MedStar Health

MedStar Health
Ambulatory Best Practice Group
Recommended Screening Guidelines for Adults
2019

The Ambulatory Best Practice Group, chartered in 2001 by MedStar Health Chief Medical Officer Dr. William Thomas, is composed of experts in primary care from across our system. This multidisciplinary group of health professionals meets on a regular basis to revise, update and create clinical practice guidelines relevant for adult patients seen in primary care practices. The Ambulatory Best Practice Group reports to the MedStar Primary Care Council.

During the preparation of these screening guidelines, the Ambulatory Quality Best Practices Group reviews multiple sources of information including current literature, community practice standards, expert opinion from subject matter experts from within our system, national recommendations from clinical specialty organizations and information available regarding recommendations for health and prevention screening guidelines.

This document is a summary of our recommendations for the appropriate screening of adult patients by primary care practitioners in the MedStar Health system. In each of the sections the recommendations are alphabetized. Note that the provision of preventive services may occur in a periodic health maintenance visit devoted to screening, counseling and prevention or be incorporated into follow up or urgent visits based on patient and clinician preferences and office workflows.

Successful implementation of the screening guidelines is at least in part related to a successful education process for providers, patients and families. To that end, we have included information that is available free of charge through specific Internet sites. At times the information on the Internet sites discusses some recommendations that have not been put forward in this document so elimination of that information is an important consideration prior to printing and distribution of the information.

These recommendations are provided to assist physicians and other clinicians making decisions regarding the care of their patients. As such, they cannot substitute for the individual judgment brought to each clinical situation by the patient's primary care provider and in collaboration with the patient. As with all clinical reference resources, they reflect the best understanding of the science of medicine at the time of publication, but should be used with the clear understanding that continued research may result in new knowledge and recommendations.

Federal and state law, particularly laws and regulations relative to provision of care under governmental programs such as Medicare/Medicaid, may mandate the provision of certain screening and preventive care. Any questions regarding these requirements should be reviewed with legal counsel or a member of our committee. Member names and phone numbers are listed on the next page of this document.

The Ambulatory Best Practice Group will review these guidelines on an annual basis for additions, deletions or clarifications and distribute as appropriate.

Initial Approval Date and Reviews:	**Most Recent Revision and Approval Date:**	**Next Scheduled Review Date:**
By 2010, 01/12, 01/14, 01/15, 01/16, 01/17, 01/18, 01/19 Ambulatory Best Practice Committee	**January 2019**	January 2020Ambulatory Best Practice Committee

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Adult Populations

Preventive Service	Guideline
Abdominal Aortic Aneurysm[1]	One-time screening for abdominal aortic aneurysm by ultrasonography in men age 65 to 75 years who have ever smoked.
Aspirin chemoprevention [2-6]	The USPSTF recommends initiating low-dose aspirin use for the primary prevention of cardiovascular disease (CVD) and colorectal cancer (CRC) in adults aged 50 to 59 years who have a 10% or greater 10-year CVD risk, are not at increased risk for bleeding, have a life expectancy of at least 10 years, and are willing to take low-dose aspirin daily for at least 10 years. The decision to initiate aspirin in patients between 60 and 69 should be individualized. There is insufficient evidence to assess the balance of benefits and harms for patients younger than age 50 or older than age 70 **A series of studies on aspirin use in primary prevention, published in 2018, highlight the very small risk-benefit ratio of aspirin in the primary prevention setting.**
Blood Pressure [7-8]	Blood pressure should be measured at each visit beginning at age 18. • "The USPSTF recommends annual screening for adults aged 40 years or older and for those who are at increased risk for high blood pressure. Persons at increased risk include those who have high-normal blood pressure (130 to 139/85 to 89 mm Hg), those who are overweight or obese, and African Americans. Adults aged 18 to 39 years with normal blood pressure (<130/85 mm Hg) who do not have other risk factors should be rescreened every 3 to 5 years. The USPSTF recommends rescreening with properly measured office blood pressure and, if blood pressure is elevated, confirming the diagnosis of hypertension with ABPM." • The ACC/AHA guideline recommends annual screening for HTN in all normotensive (BP < 120/80) patients with more frequent monitoring and management for patients with higher blood pressure readings.
Breast Cancer Screen Self Breast Exam (SBE)[9-13]	Beginning in their 20's, women should be told about the benefits and limitations of BSE, it is acceptable for women to choose not to do BSE, or to do it occasionally. The importance of promptly reporting changes to a physician is emphasized.
Clinical Breast Exam/Mammography [9-13]	A clinical breast exam (CBE) may be performed though there is insufficient evidence to assess additional benefit beyond that of mammography. For women in their 40's, the decision to perform mammography and the frequency of mammograms should be individualized. For women ages 50-74, mammograms should be performed biennially. For women > 75 years of age, the decision to continue screening should be individualized. Screening should be discontinued for women with a life expectancy < 10 years. Women known to be at increased risk (Family history, Positive Gail risk screen[13]) may benefit from earlier initiation of screening and/or referral to Breast Specialist.

