The third report of the US Preventive Services Task Force

New guidelines are timely, accessible, and useful in primary care

Papers p 187

This month the first four installments in the third US Preventive Services Task Force (USPSTF) report are being published. Unlike the first two reports, published in 1989 and 1996 in single volumes, the third report will appear sequentially and in a variety of formats. Each of the topics reviewed by the Task Force will be available as: 1) a detailed, systematic evidence report published on the Agency for Healthcare Research and Quality's (AHRQ's) web site (www.ahrq.gov/clinic/uspstfix. htm), 2) a shorter synthesis of the evidence published in a variety of general medicine and family practice journals, and 3) a recommendation and rationale statement (R&R) containing the clinical conclusions derived by the Task Force.

The first four topics reviewed by the Task Force are screening for lipid disorders in adults, chlamydial infection, bacterial vaginosis during pregnancy, and skin cancer. The results are being published in a supplement to the *American Journal of Preventive Medicine*.[1] A clinical review of these four areas appears in this issue of *BMJ USA* (p 187).[2]

The primary mission of the USPSTF from its inception in 1984 has been to promote effective clinical prevention. Using evidence-based methodology, the Task Force reports have become the single best reference on the effectiveness of screening procedures. Still, studies have shown that primary care physicians have generally low awareness of and compliance with the USPSTF guidelines.[3-5] Barriers to guideline adoption are complex and involve both patient and clinician factors. Availability of the third Task Force report in a variety of formats, combined with changes in how it is disseminated, will address these deficiencies, in part, by improving accessibility. Publication of individual reports in specialty journals ensures that a wider audience will be reached. Web availability of technical reports and R&R statements is essential, given that provision of medical care increasingly relies on access to electronic information.

Timely dissemination of information has become a priority of the third Task Force and its new sponsor, the AHRQ (the first two reports were sponsored by the Office of Disease Prevention and Health Promotion). To that end, expedited evaluations may be performed on topics in which advances are being made. Publication of individual topic reviews as they are completed, rather than all at once in a single volume, will improve physician confidence that the information represents the current state of knowledge.

The R&R statements are concise and clearly written, making them practical to refer to in the middle of a busy clinic. The statements summarize the Task Force recommendations using terminology similar to that in the second report: A = strong recommendation for, B = recommendation for, C = no recommendation for or against, D = recommendation against, and I = insufficient evidence for recommendation for or against. Also included are the recommendations from other groups, which provide a useful counterpoint to the USPSTF guidelines.

Of the four recently published guidelines, the most surprising recommendation to many clinicians will be the "I" given to skin cancer screening, even in high-risk groups. The Task Force makes the point that when screening is done by nondermatologists, its sensitivity for detecting carcinomas or melanomas is probably lower than it is when done by dermatologists; also, such screening could lead to unnecessary biopsies and expense. Most importantly, the skin exam has not been shown to lower mortality, mainly because other than melanomas, most skin cancers are not fatal.

Guidelines for chlamydia screening are based on age, risk, pregnancy status, and symptoms, with the strongest "A" recommendation for sexually active women age 25 and under and other asymptomatic but high-risk women. Pregnant women under age 25, even though asymptomatic, get a "B" recommendation for screening, as do high-risk pregnant women at any age. Asymptomatic, low-risk pregnant women age 26 and older and asymptomatic low-risk women in the general population get a "C" recommendation (neither for nor against routine chlamydial infection screening). Primary care physicians who care for women will find these very specific guidelines useful in decision making.

Obstetricians and primary care physicians who do obstetric care may be a little puzzled by the recommendations on screening for bacterial vaginosis in pregnancy. The USPSTF concludes that the evidence is insufficient to recommend for or against routinely screening high-risk pregnant women for bacterial vaginosis ("I" recommendation), although they admit that some studies have found that screening and treatment of asymptomatic bacterial vaginosis in high-risk pregnant women reduces the incidence of preterm delivery (see the paper by Atkins on page 187 for a description of the studies). The "I" recommendation indicating "insufficient evidence" in this case really translates into "conflicting evidence," leaving the decision up to the discretion of the physician. The USPSTF recommends against routinely screening average-risk asymptomatic pregnant women for bacterial vaginosis because

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it does not improve outcomes, such as the incidence of preterm labor or preterm birth.

