits for chronic disease prevention for most women, the differences are small and some women may choose to take hormone therapy, depending on their personal preferences and values. Women and their providers should discuss these issues together before making a decision to start, continue, or stop hormone therapy. **Such decisions should not be made with a sense of urgency but can wait for scheduled appointments and time for consideration of all the factors.**

Providers should discuss chronic disease prevention with perimenopausal and postmenopausal women, using a shared decision-making approach that takes into account individual risk factors and preferences when selecting effective interventions for reducing the risks for fracture, heart disease, and cancer. Providers and women may wish to consider other effective strategies for preventing osteoporosis and fractures. Evidence is inconclusive about the effectiveness of soy products in chronic disease prevention.

These recommendations are based, in part, on randomized controlled trials that used conjugated equine estrogen and medroxyprogesterone acetate. Previous observational studies included a variety of hormone preparations. Until data indicate that other hormone regimens have a favorable balance of benefits to harms, providers should be cautious in selecting alternate regimens for chronic disease prevention.

Treatment of Menopausal Symptoms

The USPSTF recommendations do not address the use of hormone therapy for menopausal symptoms, such as hot flashes, night sweats, or urogenital symptoms. Women should discuss with their providers the potential benefits and harms from hormone

Continued on page 10

therapy for treatment of menopausal symptoms. Women should be informed that there are some risks (such as the risk for venous thromboembolism, CHD, and stroke) within the first 1 to 2 years of therapy, whereas other risks (such as the risk for breast cancer) appear to increase with longer-term hormone therapy. Other expert groups have recommended that women who decide to take hormone therapy for the relief of menopausal symptoms use the lowest effective dose for the shortest possible time, with regular follow-up with their providers.

For Further Information

The complete recommendations and rationale can be found at <http://www.ahrq/clinic/3rduspstf/hrt/hrtrr.htm>

USPSTF recommendations can be viewed at <http://www.ahrq.gov/clinic/3rduspstf/hrt>

These recommendations appeared in the 15 October 2002 *Annals of Internal Medicine*. Any or all USPSTF recommendations, summaries of the evidence, easy-to-read fact sheets explaining the recommendations, and related materials are available from the AHRQ Publications Clearinghouse by calling (800) 358-9295 or sending email to ahrqpubs@ahrq.gov.

Influenza Vaccine

Recommendations

The *Influenza Vaccine-Recommendations for 2002-2003* (VHA Directive 2002-044), approved by the USH on July 29, 2002, has been released. The Chief Officer, Patient Care Services (11), is responsible for the contents of this Directive.

Questions related to the implementation of the influenza immunization program are referred to the National Center for Health Promotion and Disease Prevention (NCHPDP) telephones (919) 383-7874 ext. 234, 227 or 224.

Questions related to influenza and/or influenza vaccine are referred to the Infectious Diseases Program Office, telephone number (513) 475-6398.

The Directive can be found at <http://vaww.nchpdp.med.va.gov/FinishedFluDirective.DOC>

Lipid Disorders in Adults

*U.S. Preventive Services Task Force
Update, 2001 Release*

Recommendations

Strongly recommends routine screening for:

- Men ages 35 and older.
- Women ages 45 and older (A recommendation).

Recommends routine screening for younger adults if they have other risk factors for coronary heart disease:

- Men ages 20 to 35.
- Women ages 20 to 45 (B recommendation).

Makes no recommendation for or against routine screening for younger adults if they have no known risk factors for coronary heart disease:

- Men ages 20 to 35.
- Women ages 20 to 45 (C recommendation).

Recommends that screening include measurement of:

- Total cholesterol (TC).
- High-density lipoprotein cholesterol (HDL-C) (B recommendation).