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Preventive Service	Guideline
Cervical Cancer Screening [14-16]	Cervical cancer screening should begin at age 21 years (regardless of sexual history or HPV vaccination history*). Screening before age 21 should be avoided because women less than 21 years old are at very low risk of cancer. Screening these women may lead to unnecessary and harmful evaluation and treatment* (ACOG 2009). • Women from ages 21 to 29 should be screened every three years, using either the standard Pap or liquid-based cytology. HPV co-testing (cytology + HPV test administered together) should **not be** used for women aged <30 years • Women ages 30-65 may be screened once every three years with either the standard Pap or liquid-based cytology OR every 5 years with HPV testing alone or every 5 years with co-testing (cytology + HPV test administered together) • Women with certain risk factors may need more frequent screening, including those who have HIV, are immunosuppressed, were exposed to diethylstilbestrol (DES) in utero, and have been treated for cervical intraepithelial neoplasia (CIN) 2, CIN 3, or cervical cancer.(ACOG- 2009) • May discontinue screening >65 years in women with adequate screening history
Chlamydia & Gonorrhea Infection[17]	Sexually active women aged 24 years and younger and other asymptomatic women at increased risk for infection.
Cholesterol Screening[18-20]	• The age at which screening should begin should be based on an individual's other cardiac risk factors and desire to be screened. • Screening may begin in non-pregnant adults at any age but no later than age 40 (the age at which statin therapy for primary prevention is recommended). • 10-year risk should be re-evaluated every 4-6 yrs between 40-75 years old. • The development of diabetes or clinical ASCVD should prompt evaluation as well. • Screening may be done with either a fasting lipid profile or non-fasting total cholesterol and HDL measurement. If a non-fasting measurement reveals a triglyceride value > 400, a fasting lipid profile should be measured.
Colorectal Cancer Screening[21-24]	Beginning at age 50, both men and women at *average risk* for developing colorectal cancer should use one of the screening tests below. The tests that are designed to find both early cancer and polyps are preferred if these tests are available and the patient is willing to undergo one of these more invasive tests. **Tests that find polyps and cancer** ▪ Flexible sigmoidoscopy every 5 years* ▪ Colonoscopy every 10 years ▪ CT colonography (virtual colonoscopy) every 5 years* (consider community availability) ▪ Combination Flex sig every 10 yrs with annual FIT testing **Tests that mainly find cancer** ▪ Fecal occult blood test (FOBT) every year*,** ▪ Fecal immunochemical test (FIT) every year*,** ▪ FIT- DNA test (sDNA), q 1 or 3 yrs *Colonoscopy should be done if test results are positive. **For FOBT or FIT used as a screening test, the take-home multiple sample method should be used. A FOBT or FIT done during a digital rectal exam in the doctor's office is not adequate for screening.

