U.S. Preventive Services Task Force Update

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John Epling, MD, MS, FAAFP

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Alex Krist, MD, MPH, FAAFP

Faculty, Fairfax Family Practice Residency, Virginia; Family physician, Privia Medical Group, Fairfax, Virginia; Professor/Director of Research, Department of Family Medicine and Population Health, Virginia Commonwealth University (VCU), Richmond; Director, Virginia Ambulatory Care Outcomes Research Network, Richmond

Dr. Krist is a clinician and teacher at Fairfax Family Practice Residency in Virginia. He is a researcher in VCU’s Department of Family Medicine and Population Health and director for community-engaged research at VCU’s Center for Clinical and Translational Research. His research supports Virginia’s practice-based research network (PBRN), which spans eight health systems and represents the full spectrum of primary care practice structures and cultures. In addition, Dr. Krist is a member of the U.S. Preventive Services Task Force (USPSTF) and currently serves as vice chair. He has been one of the leading thinkers on how to operationalize USPSTF recommendations in clinical practice through patient activation and engagement, practice workflow and redesign, promotion of shared decision-making, and optimization of health information technology (HIT).
John Epling, MD, MS, FAAFP

Professor/Medical Director of Research, Department of Family and Community Medicine, Virginia Tech Carilion School of Medicine, Roanoke; Medical Director of Employee Health and Wellness, Carilion Clinic, Roanoke, Virginia; Member, U.S. Preventive Services Task Force (USPSTF)

Dr. Epling earned his medical degree from Tufts University School of Medicine in Boston, Massachusetts. He completed an internship at the U.S. naval hospital in Charleston, South Carolina, and a family medicine residency at the Medical University of South Carolina in Charleston. He also completed a faculty development fellowship in evidence-based practice, policy, and education at State University of New York (SUNY) Upstate Medical University in Syracuse and a vaccine science fellowship with the AAFP. Dr. Epling maintains an active clinical family medicine practice and has taught family medicine, evidence-based medicine, and clinical prevention to all levels of learners throughout his career. His principal research interests include evidence-based medicine; translation of research into practice; quality improvement and human performance technology; and technology integration in medical education and practice. His clinical research areas of focus include clinical preventive services (i.e., screening, vaccination, preventive medication, behavioral risk counseling) and intimate partner violence. He has participated in several vaccination-related work groups on the state and national levels, and he joined the USPSTF in January 2016.

Learning Objectives

1. Participants will be better able to implement new recommendations from the USPSTF into practice including recommendations for cancer screening, health behavior counseling, and chemoprevention.

2. Participants will better know how to access, read, and understand the methods used by and recommendations from the USPSTF.

3. Participants will be able to better use the evidence supporting the USPSTF recommendations to motivate patients to receive services with clear benefit and engage patients in shared decision-making for decisions with a close balance of benefits and harms.
Audience Engagement System

Overview

- Overview of Task Force Methods
- Where to get our recommendations
- 2018-9 Highlight Recommendations
  - Cervical Cancer Screening
  - HIV Pre-Exposure Prophylaxis (PrEP)
  - Unhealthy Alcohol Use
  - Prevention of Perinatal Depression
General USPSTF Methods

US Preventive Services Task Force…

• Makes recommendations on clinical preventive services to primary care clinicians
• The USPSTF scope for clinical preventive services include:
  – Screening tests
  – Counseling
  – Preventive medications
• Recommendations address only services offered in the primary care setting or services referred by a primary care clinician.
• Recommendations apply to adults & children with no signs or symptoms
# USPSTF Members

- The 16 volunteer members represent disciplines of primary care including family medicine, internal medicine, nursing, obstetrics/gynecology, pediatrics, and behavioral medicine
- Led by a Chair & Vice Chairs
- Serve 4-year terms
- Appointed by AHRQ Director with guidance from Chair & Vice Chairs
- Complete a rigorous review of potential conflicts of interests
- Current members include deans, medical directors, practicing clinicians, and professors
  - [http://www.uspreventiveservicestaskforce.org/members.htm](http://www.uspreventiveservicestaskforce.org/members.htm)