Guide to Clinical Preventive Services, 3rd Edition: Periodic Updates (available Fall 2002)

Lipid Disorders in Adults: Screening, 2001

Recommendations and Rationale

<http://www.ahrq.gov/clinic/ajpmsuppl/lipidrr.htm>

<http://www.ahrq.gov/clinic/ajpmsuppl/lipidrr.pdf> (PDF 68KB)

Summary of Evidence

<http://www.ahrq.gov/clinic/ajpmsuppl/pignone1.htm>

<http://www.ahrq.gov/clinic/ajpmsuppl/lipsum.pdf> (PDF 122KB)

Systematic Evidence Review

<http://hstat.nlm.nih.gov/hq/Hquest/screen/DirectAccess/db/3608>

<http://www.ahrq.gov/clinic/serfiles.htm#lipid> (File Download 2.1MB)

Prevention Program Fact Sheets

<http://www.ahrq.gov/clinic/ppipix.htm#factsheets>

Screening Adults for Lipid Disorders: What's New

<http://www.ahrq.gov/clinic/prev/lipidwh.htm>

Guide to Clinical Preventive Services, 2nd Edition

<http://hstat.nlm.nih.gov/hq/Hquest/screen/DirectAccess/db/2>

Screening for High Blood Cholesterol and Other Lipid Abnormalities, 1996

<http://hstat.nlm.nih.gov/hq/Hquest/screen/DirectAccess/db/local.gcps.cps/IHR/CH02>

Screening for Osteoporosis in Postmenopausal Women

Recommendations

After reviewing new clinical trial data that showed various medications can reduce the risk of fracture, the third U.S. Preventive Services Task Force recommended that clinicians routinely provide screening for women 65 and older and those 60 to 64 who have risk factors for osteoporosis (those under 154 pounds and not using estrogen).

“The USPSTF found good evidence that the risk for osteoporosis and fracture increases with age and other factors, that bone density measurements accurately predict the risk for fractures in the short-term, and that treating asymptomatic women with osteoporosis reduces their risk for fracture. The USPSTF concludes that the benefits of screening and treatment are of at least moderate magnitude for women at increased risk by virtue of age or presence of other risk factors.”

Risk Factors

Risk for osteoporosis increases steadily and substantially with age. Low body weight or body-mass index (BMI) and not using estrogen replacement were also consistently associated with osteoporosis but to a lesser degree than age. Other risk factors for fracture or low bone density found in some studies include: white or Asian ethnicity, history of fracture, family history of osteoporotic fracture, history of falls, low levels of physical activity, smoking, excessive alcohol or caffeine use, low calcium or vitamin D intake, and the use of various medications.

Screening

The Task Force found that dual-energy x-ray absorptiometry (DXA), a non-invasive test, is the most accurate method for measuring bone density. DXA of the hip is the best predictor of hip fracture, but bone density of the hand, wrist, forearm and heel also can be measured to detect risk. Optimal intervals for repeated screening and the appropriate age to stop screening have not been defined.

Definition of Osteoporosis

Osteoporosis is commonly defined as a bone mineral density (BMD) more than 2.5 standard deviations (SD) below the mean for a young healthy adult woman, and a BMD between 1 and 2.5 SD below the mean as osteopenia.

Treatment

The U.S. Food and Drug Administration has approved various medications for the treatment of osteoporosis. The USPSTF recommends that clinicians discuss the potential benefits and risks of available treatment options with their patients.

For Further Information

The complete recommendations and rationale can be found at <http://www.ahrq.gov/clinic/3rduspstf/osteoporosis/osteorr.htm>

USPSTF recommendations can be viewed at <http://www.ahrq.gov/clinic/3rduspstf/osteoporosis>

The recommendations appear in the September 17, 2002 Annals of Internal Medicine. Any or all USPSTF recommendations, summaries of the evidence, easy-to-read fact sheets explaining the recommendations, and related materials are available from the AHRQ Publications Clearinghouse by calling (800) 358-9295 or sending e-mail to ahrqpubs@ahrq.gov.

Behavioral Counseling for Physical Activity

The U.S. Preventive Services Task Force (USPSTF) has concluded that there is a lack of adequate research data to recommend for or against Behavioral Counseling by providers in the Primary Care setting to promote Physical Activity.

However, the NCHPDP emphasizes strongly that the evidence for health benefits of physical activity is well documented and extremely strong, therefore adds these further recommendations to avoid misinterpretation of the USPSTF announcement.

NCHPDP Recommendations for Physical Activity in the VA

- 1) Primary care clinicians, as well as clinicians in other settings, continue to counsel patients to engage in physical activity.
- 2) Wherever possible, counseling should seek to include exercise prescriptions, individually tailored physical activity regimens, assisting patients with physical activity goals, frequent follow up, and linking patients up with community physical activity programs and resources.

Synopsis of USPSTF Findings

The USPSTF concluded that it simply did not have enough evidence in the available literature to recommend *for or against counseling* for physical activity by clinical providers in the primary care setting at this time.

