Recommendations of the U.S. Preventive Services Task Force
as of January 2014

The U.S. Preventive Services Task Force (USPSTF) is an independent, non-governmental panel of experts in prevention and primary care that is convened by the Agency for Healthcare Research and Quality (AHRQ). The work of the USPSTF supports AHRQ's mission, which is "to improve the quality, safety, efficiency, and effectiveness of health care for all Americans."

The USPSTF conducts rigorous, impartial assessments of the scientific evidence for the effectiveness of a broad range of clinical preventive services, including screening, counseling, and preventive medications. Topics are updated as new research becomes available.

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Recommendations of the U.S. Preventive Services Task Force (USPSTF)

Grade A Recommendations: The USPSTF recommends the service. There is a high certainty[1] that the net benefit is substantial. Suggestion for Practice: offer or provide this service.

Service	Recommended for	Detail/Comments	Frequency of service
Aspirin to prevent myocardial infarctions	Men age 45 to 79 years	When the potential benefit due to a reduction in myocardial infarctions outweighs the potential harm due to an increase in gastrointestinal hemorrhage	Discussion every 5 years in middle age and later and also whenever other cardiovascular risk factors are detected.
Aspirin to prevent ischemic strokes	Women age 55 to 79 years	When the potential benefit of a reduction in ischemic strokes outweighs the potential harm of an increase in gastrointestinal hemorrhage	Discussion every 5 years in middle age and later and also whenever other cardiovascular risk factors are detected.
Asymptomatic bacteriuria screening with urine culture	Pregnant women	The optimal frequency of subsequent urine testing during pregnancy is uncertain.	At 12 to 16 weeks' gestation or at the first prenatal visit, if later.
Cervical cancer screening	Women ages 21 to 65 years	Cytology (Pap smear) every 3 years or, for women ages 30-65 who want to lengthen the screening interval, combination of cytology and HPV testing every 5 years.	Every 3-5 years
Chlamydial infection screening	All sexually active non-pregnant women aged 24 and younger	And for older non-pregnant women who are at increased risk (history of chlamydial or other sexually transmitted infection, new or multiple sexual partners, inconsistent condom use, and exchanging sex for money or drugs)	No frequency of service information is currently available.
Colorectal cancer screening	Adults beginning at age 50 years, continuing until age 75 years	Using fecal occult blood testing, sigmoidoscopy, or colonoscopy. Risks and benefits of these screening modalities vary.	iFOBT annually OR sigmoidoscopy every 5 years with iFOBT every 3 years OR colonoscopy every 10 years
Congenital hypothyroidism (CH) screening	Newborns	Applies to all infants born in the U.S.	At 2-4 days of age
Folic acid supplement	Women planning or capable of pregnancy	Daily supplement containing 0.4 to 0.8 mg (400 to 800 µg) of folic acid	Start supplement at least 1 month before conception and continue through the first 2-3 months of pregnancy.
Gonococcal ophthalmia neonatorum prophylactic treatment	All newborns	Prophylactic ocular topical medication.	Within 24 hours after birth
Hepatitis B virus (HBV) screening	Pregnant women	Infants born to HBV infected mothers should receive Hepatitis B vaccine and Hepatitis B immune globulin within 12 hours of birth.	At first prenatal visit

[1] Description of High level of certainty: Available evidence usually includes consistent results from well-designed, well-conducted studies in representative primary care populations. These studies assess the effects of the preventive service on health outcomes. This conclusion is therefore unlikely to be strongly affected by the results of future studies.

(Grade A: Provide the service)