# USPSTF Methods

- Rigorous 4-stage recommendation development process
  - Topic nomination
  - Draft and final research plans
  - Draft evidence review and recommendation statement
  - Final evidence review and recommendation statement
- 4-week public comment period on all drafts
- Consult with external subject matter experts through Evidence-based Practice Centers and Partners
Input from the Public

- Anyone can nominate a topic for the USPSTF to consider via the web site:
  - [http://www.uspreventiveservicestaskforce.org/tftopicnom.htm](http://www.uspreventiveservicestaskforce.org/tftopicnom.htm)
- Anyone can comment on:
  - Posted Draft Research Plans
  - Posted Draft Evidence Reports and Recommendation Statements.
- We read every nomination and comment

USPSTF Steps: Brief and Generic

- The USPSTF assesses the evidence across the analytic framework:
  - Judges the **certainty** of the estimates of the potential benefits and harms
  - Judges the **magnitude** of the potential benefits and harms
  - The ultimate goal is to judge the **balance** of the benefits and harms, or the **magnitude of the net benefit** of the preventive service
  - When evidence is insufficient (low certainty), the USPSTF does not use “expert opinion”
Basic USPSTF Methods for Developing Recommendations: The Letter Grades

<table>
<thead>
<tr>
<th>Certainty of Net Benefit</th>
<th>Magnitude of Net Benefit</th>
</tr>
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<tbody>
<tr>
<td></td>
<td>Substantial</td>
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<tr>
<td>High</td>
<td>A</td>
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<tr>
<td>Moderate</td>
<td>B</td>
</tr>
<tr>
<td>Low</td>
<td>I—insufficient evidence</td>
</tr>
</tbody>
</table>

What Grades Suggest for Practice

<table>
<thead>
<tr>
<th>Grade</th>
<th>Definition</th>
<th>Suggestions for Practice</th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td>The USPSTF recommends the service. There is high certainty that the net benefit is substantial.</td>
<td>Offer or provide this service.</td>
</tr>
<tr>
<td>B</td>
<td>The USPSTF recommends the service. There is high certainty that the net benefit is moderate or there is moderate certainty that the net benefit is moderate to substantial.</td>
<td>Offer or provide this service.</td>
</tr>
<tr>
<td>C</td>
<td>The USPSTF recommends selectively offering or providing this service to individual patients based on professional judgment and patient preferences. There is at least moderate certainty that the net benefit is small.</td>
<td>Offer or provide this service for selected patients depending on individual circumstances.</td>
</tr>
<tr>
<td>D</td>
<td>The USPSTF recommends against the service. There is moderate or high certainty that the service has no net benefit or that the harms outweigh the benefits.</td>
<td>Discourage the use of this service.</td>
</tr>
<tr>
<td>I</td>
<td>The USPSTF concludes that the current evidence is insufficient to assess the balance of benefits and harms of the service. Evidence is lacking, of poor quality, or conflicting, and the balance of benefits and harms cannot be determined.</td>
<td>Read the clinical considerations section of USPSTF Recommendation Statement. If the service is offered, patients should understand the uncertainty about the balance of benefits and harms.</td>
</tr>
</tbody>
</table>
How can you find our recommendations?

It’s All on the Website!
Clinical Summary

Hormone Therapy in Postmenopausal Women: Primary Prevention of Chronic Conditions

Recommendations made by the USPSTF are independent of the U.S. government. They should not be construed as an official position of the Agency for Healthcare Research and Quality or the U.S. Department of Health and Human Services.

Dissemination & Implementation (D&I)

- USPSTF Partners provide input on recommendations and facilitate dissemination and implementation. Partners represent:
  - Primary care clinicians, consumers, and other stakeholders
  - Federal agencies
- D&I resource examples:
  - HealthFinder - [http://healthfinder.gov/](http://healthfinder.gov/)
Poll Question 1

The USPSTF makes recommendations about clinical preventive services based on:

a) A full consensus of expert opinion
b) Rigorous assessment of certainty of evidence and magnitude of net benefit
c) The cost-effectiveness analysis of preventive interventions
USPSTF Recommendations
In Progress

