



MedStar Health Ambulatory Best Practice Group Recommended Screening Guidelines for Adults 2021

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 the 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.

<p><u>Initial Approval Date and Reviews:</u> By 2010, 01/12, 01/14, 01/15, 01/16, 01/17, 01/18, 01/19, 01/20, 1/21 Ambulatory Best Practice Committee</p>	<p><u>Most Recent Revision and Approval Date:</u> <u>January 2021</u> © Copyright MedStar Health, 2014</p>	<p><u>Next Scheduled Review Date:</u> January 2022 Ambulatory Best Practice Committee</p>
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Adult Populations

Preventive Service	Guideline
Abdominal Aortic Aneurysm ¹	<p>For men aged 65-75 who have ever smoked: One-time screening for abdominal aortic aneurysm by ultrasonography</p> <p>For men aged 65-75 who have never smoked: Selectively offer screening for abdominal aortic aneurysm by ultrasonography based on patient's medical history, family history, other risk factors and personal values.</p> <p>For women aged 65-75 who have ever smoked or have a family history of AAA: evidence for screening for AAA is insufficient</p> <p>For women aged 65-75 who have never smoked and have no family history of AAA: Do not screen for AAA</p>
Aspirin chemoprevention ²⁻⁷	<p>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.</p> <p>There is insufficient evidence to assess the balance of benefits and harms for patients younger than age 50 or older than age 70</p> <p>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.</p> <p>The American College of Cardiology recommends that aspirin might be considered for the primary prevention of ASCVD among select adults 40 to 70 years of age who are at higher ASCVD risk but not at increased bleeding risk</p>
Blood Pressure ⁸⁻⁹	<p>Blood pressure should be measured at each visit beginning at age 18.</p> <ul style="list-style-type: none"> • “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 Screening: Self Breast Exam (SBE) ¹⁰⁻¹⁴	<p>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.</p>

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Preventive Service	Guideline
Breast Cancer Screening; Clinical Breast Exam/Mammography ¹⁰⁻¹⁴	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.
Breast Cancer Screening: Risk assessment and Risk Reduction ¹⁵⁻¹⁶	Women with a personal or family history of breast, ovarian, tubal or peritoneal cancer or who have an ancestry associated with BRCA 1 / 2 gene mutations should be assessed with an appropriate brief familial risk assessment tool. Those with a positive result should receive genetic counseling, and if indicated, genetic testing. Suitable screening tools include the Ontario Family History Assessment Tool, Manchester Scoring System, Referral Screening Tool, Pedigree Assessment Tool, 7-Question Family History Screening Tool, Tyrer-Cuzick tool and brief versions of BRCAPRO. Clinicians should offer to prescribe risk reducing medications such as tamoxifen, raloxifene or aromatase inhibitors to women at increased risk for breast cancer (women with LCIS, atypical hyperplasia and 5yr risk > 3% calculated by NCI Breast Cancer Risk Assessment Tool) at low risk for adverse medication effects.
Cervical Cancer Screening ¹⁷⁻¹⁹	Cervical cancer screening should begin at age 21 years (regardless of sexual history or HPV vaccination history). <i>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).</i> <ul style="list-style-type: none"> • 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 ²⁰	Sexually active women aged 24 years and younger and other asymptomatic women at increased risk for infection.
Cholesterol Screening ²¹⁻²³	<ul style="list-style-type: none"> • 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 the ages of 40 and 75. • 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

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	a non-fasting measurement reveals a triglyceride value > 400, a fasting lipid profile should be measured.
Cognitive Impairment in older adults ²⁴	The USPSTF concludes that the current evidence is insufficient to assess the balance of benefits and harms of screening for cognitive impairment in older adults.
Colorectal Cancer Screening ²⁵⁻²⁸	<p>Beginning at age 50, both men and women at <i>average risk</i> 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.</p> <p>Tests that find polyps and cancer</p> <ul style="list-style-type: none"> ▪ 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 <p>Tests that mainly find cancer</p> <ul style="list-style-type: none"> ▪ Fecal occult blood test (FOBT) every year*,** ▪ Fecal immunochemical test (FIT) every year*,** ▪ FIT- DNA test (sDNA), q 1 or 3 yrs <p>*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.</p> <p>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).</p> <p>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.</p> <p>The USPSTF recommends against screening in adults older than age 85 and recommends that decisions between ages 75-85 should be individualized based on prior screening and overall health risks.</p>