Service	Recommended for	Detail/Comments	Frequency of service
Human immunodeficiency virus (HIV) screening	All adolescents and adults ages 15-65.	Also screen younger adolescents and older adults who are at increased risk: actively engaged in risky behaviors and those who live or receive medical care in a high-prevalence setting (STD clinics, correctional facilities, homeless shelters, clinics serving men who have sex with men, adolescent health clinics with a high prevalence of STDs.)	One reasonable approach would be one-time screening of adolescent and adult patients to identify those already HIV-positive, with repeated screening annually of those at very high risk and every 3-5 years for those at increased risk.
HIV screening	All pregnant women	Includes those who present in labor who are untested and whose HIV status is unknown. Identification allows early antiretroviral treatment to prevent mother to child transmission.	No frequency of service information is currently available.
High blood pressure screening	All adults aged 18 and over	Every 2 years in persons with blood pressure less than 120/80 and every year with systolic blood pressure of 120 to 139 mm Hg or diastolic blood pressure of 80 to 90 mm Hg.	JNC recommendations are listed; evidence is lacking on the optimal interval for screening adults for hypertension.
Lipid disorder screening	Men aged 35 and older	Strongly recommended	On the basis of other guidelines and expert opinion, reasonable options include every 5 years, shorter intervals for people who have lipid levels close to those warranting therapy, and longer intervals for those not at increased risk who have had repeatedly normal lipid levels.
Lipid disorder screening	Women aged 45 and older if at increased risk for coronary heart disease	Increased risk: diabetes; previous personal history of CHD or non-coronary atherosclerosis (e.g. abdominal aortic aneurysm, peripheral artery disease, carotid artery stenosis); family history of cardiovascular disease before age 50 in male relatives or age 60 in female relatives; tobacco use; hypertension; obesity (BMI $\geq$ 30). Strongly recommended.	Reasonable options include every 5 years, shorter intervals for people who have lipid levels close to those warranting therapy, and longer intervals for those not at increased risk who have had repeatedly normal lipid levels.
Lung cancer screening	Adults aged 55 to 80 with smoking history	Specifically, a 30 pack-year smoking history and currently smoke or have quit within the past 15 years, with low-dose computed tomography.	Annually. Screening should be discontinued once a person has not smoked for 15 years or develops a health problem that substantially limits life expectancy or the ability or willingness to have curative lung surgery.
Phenylketonuria (PKU) screening	Newborns	Infants who are tested within the first 24 hours after birth should receive a repeat screening test by 2 weeks of age.	Premature infants and those with illnesses should be tested at or near 7 days of age, but in all cases before newborn nursery discharge.
Rh (D) blood typing and antibody testing	All pregnant women	During their first visit for pregnancy-related care; strongly recommended.	First prenatal visit

(Grade A: Provide the service)

Service	Recommended for	Detail/Comments	Frequency of service
Sickle cell disease screening	Newborns	Regardless of birth setting; birth attendants should make arrangements for samples to be obtained, and the first physician to see the child at an office should verify screening results	Confirmatory testing should occur no later than 2 months of age.
Syphilis infection screening	Pregnant women	Most states mandate that all pregnant women be screened at some point during pregnancy, and many mandate screening at the time of delivery.	At the time of the first prenatal visit. For women in high-risk groups, many organizations recommend repeat serologic testing in the third trimester and at delivery.
Syphilis infection screening	Persons at increased risk	Increased risk: men who have sex with men and engage in high-risk sexual behavior; commercial sex workers; persons who exchange sex for drugs; those in adult correctional facilities. Consider community characteristics: prevalence of syphilis infection varies widely among communities and patient populations. Strongly recommended.	No frequency of service information is currently available.
Tobacco cessation counseling	All adults	Ask about tobacco use and provide tobacco cessation interventions for those who use tobacco products.	No frequency of service information is currently available.
Tobacco cessation counseling	Pregnant women	Ask about tobacco use and provide augmented, pregnancy-tailored counseling for those who smoke.	No frequency of service information is currently available.

Grade B Recommendations: The USPSTF recommends the service. There is a high certainty that the net benefit is moderate or there is moderate certainty[2] that the net benefit is moderate to substantial. Suggestion for Practice: offer or provide this service.

Service	Recommended for	Detail/Comments	Frequency of service
Abdominal aortic aneurysm screening	Men aged 65 to 75 who have ever smoked	By ultrasonography	One time
Alcohol misuse screening	Adults aged 18 or older	Provide persons engaged in risky or hazardous drinking with brief behavioral counseling interventions to reduce alcohol misuse.	Evidence is lacking to determine the optimal interval for screening
BRCA-related cancer	Women who have family members with breast, ovarian, tubal or peritoneal cancer	Screen for family history.3 Women with positive screening results should receive genetic counseling and, if indicated after counseling, BRCA testing.	No frequency of service information is currently available.