Final Research Plans

- Chlamydial or Gonococcal Infections (S)
- Hepatitis B – Non-pregnant Adolescents and Adults (S)
- Hearing Loss – Older Adults (S)
- Vitamin D Deficiency – Adults (S)
- Abnormal Blood Glucose and Type 2 Diabetes (S)
- High Blood Pressure – Children and Adolescents (S)
- High Blood Pressure – Adults (S)
- Diet and Physical Activity Counseling for CVD Prevention - Adults (C)
- Illicit Drug Use- Children and Adolescents (C)
- Lung Cancer (S) – Adults
- STI (C) – Adults
- Healthy Weight (C) – Pregnant Women
- Tobacco Cessation (C) – Adults (including during Pregnant Women)
- Bacterial Vaginosis (S) – Pregnant Women

(S) = Screening recommendation (C) = Counseling recommendation
Draft Recommendation Statements

- Asymptomatic Bacteriuria (S) – Adults
- BRCA-Related Cancer (S&C)–Women
- Pancreatic Cancer (S) – Adults
- Risk Reducing Medications for Breast Cancer (PM) – Women
- HBV (S) – Pregnant Women

(S) = Screening recommendation  (C) = Counseling recommendation
(PM) = Preventive medication

Brief Summary:
May 2018 – September 2019
### Final Recommendations

<table>
<thead>
<tr>
<th>Topic</th>
<th>Population</th>
<th>Recommendation</th>
<th>Grade</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lead screening (S)</td>
<td>Children and pregnant women</td>
<td>Insufficient evidence</td>
<td>I</td>
</tr>
<tr>
<td>Gonococcal Ophthalmia Neonatorum (PM)</td>
<td>Neonates</td>
<td>Recommends prophylactic ocular topical medication for all newborns</td>
<td>A</td>
</tr>
<tr>
<td>Child maltreatment prevention (S&amp;C)</td>
<td>Children and adolescents 18 years and younger</td>
<td>Insufficient evidence on interventions to prevent maltreatment; children with signs or symptoms of maltreatment should be assessed or reported according to state law</td>
<td>I</td>
</tr>
<tr>
<td>Intimate partner violence &amp; elder abuse (S)</td>
<td>Women of reproductive age</td>
<td>Recommends screening for Intimate Partner Violence (IPV); provide or refer women who screen positive to ongoing support services</td>
<td>B</td>
</tr>
<tr>
<td></td>
<td>Older adults</td>
<td>Insufficient evidence</td>
<td>I</td>
</tr>
<tr>
<td>Behavioral interventions for weight loss (C)</td>
<td>Adults</td>
<td>Recommends offer or referral to behavioral interventions for adults with a BMI of 30 or higher</td>
<td>B</td>
</tr>
<tr>
<td>Syphilis screening (S)</td>
<td>Pregnant women</td>
<td>Recommends early screening for syphilis infection in all pregnant women</td>
<td>A</td>
</tr>
</tbody>
</table>
## Final Recommendations

<table>
<thead>
<tr>
<th>Topic</th>
<th>Population</th>
<th>Recommendation</th>
<th>Grade</th>
</tr>
</thead>
<tbody>
<tr>
<td>Screening for PAD and CVD (S)</td>
<td>Adults</td>
<td>Insufficient evidence to recommend screening for PAD and CVD with ankle-brachial index (ABI)</td>
<td>I</td>
</tr>
<tr>
<td>Screening for osteoporosis (S)</td>
<td>Women 65 years and older</td>
<td>Recommends screening with bone measurement testing</td>
<td>B</td>
</tr>
<tr>
<td></td>
<td>Postmenopausal women younger than 65 years</td>
<td>Recommends screening with bone measurement testing in women at increased risk as determined by a formal clinical risk assessment tool</td>
<td>B</td>
</tr>
<tr>
<td></td>
<td>Men</td>
<td>Insufficient evidence to assess</td>
<td>I</td>
</tr>
</tbody>
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<table>
<thead>
<tr>
<th>Topic</th>
<th>Population</th>
<th>Recommendation</th>
<th>Grade</th>
</tr>
</thead>
<tbody>
<tr>
<td>HIV Screening</td>
<td>Adolescents and adults 15-65 years (older and younger if HR), all pregnant persons</td>
<td>Recommend screening for HIV</td>
<td>A</td>
</tr>
</tbody>
</table>
Detailed Summary:
May 2018 – September 2019

