Letters to the Editor

Women's Preventive Services Initiative Guidelines Supersede Other Cervical Cancer Screening Guidelines

To the Editor: We appreciated the cervical cancer screening article by Drs. Wiser and Quinlan.[1] It focused on updated guidelines from the US Preventive Services Task Force (USPSTF) and the American Cancer Society; however, the Women's Preventive Services Initiative (WPSI) guidelines published in January 2026 have become the new standard for cervical cancer screening in the United States. This is in part because these recommendations are approved by the Health Resources and Services Administration and linked to insurance coverage with no out-of-pocket costs for cervical cancer screening.[2] Critical points in the guidelines include a preference for primary human papillomavirus (HPV) screening over cotesting for asymptomatic, average-risk women 30 to 65 years of age and offering all patients the option of self-collection.

Although the article suggests that primary HPV screening increases colposcopies compared with cotesting, it does not. Instead, the modeling report commissioned for the USPSTF found that cotesting results in 60% more tests performed for the same outcomes and causes harm by directing falsely positive women to more colposcopies for which they have a nontrivial out-of-pocket cost.[3]

Primary HPV screening simplifies the algorithms: patients who are HPV negative should have repeat testing in 5 years (regardless of collection technique), those who are positive for HPV 16 or 18 warrant colposcopy, and those positive for HPV that is not 16 or 18 (about 7% of screening tests) require a triage test. Triage testing is moving toward dual staining biomarkers (p16/Ki67) and away from cytology. Biomarker testing is simpler for the clinician to interpret and significantly more cost-effective than cytology.[4]

Family physicians screen nearly 60% of women who are screened for cervical cancer.[5] With the self-collection option, family physicians can offer all asymptomatic, average-risk women screening, without the need for a pelvic examination.

For the United States to reach the World Health Organization (WHO) cervical cancer elimination goal of an overall incidence of less than 4 per 100,000 women with cervical cancer, both HPV vaccination and self-collection are needed.[6] HPV vaccination in the United States has already reduced the cervical cancer incidence to 3.1 per 100,000 among women 18 to 34 years of age.[7] Implementing self-collection can increase adherence to cervical cancer screening from the current rate of 70% to the WHO goal of 90%. If family physicians can reach 90% of all US women, we can reduce the time needed to reach the 4 per 100,000 goal within a decade![6]

We encourage all family physicians to step up and provide patient-centered cervical cancer screening by implementing the WPSI guidelines in their practices and health systems without delay.

Diane M. Harper, MD, MPH, MS
Ann Arbor, Michigan
harperdi@med.umich.edu

Alisa P. Young, MD
Ann Arbor, Michigan

Marie Claire O'Dwyer, MB, BCh, BAO
Ann Arbor, Michigan

Author Disclosure: No relevant financial relationships.

In Reply: We thank the authors for their thoughtful response to our article. We appreciate the work put into the development of the WPSI guidelines; however, they were not yet published at the time our article was written. We agree that they are likely to inform screening for cervical cancer moving forward.

Although the USPSTF's modeling study found that cotesting results in more tests and colposcopies than a primary HPV screening strategy, their draft evidence report on 11 comparative studies with concurrent controls does not support this conclusion.[3] In six randomized controlled trials (n = 563,818), primary HPV screening was associated with an increase in colposcopies compared with cytology (relative risk = 1.23 [95% CI, 1.16-1.31] to 3.05 [95% CI, 2.75-3.38]). Two studies (n = 161,228) demonstrated reduced use of colposcopies; however, these studies had lower test positivity overall and used a more conservative referral protocol, which likely led to these results. Finally, in two trials (n = 69,684), cotesting increased colposcopies compared with cytology. These data seem to support an increased risk of colposcopy with primary HPV screening. We look forward to postimplementation data to determine the real-world impact of primary HPV screening on the use of colposcopy and other harms.

Jeffrey D. Quinlan, MD
Iowa City, Iowa

Amy Wiser, MD
Iowa City, Iowa
amy-wiser@uiowa.edu

Author Disclosure: Dr. Wiser disclosed a relationship with Merck as a consultant on HPV vaccination. All other individuals in a position to control content for this activity have indicated that they have no relevant financial relationships to disclose.

Email submissions to afplet@aafp.org.