[2] Description of Moderate level of certainty: The available evidence is sufficient to determine the effects of the preventive service on health outcomes, but confidence in the estimate is constrained by such factors as: the number, size, or quality of individual studies, inconsistency of findings across individual studies, limited generalizability of findings to routine primary care practice, lack of coherence in the chain of evidence. As more information becomes available, the magnitude or direction of the observed effect could change, and this change may be large enough to alter the conclusion.

[3] Several tools are listed at http://www.uspreventiveservicestaskforce.org/uspstf12/brcatest/brcatestfinalrs.htm

(Grade B: Provide the service)

Service	Recommended for	Detail/Comments	Frequency of service
Breast cancer chemoprevention discussion	Women at high risk for breast cancer and at low risk for adverse effects of chemoprevention	Engage in shared, informed decision making about medications to reduce risk. If at increased risk for breast cancer, and at low risk for adverse medication effects, offer to prescribe risk-reducing medications, such as tamoxifen or reloxifene. See **www.cancer.gov/bcrisktool** for a tool to estimate the 5-year incidence of invasive breast cancer.	No frequency of service information is currently available.
Breast cancer screening with mammography	Women aged 50-74 years	Increasing age is the most important risk factor for breast cancer in most women.	Every two years
Breastfeeding support	Women	Interventions to promote and support breastfeeding	During pregnancy and after birth
Chlamydial infection screening	Pregnant women aged 24 and younger and older pregnant women at increased risk	Increased risk: sexually active, history of STIs, new or multiple sex partners, inconsistent condom use, exchanging sex for money or drugs. Prevalence of chlamydial infection varies widely among patient populations.	No frequency of service information is currently available.
Major depressive disorder (MDD) screening	Adolescents, 12-18 years of age	When systems are in place to ensure accurate diagnosis, psychotherapy (cognitive-behavioral or interpersonal), and follow-up. Important risk factors that can be assessed relatively accurately and reliably include parental depression, having comorbid mental health or chronic medical conditions, and having experienced a major negative life event.	No frequency of service information is currently available.
Depression screening	Adults	When staff-assisted depression care supports are in place to assure accurate diagnosis, effective treatment, and follow-up	Optimal interval for screening is unknown. Recurrent screening may be most productive in patients with a history of depression, unexplained somatic symptoms, comorbid psychological conditions (panic disorder or generalized anxiety), substance abuse, or chronic pain.
Type 2 diabetes screening	Adults with elevated blood pressure	Asymptomatic adults with sustained elevated blood pressure (>135/80) either treated or untreated	No frequency of service information is currently available.
Dietary counseling, intensive behavioral, for CVD	Adult patients with hyperlipidemia and other known risk factors for cardiovascular and diet-related chronic disease	Intensive counseling can be delivered by primary care clinicians or by referral to other specialists, such as nutritionists or dieticians. Risk factors for CVD: hypertension, family history of heart disease, overweight/obesity, smoking, sedentary lifestyle	The largest effect of dietary counseling in asymptomatic adults has been observed with more intensive interventions (multiple sessions lasting 30 minutes or longer) among patients with hyperlipidemia or hypertension, and others at increased risk.

(Grade B: Provide the service)