CERVICAL CANCER SCREENING
AUGUST 2018
Cervical Cancer

- Deaths have decreased substantially since the implementation of widespread cervical cancer screening
- 2.8 per 100,000 women in 2000
  \[ \rightarrow \] 2.3 deaths per 100,000 women in 2015
- Most cases occur among women who have not been screened or had inadequate follow-up

Cervical Cancer Screening

### Recommendation Summary

<table>
<thead>
<tr>
<th>Population</th>
<th>Recommendation</th>
<th>Grade (What's This?)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Women aged 21 to 65 years</td>
<td>The USPSTF recommends screening for cervical cancer every 3 years with cervical cytology alone in women aged 21 to 29 years. For women aged 30 to 65 years, the USPSTF recommends screening every 3 years with cervical cytology alone, every 5 years with high-risk human papillomavirus (hrHPV) testing alone, or every 5 years with hrHPV testing in combination with cytology (cotesting). See the Clinical Considerations section for the relative benefits and harms of alternative screening strategies for women 21 years or older.</td>
<td>A</td>
</tr>
</tbody>
</table>
Cervical Cancer Screening

<table>
<thead>
<tr>
<th>Population</th>
<th>2012</th>
<th>2018</th>
</tr>
</thead>
<tbody>
<tr>
<td>Women older than 65 years</td>
<td>D</td>
<td>D</td>
</tr>
<tr>
<td>Women younger than 21 years</td>
<td>D</td>
<td>D</td>
</tr>
<tr>
<td>Women who have had a hysterectomy</td>
<td>D</td>
<td>D</td>
</tr>
</tbody>
</table>

Change from Prior Recommendations

<table>
<thead>
<tr>
<th>Population</th>
<th>2012</th>
<th>2018</th>
</tr>
</thead>
<tbody>
<tr>
<td>Women 21 to 29: 3 years cervical cytology</td>
<td>-</td>
<td>A</td>
</tr>
<tr>
<td>Women 30 to 65: 3 years cervical cytology or 5 years hrHPV with cytology</td>
<td>-</td>
<td>A</td>
</tr>
<tr>
<td>Women 21 to 29: 3 years cervical cytology or 5 years hrHPV alone</td>
<td>A</td>
<td>-</td>
</tr>
<tr>
<td>Women older than 65 years - USPSTF recommends against screening</td>
<td>D</td>
<td>D</td>
</tr>
<tr>
<td>Women younger than 21 years - USPSTF recommends against screening</td>
<td>D</td>
<td>D</td>
</tr>
<tr>
<td>Women who have had a hysterectomy - USPSTF recommends against screening</td>
<td>D</td>
<td>D</td>
</tr>
</tbody>
</table>
Review of Evidence

Systematic Review
Screening for cervical cancer with high-risk human papillomavirus testing

Decision Analysis Model
Age to begin, optimal interval, screening strategy effectiveness, benefits and harms

Updated 2012 recommendation:
Women 30 to 65: Screening every 5 years with hrHPV +/- cytology as an alternative to every 3 years with cytology alone or co-testing every 5 years

Summary of Review Findings

• hrHPV Primary Screening
  – 4 RCTs, 1 cohort study
  – hrHPV screening found more CIN 3+ versus cytology alone
  – Overall CIN 3+ detection ranged from 0.3% to 0.8% across studies

• hrHPV Cotesting with Cytology
  – 4 RCTs, 2 cohort study
  – Cotesting found similar rates of CIN 3+ versus cytology alone

• Both hrHPV screening strategies
  – Higher false-positive and colposcopy rates than cytology
  – Could lead to more treatments with potential harms
Summary of Review Findings

• Screening Interval Based on Decision Modeling
  – 2012 model: Screening every 3 years with cytology alone confers a similar number of life-years gained as annual screening
  – 2018 model: With hrHPV, similar life-years gained with 3- and 5-year screening intervals

Summary of Review Findings (Harms)