REFERENCES

1. Wiser A, Quinlan JD. Cervical cancer screening. *Am Fam Physician*. 2026;113(2):137-144.
2. US Department of Health and Human Services. Update to the Women's Preventive Services guidelines. January 5, 2026. Accessed

May 13, 2026. https://www.federalregister.gov/documents/2026/01/05/2025-24235/update-to-the-womens-preventive-services-guidelines
3. US Preventive Services Task Force. Draft modeling report. Cervical cancer screening. December 10, 2024. Accessed May 13, 2026. https://www.uspreventiveservicestaskforce.org/uspstf/document/draft-modeling-report/cervical-cancer-screening-adults-adolescents
4. Harper DM, Anderson RJ, Baker E, et al. Cost-effectiveness of p16/Ki-67 dual-stained cytology reflex following co-testing with hrHPV genotyping for cervical cancer screening. *Cancer Prev Res (Phila)*. 2023;16(7):393-404.
5. Soltani LF, Addis I, Lin P, et al. Characterizing cervical cancer screening in the US: preparing for the era of self-collection. *J Am Board Fam Med*. 2026;38(6):1026-1048.
6. Burger EA, Smith MA, Killen J, et al. Projected time to elimination of cervical cancer in the USA: a comparative modelling study. *Lancet Public Health*. 2020;5(4):e213-e222.
7. Epic Research. Adult cancer incidence. Accessed May 13, 2026. https://www.epicresearch.org/data-tracker/cancer-rates/cervical

Topical Fluoride as a Cause of Dental Fluorosis in Children

To the Editor: We write in response to the recent Cochrane for Clinicians review on topical fluoride.[1] We appreciate its discussion of the risks of dental caries and its acknowledgment that dental fluorosis, although undesirable, is mostly cosmetic. However, we are concerned about the concluding recommendation to follow 2014 American Dental Association guidance suggesting toothbrushing with only water in children younger than 2 years, and the conditional phrasing "if [toothpaste is] used…."[2] This framing may inadvertently convey an unclear message to family physicians. More recent guidance from the American Academy of Pediatrics and American Academy of Pediatric Dentistry recommends using a smear amount (or the size of a grain of rice) of fluoridated toothpaste for children younger than 3 years.[3,4] The Cochrane review also omitted the conclusion from the cited American Dental Association document that supports initiating toothbrushing with a smear of fluoridated toothpaste starting at tooth eruption.[2]

Fluoridated toothpaste, when used in recommended amounts, effectively prevents caries without meaningfully increasing fluorosis risk. The Cochrane review cites 0.06 mg/kg as a threshold above which fluorosis risk rises. For an average 8-month-old infant (approximately 8 kg), this corresponds to 0.48 mg of fluoride daily.[5] A smear of toothpaste contains 0.1 mg; therefore, twice-daily brushing yields 0.2 mg, well below this threshold.[1] Even with additional fluoride exposure from water or a supplement, recommended dosing remains within safe limits. The critical factor, as emphasized by the American Dental Association, is caregiver supervision of toothpaste quantity.[2]

At appropriate doses, fluorosis is uncommon, while the benefits of fluoride in preventing caries are substantial. Consistent with this, the American Dental Association has previously advised against recommending nonfluoride toothpaste for infants and children in its Choosing Wisely guidance.[6] We agree.

Lisa Thompson, DMD
Boston, Massachusetts

Hugh Silk, MD, MPH, FAAFP
Worcester, Massachusetts
hugh.silk@umassmemorial.org

Author Disclosure: Dr. Silk disclosed a relationship with Colgate-Palmolive as a researcher on oral health education in primary care and a relationship with Philips as a consultant on a prenatal oral health education app. All other individuals in a position to control content for this activity have indicated they have no relevant financial relationships to disclose.

In Reply: We appreciate the thoughtful response and the emphasis on clear, evidence-based guidance for primary care clinicians.

We agree that more recent recommendations from the American Academy of Pediatrics and American Academy of Pediatric Dentistry support the use of a smear of fluoridated toothpaste beginning at tooth eruption. Our intent in referencing earlier American Dental Association guidance was to highlight the balance between caries prevention and fluorosis risk. However, we acknowledge that our phrasing may not have reflected the evolution toward more consistent endorsement of early fluoride toothpaste use and should have included the more recent guidelines.`

Importantly, as the letter authors note, available evidence suggests that when used in appropriate amounts under caregiver supervision, fluoridated toothpaste provides substantial protection against dental caries with minimal risk of clinically significant fluorosis. For family physicians, the key practical message is not whether to use fluoride toothpaste, but how to use it safely.

We appreciate the opportunity to clarify this point and reinforce current guidance that supports early initiation of fluoridated toothpaste in young children.

Alexis Reedy-Cooper, MD, MPH
El Paso, Texas
areedyco@ttuhsc.edu

Author Disclosure: No relevant financial relationships.