Service	Recommended for	Detail/Comments	Frequency of service
Falls prevention	Community-dwelling adults age 65 years or older at increased risk for falls	Exercise or physical therapy and vitamin D supplementation to prevent falls. Age itself is strongly related to risk for falls.	No frequency of service information is currently available.
Fluoride supplementation, oral	Preschool children older than 6 months of age	Prescription recommended if primary water source is deficient in fluoride	Dosage recommendations based on the fluoride level of the local community's water supply; available online at www.ada.org
Gestational diabetes	Asymptomatic pregnant women		After 24 weeks gestation
Gonorrhea infection screening	Sexually active women, including those who are pregnant, if at increased risk	Increased risk: women and men under the age of 25 (including sexually active adolescents); history of previous gonorrhea infection, other sexually transmitted infections, new or multiple sex partners, inconsistent condom use, sex work and drug use. Risk factors for pregnant women are the same as for non-pregnant women. Individual risk depends on the local epidemiology of disease.	At the first prenatal visit for pregnant women at increased risk; if at continued risk, a second screening during the third trimester. Optimal interval for screening in the non-pregnant population is unknown.
Hearing loss screening	All newborn infants	Those infants who do not pass the newborn screening should undergo audiologic and medical evaluation before 3 months of age for confirmatory testing.	Before 1 month of age. Because of the elevated risk of hearing loss in infants with risk indicators, an expert panel has made a 2000 recommendation that these children should undergo periodic monitoring for 3 years.
Hepatitis C infection screening	Persons at high risk for infection	Also recommend offering one-time screening for HCV infection to adults born between 1945 and 1965.	Top two risk factors: past or current injection drug use, blood transfusion recipient before 1992.
Intimate partner violence screening	Women of childbearing age	Screen for domestic violence and provide or refer women who screen positive to intervention services; applies to women who do not have signs or symptoms of abuse	No frequency of service information is currently available.
Iron deficiency anemia screening	Asymptomatic pregnant women	Iron deficiency anemia during pregnancy has been associated with increased risk for low birth weight, preterm delivery, and perinatal mortality.	No frequency of service information is currently available.
Iron supplementation, routine	Asymptomatic children aged 6-12 months who are at increased risk for iron deficiency anemia	Increased risk: recent immigrants, premature and/or low birth weight	No frequency of service information is currently available.
Lipid disorders screening	Men aged 20-35 if they are at increased risk for coronary heart disease	The greatest risk for CHD is a combination of multiple risk factors: diabetes; personal history of CHD or non-coronary atherosclerosis (e.g., abdominal aortic aneurysm, peripheral artery disease, carotid artery stenosis); family history of cardiovascular disease before age 50 in male relatives or age 60 in female relatives; tobacco use; hypertension; obesity (BMI ≥30)	Reasonable options include every 5 years, shorter intervals for people who have lipid levels close to those warranting therapy, and longer intervals for those not at increased risk who have had repeatedly normal lipid levels.

(Grade B: Provide the service)

Service	Recommended for	Detail/Comments	Frequency of service
Lipid disorders screening	Women aged 20-45 if they are at increased risk for coronary heart disease	See above.	See above.
Obesity screening	Children 6 years and older	Offer or refer for comprehensive, intensive behavioral interventions to promote improvement in weight status.	No evidence on appropriate intervals for screening. Height and weight, from which BMI is calculated, are routinely measured during health maintenance visits.
Obesity screening	Adults	Offer or refer patients with a body mass index (BMI) of 30 kg/m2 or higher to intensive, multi-component behavioral interventions.	Higher-intensity behavioral interventions include multiple behavioral management activities, such as group and individual sessions, setting weight-loss goals, improving diet or nutrition, physical activity sessions, addressing barriers to change, active use of self-monitoring and strategizing how to maintain lifestyle changes.
Osteoporosis screening	Women aged 65 and older and in younger women whose fracture risk is equal or greater than that of a 65 year old woman who has no additional risk factors	The potential value of rescreening women whose initial screening test did not detect osteoporosis is to improve future fracture risk prediction. See FRAX tool http://www.sheffield.ac.uk/FRAX/index.jsp to predict 10-year fracture risk	A lack of evidence exists about optimal intervals for repeated screening and whether repeated screening is necessary in a woman with normal BMD. Because of limitations in the precision of testing, a minimum of 2 years may be needed to reliably measure a change in BMD; however, longer intervals may be necessary to improve fracture risk prediction.
Rh (D) antibody repeat testing	Unsentitized Rh (D)-negative pregnant women	Unless the biological father is known to be Rh (D)-negative.	At 24-28 weeks gestation
Sexually transmitted infections (STIs), high-intensity behavioral counseling to prevent	Sexually active adolescents and adults at increased risk for STIs	Increased risk: all sexually active adolescents; adults with current STIs or infections within the past year are at increased risk for future STIs; adults who have multiple current sexual partners. Consider the community served. If the population has a high rate of STIs, all sexually active patients in non-monogamous relationships may be considered to be at increased risk.	No frequency of service information is currently available.
Skin cancer counseling	Children, adolescents and young adults aged 10 to 24 years with fair skin	Behavioral counseling about minimizing their exposure to ultraviolet radiation to reduce risk for skin cancer	No frequency of service information is currently available.
Tobacco use counseling	Children and adolescents	Primary care physicians provide interventions, including education or brief counseling, to prevent initiation of tobacco use among school-aged children and adolescents.	
Vision screening	Children ages 3-5 years	To detect the presence of amblyopia, or its risk factors	At least once

Grade C Recommendations: The USPSTF recommends against routinely providing the service. There may be considerations that support providing the service in an individual patient. There is at least moderate certainty that the net benefit is small. Offer or provide this service only if other considerations support the offering or providing the service in an individual patient.