• Screening Interval
  – Cytology alone: More frequently than every 3 years
    • Little additional benefit
    • Large increase in harms; cervical incompetence and preterm labor (through overtreatment)
  – hrHPV testing alone or cotesting: More frequently than every 5 years
    • Does not substantially improve benefit
    • Significantly increases the number of screening tests and colposcopies
Guidance on Implementation

• Participation in regular screening is key
  – Greater effect on cervical cancer morbidity and mortality than chosen screening strategy
  – Focus on ensuring that women receive adequate screening, especially underserved women (African American, Native American Indians, rural and low-income women)
  – Ensure solid evidence for stopping screening (adequate prior screening and reason for hysterectomy)

Guidance on Implementation

• Important to have systems in place to ensure
  – Follow-up of abnormal results
  – Appropriate treatment of any pathology
  – Support to retain patients throughout the entirety of cancer treatment
Poll Question 2

Which of the following recommendations is correct for cervical cancer screening?

1. For women with a hysterectomy for benign reasons, continue screening for 10 years after the procedure.
2. For women 30 to 65 years, HPV testing alone every 5 years is an option.
3. For women at age 65, stop screening no matter what prior screening they have had.
Human Immunodeficiency Virus

- 1.1 million persons living with HIV in U.S.
- 700,000+ American AIDS deaths since 1981
- 2016: Estimated 40,000 new diagnoses of HIV infection
- New HIV diagnosis: 80% male, 20% female
- **Why prevent?** Though treatable, HIV infection is not curable and has significant health consequences

Pre-Exposure Prophylaxis

<table>
<thead>
<tr>
<th>Population</th>
<th>Recommendation</th>
<th>Grade (What’s This?)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Persons at high risk of HIV acquisition</td>
<td>The USPSTF recommends that clinicians offer preexposure prophylaxis (PrEP) with effective antiretroviral therapy to persons who are at high risk of HIV acquisition.</td>
<td>A</td>
</tr>
</tbody>
</table>
Summary of Review Findings

- **Effectiveness of Preventive Medication**
  12 RCTs evaluated effect of PrEP:
  - Meta-analysis: PrEP vs Placebo/No PrEP
    - Relative Risk: 0.46 (95% CI 0.33 to 0.66)
    - Absolute Risk Reduction: -2.0% (95% CI -2.8% to -1.2%)
  - Tenofovir-emtricitabine and tenofovir alone equally effective
    - Only tenofovir-emtricitabine has FDA approval for PrEP

Summary of Review Findings

Higher adherence to PrEP reduced risk of HIV acquisition:

<table>
<thead>
<tr>
<th>Adherence</th>
<th>Relative Risk</th>
</tr>
</thead>
<tbody>
<tr>
<td>&gt;70%</td>
<td>0.27 [0.19 to 0.39]</td>
</tr>
<tr>
<td>&gt;40% &amp; &lt;70%</td>
<td>0.51 [0.38 to 0.70]</td>
</tr>
<tr>
<td>&lt;40%</td>
<td>0.93 [0.72 to 1.20]</td>
</tr>
</tbody>
</table>
Summary of Review Findings

Adherence to PrEP: 66% to 90% over 4 to 48 weeks

Adherence of Younger MSM: 50% at 12 weeks, 22-34% at 48

Self-reported adherence: Highly correlated with adherence

Multivariate analysis:
- Lower adherence: Black race (OR 0.28; 95% CI 0.12 to 0.64)
- Increased adherence: stable housing; receptive anal sex
- No association: age, educational attainment, income level, health insurance status, and alcohol or drug use

Summary of Review Findings

- **Potential Harms of Risk Assessment and Preventive Medication**
  - Increased risk of renal adverse events:
    Absolute Risk Difference: 0.56% (95% CI 0.09% to 1.04%)
  - Increased risk of gastrointestinal adverse events:
    Absolute Risk Difference: 1.95% (95% CI 0.48% to 3.43%)

- **Estimate of Magnitude of Net Benefit**
  - Convincing evidence that PrEP is of substantial benefit
  - Adherence to PrEP is highly correlated with its efficacy
Guidance on Implementation