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Preventive Service	Guideline
Counseling ^{7, 29-39}	<p>For all adults, screen using appropriate screening tools as specified for the following conditions not covered elsewhere:</p> <ul style="list-style-type: none"> ▪ 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 <p>For women of childbearing age:</p> <ul style="list-style-type: none"> • 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 <p>Alcohol use screening and counseling:</p> <ul style="list-style-type: none"> • 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. Risky drinking is defined as more than 4 drinks per day or 14 drinks per week for men ages 21-64 and more than 3 drinks per day or 7 drinks per week for women of any age and men 65 or older. • Individuals who do not drink alcohol should not be advised to start. • Individuals who already drink alcohol should be advised to drink in moderation--for women ≤ 1 drink/day and for men ≤ 2 drinks per day.* <ul style="list-style-type: none"> • Alcohol consumption has been associated with an increased risk of developing hypertension and cancer (including breast, colorectal, liver, stomach and aerodigestive) • There is evidence that moderate alcohol consumption may be protective in at least some people against coronary artery disease. <p>*A standard drink is defined as 5 ounces of wine, 12 ounces of beer or 1.5 ounces of distilled spirits</p> <p>Unhealthy use of other drugs: All adults age 18 and should be screened for unhealthy drug use by asking questions (not testing biological specimens). Evidence is insufficient to recommend screening for adolescents. 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?” is highly sensitive and specific both for drug use in the past year as well as a drug use disorder. Multiple other screening tools including the NIDA Quick Screen (4 questions) or longer tools (such as ASSIST) are also available.</p>

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	<p>Obesity: refer adults with a BMI of 30 or more to intensive multi-component behavioral counseling.</p> <p>Adults with cardiovascular disease (CVD) risk factors: The USPSTF recommends offering or referring adults with CVD risk factors to behavioral counseling interventions to promote a healthy diet and physical activity.</p>
<p>Diabetes Mellitus and Pre-Diabetes ⁴⁰⁻⁴¹</p>	<p>The American Diabetes Association recommends that all individuals 45 years and older be screened for diabetes and pre-diabetes.</p> <p>Testing should be considered in all adults who are overweight (BMI\geq25 kg/m² or \geq23 kg/m² in Asian Americans) who have one or more additional risk factors:</p> <ul style="list-style-type: none"> • 1st degree relative with diabetes. • Physically inactive. • High-risk ethnic group (African American, Latino, Native or Asian Americans, Pacific Islanders). • Hypertension (\geq140/90) 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) <p>Women planning pregnancy who are overweight or obese and/or have one or more additional risk for diabetes should be screened for diabetes and pre-diabetes.</p> <p>Patients with HIV should be screened for diabetes and pre-diabetes with a fasting glucose test before starting antiretroviral therapy, at the time of switching antiretroviral therapy, and 3-6 months after starting or switching antiretroviral therapy. If initial screening results are normal, fasting glucose should be checked annually.</p> <p>In addition, the ADA diabetes risk test is a tool which may be used to assess appropriateness of screening.⁴¹</p> <p>Screening Methods: Fasting plasma glucose, 2 hr plasma glucose following 75 gm OGTT or A1C are equally acceptable modalities.</p> <p>Screening Frequency: Re-screening should occur at a minimum every 3 yrs if results are normal with more frequent screening based on individual results and risk.</p> <p>Individuals with pre-diabetes (A1C 5.7-6.4%), impaired glucose tolerance (140-199 mg/dl) or impaired fasting glucose (100-125 mg/dl) should be tested annually.</p> <p>Women with a history of gestational diabetes should have lifelong testing at least every 3 yrs</p>

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	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 ⁴²	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 ⁴³	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 ⁴⁴⁻⁴⁵	Providers should perform subjective hearing screening periodically with counseling on hearing aid devices and making referrals as appropriate.
Height and Weight ³¹ , 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/m ²).
Hepatitis B Screening ⁴⁶	<p>The USPSTF recommends screening for hepatitis B virus infection in adolescents and adults at increased risk for infection using HBsAg testing. Persons at increased risk include:</p> <ul style="list-style-type: none"> • Persons who have used intravenous drugs • Men who have sex with men • HIV infected persons • Sexual partners or household contacts of hepatitis B infected persons • Adults and adolescents born in countries with ≥ 2% prevalence of hepatitis B • Adults and adolescents born in the US and who did not receive the hepatitis B vaccine as children and who are children of parents born in countries with ≥ 8% prevalence of hepatitis B <p>(Link to countries with moderate and high prevalence of hepatitis B): https://uspreventiveservicestaskforce.org/uspstf/recommendation/hepatitis-b-virus-infection-screening#fig</p>
Hepatitis C Screening ⁴⁷⁻⁴⁸	The USPSTF recommends screening all adults 18-79 for hepatitis C one time. Persons at continued risk (persons with past or current injection drug use) should be screened periodically.