The statements also include sections on clinical considerations that go beyond just screening evidence. For example, the statement on screening for lipid disorders in adults includes discussions of whether to measure fasting or nonfasting samples, what is the optimal interval for screening, and what is the age at which screening can be stopped. Such practical considerations increase the usefulness of the statements and also aid the clinician in explaining to patients why it is not necessary to keep checking lipid levels yearly or why it is prudent to stop screening at age 65 (because it is unlikely that lipid levels change greatly after that).

The third Task Force decided that 55 of the 70 preventive care topics (over 100 actual services) from the second *Guide to Clinical Preventive Services* required updating due to availability of new evidence or continued controversy. In addition, 15 new topics were identified. New topics currently being reviewed by the third Task Force include chemoprevention of breast cancer, vitamin supplementation to prevent cancer and cardiovascular disease, counseling to promote breastfeeding, and screening for child developmental delay. In the spirit of responsiveness to its audience, the Task Force will take suggestions for new topics to review. The third USPSTF has made significant changes since the previous report was issued, and we look forward to reading the recommendations that follow.

Mary Ann Gilligan *assistant professor of medicine*

Rebekah Wang-Cheng *professor of medicine*

Department of Medicine, Division of General Internal Medicine, Medical College of Wisconsin, Froedtert East Office Building, Suite 4200, 9200 West Wisconsin Avenue, Milwaukee, Wisconsin 53226, USA (gilligan@mcw.edu)

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Prenatal diagnoses of sex chromosome conditions

Parents need more than just accurate information

Women who receive a prenatal diagnosis of a chromosome abnormality remember the circumstances precisely. Years later they recall the exact words used to deliver the news, and many regret the manner in which they were told.[1] They read between the lines messages that their fetus is no longer worthy of life and that their feelings about the pregnancy are not important. A test result showing that a fetus has a chromosomal difference leaves women and their partners with a permanent and life altering decision whether or not to continue the pregnancy. What do women and their partners need to make a decision that they can accept for the rest of their lives? How can health care providers best help them? A paper in the February 24, 2001 issue of the *BMJ* (see abstract at the end of this editorial) represents a first attempt to understand this process,[2] with disturbing results.

Prenatal testing for chromosomal conditions has been offered in industrialised nations since the 1970s. Yet little research has been done on pretest counselling, the communication of abnormal results, their impact on parents' decision making, or the long term outcomes of such decisions. Prenatal genetic counselling is provided by several different healthcare providers, including genetic counsellors, obstetric nurses, obstetricians, and maternal-fetal medicine specialists. In the United States practice is widely variable.[3] Often prenatal testing (amniocentesis or chorionic villus sampling) is performed without prenatal counselling, leaving women and their partners ill prepared for an unexpected finding. Guidelines for prenatal testing have been issued by The American College of Obstetricians and Gynecologists, but no practice standards exist in the US for prenatal testing education and counselling.[4] Abramsky et al's paper suggests this is also so in the United Kingdom.[2]

Abramsky et al performed a pilot study into the way that news is delivered to parents about a fetus discovered on prenatal testing to have a sex chromosome abnormality. They showed that often little or inaccurate information was provided.[2] They studied one of the most problematic categories of prenatal diagnosis: healthcare providers know little about sex chromosome abnormalities, the literature is often out of date and conflicting, and women and their partners less often choose to terminate pregnancies for other prenatal diagnoses.[5,6] Accurate descriptions of sex chromosome differences are critical, the decisions potentially regrettable, and the long term outcomes devastating if a termination is

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