REFERENCES

1. Soto-Soto A, Reedy-Cooper AB. Topical fluoride as a cause of dental fluorosis in children. *Am Fam Physician*. 2026;113(3):219-220.
2. American Dental Association Council on Scientific Affairs. Fluoride toothpaste use for young children. *J Am Dent Assoc*. 2014;145(2):190-191.
3. Clark MB, Keels MA, Slayton RL. Section on oral health. Fluoride use in caries prevention in the primary care setting. *Pediatrics*. 2020;146(6):e2020034637.
4. American Academy of Pediatric Dentistry. Policy on use of fluoride. In: *The Reference Manual of Pediatric Dentistry.* American Academy of Pediatric Dentistry; 2025:110-112.
5. Centers for Disease Control and Prevention, National Center for Health Statistics. CDC growth charts. Accessed March 18, 2026. https://www.cdc.gov/growthcharts/cdc-growth-charts.htm

6. American Academy of Family Physicians. Choosing Wisely recommendations. Don't recommend nonfluoride toothpaste for infants and children. Accessed July 16, 2026. https://www.aafp.org/afp/collections/choosing-wisely

Infective Endocarditis in People Who Inject Drugs Requires Concurrent Addiction Treatment

To the Editor: We read the comprehensive review of infective endocarditis by Nohria, et al.,[1] with great interest. The authors accurately detailed the clinical presentation and severe complications of endocarditis associated with injection drug use, including its disproportionate impact on younger patients and tendency to cause right-sided heart failure. However, from a patient safety perspective, a critical component of management was overlooked: treatment of the underlying substance use disorder.

Managing the infectious sequelae of injection drug use without addressing the addiction itself results in unacceptably high rates of treatment noncompletion, as well as reinfection and mortality. Acute hospitalization for infective endocarditis must be viewed as a pivotal opportunity. Evidence demonstrates that initiating medications for opioid use disorder such as buprenorphine or methadone during the first admission significantly increases the likelihood of patients completing antimicrobial therapy and reduces postdischarge mortality.[2-4]

The American Heart Association's scientific statement on management of infective endocarditis in people who inject drugs explicitly recommends a multidisciplinary approach that includes addiction medic ne consultation. Substance use disorder screening and the prompt initiation of medications for opioid use disorder are as fundamental to the care of patients with infective endocarditis as obtaining blood cultures and echocardiography.[5]

Family physicians are uniquely positioned for both postacute follow-up and chronic management of substance use disorder. We urge readers to view addiction treatment as an indispensable pillar in the management of injection drug use–associated endocarditis.

Mohammad Hassan, MD, DABFM
Brookline, Massachusetts
mohammad.hassan@childrens.harvard.edu

Lem Atanga McCormick, MD, MPH, DABFM
Boston, Massachusetts

Author Disclosure: No relevant financial relationships.

Editor's Note: This letter was sent to the authors of "Infective Endocarditis: Diagnosis and Treatment," who declined to reply.

REFERENCES

1. Nohria R, Romaine A, Garcia-Sampson G. Infective endocarditis: diagnosis and treatment. Am Fam Physician. 2026;113(2):145-152.
2. Marks LR, Munigala S, Warren DK, et al. A comparison of medication for opioid use disorder treatment strategies for persons who inject drugs with invasive bacterial and fungal infections. J Infect Dis. 2020; 222(suppl 5):S513-S520.
3. Harris MTH, Weinstein ZM, Walley AY. Medications for opioid use disorder, opioid withdrawal, and opioid overdose: a review. JAMA. 2026;335(11):986-998.
4. Blair N, Kopp A, Kubin CJ, et al. P-862. Hospital administered MOUD is associated with decreased one-year mortality among PWUD admitted with bloodstream infections. Open Forum Infect Dis. 2025; 12(suppl 1):ofae631.1054.
5. Baddour LM, Weimer MB, Wurcel AG, et al.; American Heart Association Rheumatic Fever, Endocarditis and Kawasaki Disease Committee of the Council on Lifelong Congenital Heart Disease and Heart Health in the Young; Council on Cardiovascular Surgery and Anesthesia; Council on Cardiovascular and Stroke Nursing; Council on Clinical Cardiology; and Council on Peripheral Vascular Disease. Management of infective endocarditis in people who inject drugs: a scientific statement from the American Heart Association. Circulation. 2022;146(14):e187-e201.

Correction

Incorrect test and testing requirements. "HIV Infection: What Is New in Prevention and Treatment?" (May 2026, p. 479) incorrectly identified a laboratory test in Table 3, "Recommended Laboratory Tests Before Prescribing HIV Preexposure Prophylaxis." Hepatitis B core antibody should have been listed. In the same table, an HIV testing requirement was omitted. An HIV RNA test is needed in patients with recent viral syndrome (that could be HIV) and in patients with an HIV exposure–prone event in the past 4 weeks. The online version of the article has been corrected. ■