Limitations of the USPSTF study included:

- 1) The USPSTF did not review the evidence for the effectiveness of physical activity to reduce chronic disease morbidity and mortality, which has been well documented in other recent reviews, or review evidence of counseling in other settings.

Continued on page 12

- 2) Controlled trials of physical activity counseling in adult primary care patients were of variable quality and had mixed results.
- 3) Most of the counseling interventions were described as very brief, minimal, and of low intensity, and lacked detail about the intervention itself.
- 4) Some interventions targeted other behaviors as well as physical activity;
- 5) The physical activity levels reported by patients were unverified in most cases;
- 6) No information was available concerning whether or not the providers doing the counseling had been trained in any counseling techniques.

Despite these limitations, the USPSTF report did conclude that:

- 1) **Multicomponent interventions** appear the most promising;
- 2) In addition to clinician advice, **helping patients set physical activity goals, providing an exercise prescription, individually tailoring a physical activity regimen, and mailed or telephone follow up by trained staff** are promising interventions;
- 3) Linking the patient to **community-based physical activity and fitness** programs may also enhance the effectiveness of primary care clinician counseling.

BACKGROUND for NCHPDP Recommendations

The USPSTF report simply says that rigorous scientific evidence for the efficacy of such counseling is not yet available. The evidence for health benefits of physical activity is well documented and extremely strong, such that numerous national organizations have recommended that healthcare providers counsel patients about physical activity. These include the Department of Health and Human Services, Centers for Disease Control and Prevention, National Center for Education in Maternal and Child Health, American Academy of Family Physicians, American Academy of Pediatrics, American Heart Association, and the American College of Obstetricians and Gynecologists. The CDC indicates that the health care costs associated with physical inactivity were more than \$76 billion in 2000, and that \$5.6 billion in heart disease costs could be saved each year if 10% of adults began a regular walking program.

For Further Information

The recommendation, titled, "Behavioral Counseling for Physical Activity," has been published in the 6 AUG 02 issue of *Annals of Internal Medicine*.

For the complete recommendation and rationale can be found at <http://www.ahrq.gov/clinic/3rduspstf/physactivity>.

Any or all USPSTF recommendations, summaries of the evidence, easy-to-read fact sheets explaining the recommendations, and related materials are available from the AHRQ Publications Clearinghouse by calling (800) 358-9295 or sending an e-mail to ahrqpubs@ahrq.gov.

Physical Fitness

AHRQ and CDC developed a white paper on Physical Activity in Older Americans to accompany President Bush's activities to promote physical fitness. This report describes the importance of physical activity, the prevalence and costs of inactivity, and the health benefits of regular activity. It also recommends levels of physical activity in older adults. Go to <http://www.ahrq.gov/ppip/activity.htm> to see a copy of the paper.

Skin Cancer

*U.S. Preventive Services Task Force
Update, 2001 Release*

Recommendation

Insufficient evidence to recommend for or against routine screening for the early detection of cutaneous melanoma, basal cell cancer, or squamous cell skin cancer (I recommendation).

Guide to Clinical Preventive Services, 3rd Edition: Periodic Updates (available Fall 2002)

Skin Cancer Screening, 2001

Recommendations and Rationale

<http://www.ahrq.gov/clinic/ajpmsuppl/skarr.htm>

<http://www.ahrq.gov/clinic/ajpmsuppl/skarr.pdf> (PDF 130KB)

Summary of Evidence

<http://www.ahrq.gov/clinic/ajpmsuppl/helfand1.htm>

<http://www.ahrq.gov/clinic/ajpmsuppl/skcasum.pdf> (PDF 211KB)

Systematic Evidence Review

<http://hstat.nlm.nih.gov/hq/Hquest/screen/DirectAccess/db/3601>

<http://www.ahrq.gov/clinic/serfiles.htm#skincan> (File Download 167KB)

Prevention Program Fact Sheets

<http://www.ahrq.gov/clinic/ppipix.htm#factsheets>

Guide to Clinical Preventive Services, 2nd Edition

<http://hstat.nlm.nih.gov/hq/Hquest/screen/DirectAccess/db/2>

Screening for Skin Cancer, 1996

<http://hstat.nlm.nih.gov/hq/Hquest/screen/DirectAccess/db/local.gcps.cps/IHR/CH12>