Service	Comments
Abdominal aortic aneurysm (AAA) screening in men aged 65-75 who have never smoked	No recommendation for or against
Breast cancer screening with mammography, women 40-49 years	The decision to start regular biennial screening mammography before age 50 should be an individual one and take patient context into account, including the patient's values regarding specific benefits and harms.
Chlamydial infection screening, women ages 25 and older, not at increased risk	Recommend against routinely providing screening, whether or not women are pregnant, if not at increased risk
Colorectal cancer screening, adults age 76 to 85 years	Recommend against routine colorectal cancer screening age 76 to 85. There may be considerations that support screening in an individual patient.
Depression screening in adults when staff-assisted depression care supports are not in place	There may be considerations that support screening in an individual patient
Falls prevention, multifactorial risk assessment with comprehensive management of identified risks, in community-dwelling adults aged 65 years or older	The likelihood of benefit is small. In determining whether appropriate in individual cases, consider balance of benefits and harms on the basis of circumstances of prior falls, comorbid medical conditions, and patient values.
Healthful diet and physical activity counseling for cardiovascular disease prevention in the general adult population without a known diagnosis of hypertension, diabetes, hyperlipidemia or cardiovascular disease	The health benefit of initiating behavioral counseling in the primary care setting is small. Clinicians may choose to selectively counsel patients rather than incorporating counseling into the care of all adults in the general population.
HIV infection screening, adults and adolescents not at increased risk	No recommendation for or against
Lipid disorders screening in men age 20-35, or women aged 20 and older, not at increased risk for coronary heart disease	No recommendation for or against

Grade D Recommendations: The USPSTF recommends against the service. There is moderate or high certainty that the service has no net benefit or that the harms outweigh the benefits. Discourage the use of this service.

Recommend this service not be provided	Potential harms that outweigh benefits
Abdominal aortic aneurysm, routine screening in women	Increased number of surgeries with associated morbidity and mortality, and psychological harms
Aspirin for myocardial infarction prevention in men younger than 45 years, and in women younger than 55 years, to prevent ischemic stroke	Good evidence that aspirin increases the incidence of gastrointestinal bleeding and fair evidence that it increases the incidence of hemorrhagic stroke.
Aspirin and NSAIDs, routine use, to prevent colorectal cancer in individuals at average risk for colorectal cancer	Gastrointestinal bleeding, hemorrhagic stroke, renal impairment, increased risk for cardiovascular events
Asymptomatic bacteriuria screening in men and nonpregnant women	Adverse effects from antibiotics and development of bacterial resistance
Beta-carotene supplements for prevention of cancer or cardiovascular disease	Beta-carotene supplementation is associated with higher incidence of lung cancer and higher all-cause mortality