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Preventive Service	Guideline
	Before age 50: Screening should be considered earlier and/or more often for individuals with any of the following colorectal cancer risk factors: personal Hx of colorectal cancer, a personal history of chronic inflammatory bowel disease (Crohns disease or ulcerative colitis), a strong family history of colorectal cancer or polyps (cancer or polyps in a first-degree relative [parent, sibling, or child] younger than 60 or in 2 or more first-degree relatives of any age), a known family history of hereditary colorectal cancer syndromes such as familial adenomatous polyposis (FAP) or hereditary non-polyposis colon cancer (HNPCC). The American Cancer Society has also issued a qualified recommendation that colon cancer screening be initiated at age 45 for average risk patients because of the rising incidence of colon cancer in people younger than age 50. The USPSTF recommends against screening in adults older than age 85 and that decisions between ages 75-85 should be individualized based on prior screening and overall health risks.
Counseling[25-34]	**For all adults, complete history using screening tools as specified for the following conditions not covered elsewhere:** ▪ Birth control/sexual behavior ▪ Violence detection/counseling ▪ Dental health ▪ Smoking ▪ Diet/nutrition ▪ Exercise—at least 150 minutes of moderate intensity or 75 minutes of vigorous intensity exercise per week ▪ Injury Prevention ▪ Skin Protection, particularly for adults less than 24 yrs of age and with fair skin types **For women of childbearing age**: • Screen for intimate partner violence and provide or refer women who screen positive to intervention services • Advise women planning or capable of pregnancy to take a folic acid supplement of 0.4-0.8 mg daily **Unhealthy alcohol use**: All adults age 18 and over should be screened for unhealthy alcohol use using the AUDIT-C or single question screening tool. Patients who screen positive for risky or hazardous drinking should receive brief behavioral counseling interventions. Patients with alcohol abuse or dependence should be referred for specialty treatment. **Unhealthy use of other drugs**: While the USPSTF currently states that there is insufficient evidence to support routine screening for use of illicit drugs or misuse of prescription drugs, others advocate a one sentence screening question: "How many times in the past year have you used an illegal drug or used a prescription medication for non-medical reasons?" **Obesity:** refer adults with a BMI of 30 or more to intensive multi-component behavioral counseling.

Preventive Service	Guideline
Diabetes Mellitus and Pre-Diabetes[35- 36]	The American Diabetes Association recommends that all individuals 45 years and older be screened. Testing should be considered in all adults who are overweight (BMI≥25 kg/m2 or ≥23 kg/m2 in Asian Americans) and have additional risk factors: • 1st degree relative with diabetes. • Physically inactive. • High-risk ethnic group (African American, Latino, Native or Asian Americans, Pacific Islanders). • Hypertension (≥140/90) or on therapy for hypertension. • PCOS, (polycystic ovary syndrome). • Plasma high-density lipoprotein cholesterol level <35 mg/dl or triglyceride level >250 mg/dl. • History of CVD. • Other clinical conditions associated with insulin resistance (e.g., severe obesity, acanthosis nigricans) Women with a history of gestational diabetes should have lifelong testing at least every 3 yrs In addition, the ADA diabetes risk test is another tool which may be used to assess appropriateness of screening.[36] Screening Methods: Fasting plasma glucose, 2 hr plasma glucose following 75 gm OGTT or A1C are all acceptable modalities. Re-screening should occur at a minimum every 3 yrs if results are normal with more frequent screening based on individual results and risk. Individuals with pre-diabetes, impaired glucose tolerance (140-199 mg/dl) or impaired fasting glucose (100-125 mg/dl) or an A1C of 5.7-6.4%-- should be tested annually. The USPSTF recommends screening for abnormal blood glucose as part of cardiovascular risk assessment in adults aged 40 to 70 years who are overweight or obese. Screening at an earlier age should be considered for those with a family history of diabetes, personal history of PCOS or gestational diabetes, or who are members of high risk ethnic groups.
Depression[37]	Screening for symptoms of depression should occur at the initial visit for all new patients and then annually for existing patients. The patient may complete screening during the office visit with a patient self-reported questionnaire or using one of the various screening measures that have been specifically designed to detect depression. Physicians can choose the screening measures that are appropriate for their patients and practice setting and for monitoring change in patients who are receiving treatment for depression.
Eye Disease Screening[38]	Baseline screening should start at age 40 for adults with no signs or risk factors for eye disease. Patients of any age with eye disease risk factors, such as high blood pressure, family history or diabetes, should consult with their ophthalmologist about frequency of eye exams.
Hearing [39-40]	Providers should perform subjective hearing screening periodically with counseling on hearing aid devices and making referrals as appropriate.