Persons at High Risk of HIV

- Men who have sex with men, are sexually active and:
  - A serodiscordant sex partner (or)
  - Recent syphilis, gonorrhea, or chlamydia (or)
  - Inconsistent use of condoms during receptive/insertive anal sex

- Heterosexual women and men who are sexually active and:
  - A serodiscordant sex partner (or)
  - Inconsistent use of condoms with a high-risk partner with unknown HIV status (or)
  - Recent syphilis or gonorrhea

- Persons who inject drugs and:
  - Share drug injection equipment
  - Are at risk of sexual acquisition of HIV (see above)

Focus on behaviors

Guidance on Implementation

- Identifying persons at high risk of HIV
  - Routinely obtain sexual and injection drug use history

- CDC: discussion of implementation considerations
  - Baseline/follow up testing, time to protection, and discontinuing PrEP

- Recommendation excludes acute or chronic HIV infection

- Adherence support: important component of providing PrEP
Poll Question 3

Family physicians who are considering prescribing HIV PrEP should ensure they have the following skills:

1. Taking a thorough sexual history
2. Taking a thorough substance abuse history
3. Counseling to promote adherence to medication
4. All of the above

SCREENING & BEHAVIORAL INTERVENTIONS FOR UNHEALTHY ALCOHOL USE
NOVEMBER 2018
Unhealthy Alcohol Use

- One of the most common causes of premature mortality in the US
  - Responsible for 1 in 10 deaths among adults ages 20 to 64 years
  - 88,000 alcohol related deaths (2006-2010)
    - Acute: motor vehicle collisions
    - Chronic: liver disease, cancer
- Alcohol use during pregnancy is a major preventable cause of birth defects and developmental disabilities
- Why screen? Brief behavioral counseling interventions in adults who screen positive are associated with reduced unhealthy alcohol use, which may improve health outcomes
Risky Use

• **Women and men 65 years and older:** No more than 3 drinks/day or 7 drinks/week
• **Men (21-64 years):** No more than 4 drinks/day or 14 drinks/week
• **For adolescents:**

<table>
<thead>
<tr>
<th>Moderate Risk</th>
<th>Highest Risk</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ages 12-15</td>
<td>Age 11</td>
</tr>
<tr>
<td>Ages 16-17</td>
<td>Ages 12-15</td>
</tr>
<tr>
<td>Age 18</td>
<td>Age 17</td>
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<tr>
<td>1 day/year</td>
<td>1 day</td>
</tr>
<tr>
<td>6 days/year</td>
<td>6 days</td>
</tr>
<tr>
<td>12 days/year</td>
<td>24 days</td>
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</table>

• **Pregnant women:** Avoid completely

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**Screening & Behavioral Interventions for Unhealthy Alcohol Use**

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<thead>
<tr>
<th>Population</th>
<th>Recommendation</th>
<th>Grade (What’s This?)</th>
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<tbody>
<tr>
<td>Adults 18 years or older, including pregnant women</td>
<td>The USPSTF recommends screening for unhealthy alcohol use in primary care settings in adults 18 years or older, including pregnant women, and providing persons engaged in risky or hazardous drinking with brief behavioral counseling interventions to reduce unhealthy alcohol use.</td>
<td>B</td>
</tr>
<tr>
<td>Adolescents aged 12 to 17 years</td>
<td>The USPSTF concludes that the current evidence is insufficient to assess the balance of benefits and harms of screening and brief behavioral counseling interventions for alcohol use in primary care settings in adolescents aged 12 to 17 years. See the Clinical Considerations section for suggestions for practice regarding the I statement.</td>
<td>I</td>
</tr>
</tbody>
</table>
Review of Evidence

Studies of screening test accuracy
- N=277,881 adolescents, adults and pregnant women
- 62% in US, 51% in primary care
- A variety of 1 to 2-item screening tests, and:

<table>
<thead>
<tr>
<th>Population (No. of studies)</th>
<th>Condition</th>
<th>NIAA-SASQ</th>
<th>AUDIT-C, optimal cutoff</th>
<th>AUDIT optimal cutoff</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adult (27)</td>
<td>Unhealthy Use</td>
<td>Se: 0.73-0.88, Sp: 0.74-1.0, k=4, n=44,461</td>
<td>Se: 0.70-0.88, Sp: 0.70-0.85, k=6, n=82,444</td>
<td>Se: 0.68-0.91, Sp: 0.75-0.96, k=9, n=9832</td>
</tr>
<tr>
<td>Adult (27)</td>
<td>AUD</td>
<td>Se: 0.71-0.92, Sp: 0.60-0.91, k=6, n=46,244</td>
<td>Se: 0.70-0.88, Sp: 0.70-0.85, k=6, n=82,444</td>
<td>Se: 0.48-0.96, Sp: 0.34-0.96, k=8, n=5746</td>
</tr>
</tbody>
</table>

Recommendation: 1-item to 3-item screening instruments have the best accuracy for assessing unhealthy alcohol use in adults 18 years or older (AUDIT-C & SASQ).

Review of Evidence

Trials of intervention effectiveness
- N=36,528 adolescents & adults
- 30% web-based, 4 or fewer sessions, median 30-min
- 60% US, 62% in primary care
- SBIRT, motivational techniques, feedback, CBT
  - Intervention groups in 32 studies (meta-analysis):
    - 1.6 less drinks/week
    - 14% increase to drinking w/n healthy limits NNT=7.2 [95% CI, 6.2 to 11.5]

Recommendation: Brief behavioral counseling interventions were found to reduce unhealthy alcohol use in adults 18 years or older, including pregnant women
Summary of Review Findings

Potential Harms

• Stigma, labeling, discrimination, privacy concerns, and interference with the patient-clinician relationship
• Questionable legal concerns for pregnant women in some states
• No studies evaluated the harms of screening for unhealthy alcohol use, but USPSTF estimates this as small to none

Estimate of magnitude of benefit

• Moderate, offer screening and behavioral intervention

Guidance on Implementation: Screening

The following 1- to 3-item screening instruments have the best accuracy and can assess unhealthy alcohol use in adults 18 years or older:

• (AUDIT-C) Abbreviated Alcohol Use Disorders Identification Test–Consumption
• (SASQ) Single Alcohol Screening Question-recommended by NIAAA
  – “How many times in the past year have you had 5 [for men] or 4 [for women and all adults older than 65 years] or more drinks in a day?”

No evidence to recommend optimal screening interval for unhealthy alcohol use in adults

When patients screen positive, ensure follow up and determine next steps of care (behavioral intervention)
Guidance on Implementation:
Behavioral Intervention

Effective behavioral counseling interventions vary in their specific components, administration, length, and number of interactions

- The USPSTF was unable to identify specific intervention characteristics or components that were clearly associated with improved outcomes

Consider interventions included in the systematic review:

- Web-based interventions, personalized normative feedback including peer comparison, CBT, group sessions, alcohol diaries, stress management

Poll Question 4

Which of the following screening and intervention combinations are recommended by the USPSTF?

1. AUDIT-C and disulfiram therapy
2. CAGE and Freudian psychotherapy
3. Single alcohol screening question (SASQ) and a range of behavioral counseling interventions
4. AUDIT-C and naloxone therapy
PREVENTIVE INTERVENTIONS FOR PERINATAL DEPRESSION
FEBRUARY 2019

Perinatal Depression

• Depression that develops during pregnancy or up to 1 year after childbirth
• Affects as many as 1 in 7 women, or more than 180,000 mothers annually in the US
  – One of the most common complications of pregnancy/postpartum period
• Can result in adverse short- and long-term effects on both the mother and child
**Prevention of Perinatal Depression**

<table>
<thead>
<tr>
<th>Population</th>
<th>Recommendation</th>
<th>Grade</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pregnant and postpartum persons</td>
<td>The USPSTF recommends that clinicians provide or refer pregnant and postpartum persons who are at increased risk of perinatal depression to counseling interventions.</td>
<td>B</td>
</tr>
</tbody>
</table>

**Review of Evidence**

**RCT’s of counseling intervention**
- N=3094 women (majority pregnant)
- Median intervention: 8 weeks, 8 sessions, group and individual
- 39% reduction in likelihood of depression; when outcomes of incidence, prevalence, and exceeding symptom cutoff combined

**New recommendation:** Counseling-based interventions can be effective in preventing perinatal depression, provide or refer women at risk