Recommend this service not be provided	Potential harms that outweigh benefits
BRCA: routine genetic counseling or BRCA testing for women whose family history is not associated with an increased risk for potentially harmful mutations in the *BRCA1 or BRCA 2* genes.	Women without certain specific family history patterns have a low risk for developing cancers associated with BRCA mutations. Adverse ethical, legal and social consequences could result; interventions such as prophylactic surgery, chemoprevention or intensive screening have known harms.
Breast cancer risk reduction with routine use of medications, such as tamoxifen or raloxifen, in women who are not at increased risk.	Potential harms of tamoxifen and reloxifene outweigh the potential benefits for breast cancer risk reduction in women who are not at increased risk for the disease.
Breast self-examination (BSE) teaching	Psychological harms, unnecessary imaging tests and biopsies in women without cancer, inconvenience due to false-positive screening results; teaching BSE is associated with harms that are at least small, but harms outweigh benefits.
Carotid artery stenosis (CAS) screening in the asymptomatic general adult population	Testing strategies and treatment with carotid endarterectomy can cause harm.
Cervical cancer screening in women younger than age 21 years	Abnormal test results can lead to more frequent testing and invasive diagnostic procedures such as colposcopy and cervical biopsy.
Cervical cancer screening with HPV testing, alone or in combination with cytology, in women younger than age 30 years.	Abnormal test results can lead to more frequent testing and invasive diagnostic procedures such as colposcopy and cervical biopsy.
Cervical cancer screening in women older than age 65 if they have had adequate prior screening with normal Pap tests and are not otherwise at high risk for cervical cancer	Abnormal test results can lead to more frequent testing and invasive diagnostic procedures such as colposcopy and cervical biopsy.
Colorectal cancer screening in adults older than age 85	Preparation and sedation, risks of perforation in invasive procedures; moderate certainty that the benefits of screening do not outweigh the harms
Chronic obstructive pulmonary disease (COPD) screening using spirometry	Time and effort by patients and health care system are large, even in populations at higher risk. Can lead to substantial overdiagnosis in “never-smokers” over 70.
Coronary heart disease events prediction by screening with resting or exercise electrocardiography in asymptomatic adults at low risk for CHD events	Unnecessary invasive procedures, over-treatment, and labeling.
Fracture prevention for postmenopausal women with daily supplementation of 400 IU or less of vitamin D_3 and 1000mg or less of calcium	Evidence is lacking about the benefit of daily supplementation with greater than 400 IU of vitamin D3 and greater than 1,000 mg of calcium for the primary prevention of fractures, and the balance of benefits and harms cannot be determined that daily supplementation with 400 IU or less of vitamin D3 and 1,000 mg or less of calcium has no net benefit for the primary prevention of fractures.
Gonorrhea infection screening for in men and women at low risk for infection	False-positive test results, labeling
Hereditary hemochromatosis genetic screening in the asymptomatic general population	Screening could lead to identification of a large number of individuals who possess the high-risk genotype but may never manifest clinical disease. This may result in unnecessary surveillance, labeling, unnecessary invasive work-up, anxiety and potentially, unnecessary treatments.
Hepatitis B, screening general asymptomatic population for chronic infection	No evidence that screening the general population improves long-term health outcomes such as cirrhosis, hepatocellular carcinoma, or mortality
Hormone replacement: routine use of combined estrogen and progestin for the prevention of chronic conditions in postmenopausal women	Increased risk of breast cancer, venous thromboembolism, stroke, cholecystitis, dementia and lower global cognitive function

Recommend this service not be provided	Potential harms that outweigh benefits
Hormone replacement: routine use of unopposed estrogen in postmenopausal women who have had a hysterectomy, for the prevention of chronic conditions	Increased risk for venous thromboembolism, stroke, dementia and lower global cognitive function
HSV (genital Herpes) routine serological screening in asymptomatic adolescents, adults and pregnant women	False-positive test results, labeling and anxiety
Lead, elevated blood levels (BLLs) routine screening in asymptomatic children aged 1 to 5 years who are at average risk, and in asymptomatic pregnant women	Harms of treatment and residential lead hazard abatement; no evidence of treatment benefit
Ovarian cancer, routine screening	Major surgical interventions in women who do not have cancer
Pancreatic cancer, routine screening in asymptomatic adults using abdominal palpation, ultrasonography or serologic markers	Very low prevalence of pancreatic cancer, limited accuracy of available screening tests, invasive nature of diagnostic tests, poor outcomes of treatment
Prostate-Specific Antigen (PSA)-based screening for prostate cancer, all men	Very small potential benefit and significant potential harms. Clinicians should not screen with a PSA test unless the individual being screened understands what is known about PSA screening and makes a personal decision that even a small possibility of benefit outweighs the known risk of harms
Scoliosis, idiopathic routine screening of asymptomatic adolescents	Unnecessary brace wear, unnecessary referral for specialty care. Scoliosis needing aggressive treatment, such as surgery, is likely to be detected without screening.
Syphilis routine screening of asymptomatic persons not at risk for infection	Opportunity cost, false-positive tests, and labeling in a low-incidence population
Testicular cancer, routine screening in asymptomatic adolescent and adult males	False-positive results, anxiety, and harms from diagnostic tests or procedures
Vaginosis, bacterial, screening in asymptomatic pregnant women at low risk for preterm delivery	Evidence is fair that false-positive results from screening lead to harms due to treatment.

Annual Measurement for Effectiveness of Adult Preventive Guideline

- HEDIS® Colorectal Cancer Screening, Commercial and Medicare populations
- HEDIS® Chlamydia Screening in Women, Commercial population