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HIV Testing ⁴⁹⁻⁵⁰ and Pre-exposure Prophylaxis (PrEP) ⁵¹	<p>Testing for HIV infection should be performed routinely for all patients aged 15--65 years in an "opt out" fashion. All persons likely to be at high risk should be screened at least annually (high risk includes: <i>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</i>).</p> <p>No written consent required however documentation in the medical record of informed consent is necessary in the state of Maryland.</p> <p>The USPSTF recommends that clinicians offer preexposure prophylaxis (PrEP) with effective antiretroviral therapy to persons who are at high risk of HIV acquisition:</p> <ol style="list-style-type: none"> 1. Men who have sex with men, are sexually active, and have 1 of the following characteristics: <ul style="list-style-type: none"> • A serodiscordant sex partner (ie, in a sexual relationship with a partner living with HIV) • Inconsistent use of condoms during receptive or insertive anal sex • A sexually transmitted infection (STI) with syphilis, gonorrhea, or chlamydia within the past 6 months 2. Heterosexually active women and men who have 1 of the following characteristics: <ul style="list-style-type: none"> • A serodiscordant sex partner (ie, in a sexual relationship with a partner living with HIV) • Inconsistent use of condoms during sex with a partner whose HIV status is unknown and who is at high risk (eg, a person who injects drugs or a man who has sex with men and women) • An STI with syphilis or gonorrhea within the past 6 months 3. Persons who inject drugs and have 1 of the following characteristics: <ul style="list-style-type: none"> • Shared use of drug injection equipment
Lung Cancer Screening ⁵²	<p>The USPSTF recommends annual screening for lung cancer using low-dose CT scanning in adults aged 50-80 with a 25 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.</p>
Osteoporosis Screening ⁵³⁻⁵⁴	<p>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).</p> <p>The timing of repeat screening should be individualized based on baseline results but should occur no more often than every 2 yrs.</p>

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Preventive Service	Guideline
Ovarian Cancer Screening ⁵⁵	The USPSTF recommends against screening average risk women for ovarian cancer.
Pancreatic Cancer ⁵⁶	The USPSTF recommends against screening for pancreatic cancer in asymptomatic adults
Prostate Cancer Screening ⁵⁷⁻⁶²	<p>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).</p> <ul style="list-style-type: none"> • 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). <p>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.</p>
Syphilis Screening ⁶³	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 ⁶⁴	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 ⁶⁵	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).

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Preventive Service	Guideline
IMMUNIZATIONS	<p>For complete CDC recommendations for Adult Immunizations go to: https://www.cdc.gov/vaccines/schedules/hcp/adult.html</p>

Footnotes:

1. U.S. Preventive Services Task Force (USPSTF, December 2019). Screening for Abdominal Aortic Aneurysm: Recommendation Statement. <https://www.uspreventiveservicestaskforce.org/Page/Document/UpdateSummaryFinal/abdominal-aortic-aneurysm-screening1>
2. U.S. Preventive Services Task Force (USPSTF, April 2016). Aspirin for the Prevention of Cardiovascular Disease and Colorectal Cancer: Preventive Medication. <https://www.uspreventiveservicestaskforce.org/Page/Document/UpdateSummaryFinal/aspirin-to-prevent-cardiovascular-disease-and-cancer>
3. Guidelines for the Primary Prevention of Stroke .A Statement for Healthcare Professionals From the American Heart Association/American Stroke Association. Stroke 2014; 45: 3754-3832.
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5. Effect of Aspirin on All-Cause Mortality in the Healthy Elderly.McNeil JJ, Nelson MR, Woods RL, Lockery JE, Wolfe R, Reid CM, Kirpach B, Shah RC, Ives DG, Storey E, Ryan J, Tonkin AM, Newman AB, Williamson JD, Margolis KL, Ernst ME, Abhayaratna WP, Stocks N, Fitzgerald SM, Orchard SG, Trevaks RE, Beilin LJ, Donnan GA, Gibbs P, Johnston CI, Radziszewska B, Grimm R, Murray AM, ASPREE Investigator Group N Engl J Med. 2018;379(16):1519. Epub 2018 Sep 16.
6. Use of aspirin to reduce risk of initial vascular events in patients at moderate risk of cardiovascular disease (ARRIVE): a randomised, double-blind, placebo-controlled trial.Gaziano JM, Brotons C, Coppolecchia R, Cricelli C, Darius H, Gorelick PB, Howard G, Pearson TA, Rothwell PM, Ruilope LM, Tendera M, Tognoni G, ARRIVE Executive Committee Lancet. 2018;392(10152):1036. Epub 2018 Aug 26.
7. 2019 ACC/AHA Guideline on the Primary Prevention of Cardiovascular Disease: Executive Summary. JACC 2019. 74: 1376-1414).
8. U.S. Preventive Services Task Force (USPSTF, October 2015). Blood Pressure in Adults (Screening). <http://www.uspreventiveservicestaskforce.org/Page/Document/RecommendationStatementFinal/high-blood-pressure-in-adults-screening>
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