- Pooled (RR) 0.61
  - (95% CI, 0.47 to 0.78)
  - 17 trials, I² = 39.0%
2 Effective Counseling Interventions

- **Cognitive behavioral therapy:**
  - Addresses negative thoughts and increases positive activities & actions

- **Interpersonal therapy:**
  - Focuses on an individual's relationships with other people to improve communication and address problems that contribute to depression

Summary of Review Findings

- **Potential Harms**
  - None of the non-pharmaceutical studies reported harm
  - 2/4 trials including anti-depressants reported on adverse effects, which mainly included minor side effects (constipation, drowsiness)

- **Estimate of magnitude of net benefit**
  - Moderate
  - NNT = 13.5 (95% CI, 9.9 to 23.9) at 6 months postpartum
Guidance on Implementation

Clinicians should provide counseling interventions to women with 1 or more of the following **risk factors:**

- History of depression
- Current depressive symptoms (that do not reach a diagnostic threshold)
- Certain SES risk factors such as low income or adolescent or single parenthood
- Recent intimate partner violence
- Mental health-related factors such as elevated anxiety symptoms or a history of significant negative life events

Guidance on Implementation

**Carefully review past medical history and risk factors**

**Timing of referral?**

- No data, however, most were initiated during the second trimester of pregnancy
Poll Question 5

• Which of the following statements is true about interventions to prevent post-partum depression?
  1. There are good quality screening tools available to detect women at risk.
  2. Routine SSRI/SNRI use in women at risk.
  3. No interventions have been found to provide significant benefit.
  4. Either CBT or interpersonal therapy is helpful for women at risk

LATE BREAKING ADDITIONS:
- BRCA
- BREAST CANCER CHEMOPREVENTION
- HEPATITIS C
Who to Consider?

- Women who have family members with breast, ovarian, or other BRCA-related cancers or have a personal history of these types of cancer

- Primary care providers may use one of several brief familial risk stratification tools to determine the need for in-depth genetic counseling
  - Ontario Family History Assessment Tool
  - Manchester Scoring System
  - Referral Screening Tool
  - Pedigree Assessment Tool
  - FHS-7
  - Brief versions of BRCAPRO
Who to Consider?

- Risk assessment tools can predict the number of cases of breast cancer expected to develop in a population.

- However, these risk assessment tools perform modestly at best in discriminating between women who will or will not develop breast cancer over time.

- As a woman’s risk for breast cancer increases, the net benefit of taking medications to reduce risk of breast cancer increases.

- Consider 3% risk from NCI Breast Cancer Risk Assessment Tool.
Who to Consider?

Some examples of women who may benefit:

- Atypical ductal or lobular hyperplasia or lobular carcinoma in situ on a prior biopsy
- Women age 65 years or older with one first-degree relative with breast cancer
- Women age 45 years or older with more than one first-degree relative with breast cancer or one first-degree relative who developed breast cancer before age 50 years
- Women age 40 years or older with a first-degree relative with bilateral breast cancer

Hepatitis C Screening
(Draft - Sept 2019)

<table>
<thead>
<tr>
<th>Population</th>
<th>Recommendation</th>
<th>Grade (What’s This?)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adults ages 18 to 79 years</td>
<td>The USPSTF recommends screening for hepatitis C virus (HCV) infection in adults ages 18 to 79 years.</td>
<td>B</td>
</tr>
</tbody>
</table>
Why the Change?

• Changing demographics of injection drug use is changing the prevalence of hepatitis C among different age groups

• 4 million Americans have hepatitis C and 50% of those infected unaware

• Treatments are now more effective and have lower side effects

PRACTICE RECOMMENDATIONS
Practice Recommendations

• Consider adding primary HPV testing for as an option for cervical cancer screening in women aged 30-65.
• Talk with your patients about sexual and substance abuse history and offer PrEP to your high-risk patients.

Practice Recommendations

• Routinely screen patients for risky alcohol use and provide brief counseling interventions to prevent alcohol use disorder.
• Refer pregnant women at risk for postpartum depression to counseling services.
Questions?
www.USPreventiveServicesTaskForce.org

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Questions