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Preventive Service	Guideline
Height and Weight[28], BMI	Baseline height, weight and BMI are indicated for all adults 18 yrs and older. Height and BMI annually. Weight Reduction Counseling should be recommended for all patients with BMI > 25kg/m^2 , and nutrition counseling should be given to those who are underweight (BMI < 18.5 kg/m2).
Hepatitis C Screening [41-42]	USPSTF & CDC recommend hepatitis C screening for all asymptomatic adults without known liver disease or functional abnormalities born between1945-1965. Other patients who should be screened include: • Those who have ever injected illegal drugs • Those who have received clotting factors made before 1987 • Those who have received blood/organs before July 1992 • Those who were ever on chronic hemodialysis • Those who have evidence of liver disease (elevated alanine aminotransferase [ALT] level) • Those who are infected with HIV
HIV Testing [43-44]	Testing for HIV infection should be performed routinely for all patients aged 13--64 years in an "opt out" fashion. All persons likely to be at high risk should be screened at least annually (high risk includes: *injection-drug users and their sex partners, persons who exchange sex for money or drugs, sex partners of HIV-infected persons, men having sex with men or heterosexual persons who themselves or whose sex partners have had more than one sex partner since their most recent HIV test)*. No written consent required however documentation in the medical record of informed consent is necessary in the state of Maryland.
Lung Cancer Screening [45]	The USPSTF recommends annual screening for lung cancer using low-dose CT scanning in adults aged 55-80 with a 30 pack year smoking history and who are current smokers or have quit within the past 15 yrs. Screening should be discontinued once a person has not smoked for 15 yrs, develops a health problem substantially limiting life expectancy, or is unable or unwilling to have curative lung surgery.
Osteoporosis Screening [46-47]	Recommend BMD testing to all women aged 65 and older regardless of additional risk factors. In postmenopausal women and men over age 50, recommend BMD testing when you have concern based on their risk factor profile. The WHO FRAX and other formal risk assessment tools can be used to estimate risk of osteoporosis. Routine screening of men age 70 and older regardless of additional risk factors is not recommended by the USPSTF but is by the National Osteoporosis Foundation and other groups. Bone mineral density testing should be performed on all women who are postmenopausal with fractures to confirm the diagnosis of osteoporosis and determine the severity of disease (ACOG). The timing of repeat screening should be individualized based on baseline results but should occur no more often than every 2 yrs.

Preventive Service	Guideline
Ovarian Cancer Screening[48]	The USPSTF recommends against screening average risk women for ovarian cancer.
Prostate Cancer Screening [49-54]	Offer and discuss risks and benefits of PSA-based screening and digital rectal examinations to detect prostate cancer in men age 50 who are at average risk of prostate cancer and are expected to live at least 10 more years. Discussion should begin at age 45 for men at high risk (African-American men and men with a strong family history of one or more first-degree relatives [father, brothers] diagnosed before age 65. Men at even higher risk, due to multiple first-degree relatives affected at an early age, should be counseled at age 40 (ACS). • The USPSTF recommends that for men ages 55-69, the decision to screen for prostate cancer be individualized after a discussion of risks and benefits and based on patient preference (49). • The American Academy of Family Physicians does not recommend routine screening for prostate cancer but suggests that men ages 55-69 who are considering screening engage in a discussion of risks and benefits with their clinicians (53). • The American Cancer Society emphasizes informed decision making for prostate cancer screening: men at average risk should receive information beginning at age 50 years, and black men or men with a family history of prostate cancer should receive information at age 45 years (50). • The American College of Preventive Medicine recommends that clinicians discuss the potential benefits and harms of PSA screening with men aged 50 years or older, consider their patients' preferences, and individualize screening decisions (54). Men who choose to be tested who have a PSA of less than 2.5 ng/ml may only need to be retested every 2 years. Screening (if done) should be done yearly for men whose PSA level is 2.5 ng/ml or higher.
Syphilis Screening [55]	All pregnant patients and all non-pregnant patients at increased risk of syphilis exposure should be screened. Such patients include but may not be limited to men who have sex with men, HIV infected patients, commercial sex workers, patients who have been incarcerated, men younger than age 29 and patients living in areas of high prevalence.
Testicular Self-Exam [56]	Testicular cancer screening (by clinicians or by patient self-exam) is not recommended because of the uncommon nature of the condition and the high cure rate when detected.
Tuberculosis Screening [57]	Screening for latent tuberculosis should be performed in groups at increased risk of exposure and increased risk of developing active disease including patients living in homeless shelters or correctional institutions, patients coming from countries with high prevalence of TB, immunosuppressed patients, patients with silicosis, and patients with TB exposure (household contacts or occupational exposure).
IMMUNIZATIONS	**For complete CDC recommendations for Adult Immunizations go to:** **https://www.cdc.gov/vaccines/schedules/hcp/adult.html**

Footnotes:

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