Complete Summary

GUIDELINE TITLE

Screening for gestational diabetes mellitus: U.S. Preventive Services Task Force recommendation statement.

BIBLIOGRAPHIC SOURCE(S)

U.S. Preventive Services Task Force. Screening for gestational diabetes mellitus: U.S. Preventive Services Task Force recommendation statement. Ann Intern Med 2008 May 20;148(10):759-65. PubMed

GUIDELINE STATUS

This is the current release of the guideline.

This guideline updates a previous version: U.S. Preventive Services Task Force (USPSTF). Screening for gestational diabetes mellitus: recommendations and rationale. Obstet Gynecol 2003 Feb;101(2):393-5.

COMPLETE SUMMARY CONTENT

SCOPE

DISEASE/CONDITION(S)

Gestational diabetes mellitus (GDM)

GUIDELINE CATEGORY

Prevention
Screening

CLINICAL SPECIALTY

Endocrinology
Family Practice
Internal Medicine
Obstetrics and Gynecology

INTENDED USERS

Advanced Practice Nurses
Allied Health Personnel
Health Care Providers
Nurses
Physician Assistants
Physicians

GUIDELINE OBJECTIVE(S)

- To summarize the current U.S. Preventive Services Task Force (USPSTF) recommendations and supporting scientific evidence on screening for gestational diabetes
- To update the 2003 USPSTF recommendations on screening for gestational diabetes

TARGET POPULATION

Pregnant women who have not previously been diagnosed with diabetes

INTERVENTIONS AND PRACTICES CONSIDERED

Routine screening for gestational diabetes mellitus (GDM) using a glucose challenge test (GCT) followed by an oral glucose tolerance test (OGTT) for women who screen positive on the glucose challenge test

MAJOR OUTCOMES CONSIDERED

Key Question 1: Does screening for gestational diabetes mellitus (GDM) lead to a reduction in perinatal morbidity and mortality for mother and/or infant? A) after 24 weeks gestation? B) during the first trimester and up to 24 weeks gestation?

Key Question 2: What are the sensitivities, specificities, reliabilities, and yields of current screening tests for GDM: A) after 24 weeks gestation? B) during the first trimester and up to 24 weeks gestation?

Key Question 3: Does treatment for GDM lead to reduction in perinatal morbidity and mortality for mother and/or infant? A) after 24 weeks gestation? B) during the first trimester and up to 24 weeks gestation?

Key Question 4: What are the adverse effects associated with screening for GDM?

Key Question 5: What are the adverse effects associated with treatment of GDM?

METHODOLOGY

METHODS USED TO COLLECT/SELECT EVIDENCE

Hand-searches of Published Literature (Primary Sources)
Hand-searches of Published Literature (Secondary Sources)
Searches of Electronic Databases

DESCRIPTION OF METHODS USED TO COLLECT/SELECT THE EVIDENCE

Note from the National Guideline Clearinghouse (NGC): A systematic evidence review was prepared by the Oregon Evidence-based Practice Center (EPC) for use by the U.S. Preventive Services Task Force (USPSTF) (see the "Availability of Companion Documents" field).

Literature Search Strategy

EPC staff conducted six database searches (see Appendix A, Table 2 in the Evidence Synthesis [see "Availability of Companion Documents" field) of Medline, Cochrane Central Registry of Controlled Trials, Cochrane Database of Systematic Reviews, Database of Abstracts of Reviews of Effectiveness, Health Technology Assessment, and the National Institute for Health and Clinical Excellence from 2000 to September 2006. The search regarding early screening searched 1966 to 1999 as this was not systematically reviewed for the 2003 report. Searches were extensively supplemented with the previous 2003 USPSTF review, outside source material from experts in the field, and from examining the bibliographies of other relevant systematic reviews.

Inclusion and Exclusion

While EPC staff conducted five searches to cover the separate focus of each KQ, they dual-reviewed all abstracts for potential inclusion for any of the KQs, utilizing the inclusion/exclusion criteria described in Appendix A, Table 3 of the Evidence Synthesis (see the "Availability of Companion Documents" field). For KQ1 and 3, they limited study design to randomized controlled trials (RCT) and controlled clinical trials (CCT) and accepted prospective studies if no RCTs or CCTs were available. For KQ 2, 4, and 5 they accepted RCTs, CCTs, and good quality observational studies.

NUMBER OF SOURCE DOCUMENTS

Key Question 1: No randomized controlled trials (RCTs) comparing screening with no screening were located.

Key Question 2: No articles were found that reported sensitivity, specificity, and yield rates in a U.S. population using one of the three acceptable screening methods compared to an acceptable reference standard of the specified health outcomes.

Key Question 3: Seven studies reported in eight publications are included for part A ($\geq$24 weeks gestation) of which two are treatment versus no treatment.

The remaining five studies are treatment comparisons. One prospective study evaluating early screening versus late screening and neonatal and maternal outcomes is included for part B (<24 weeks gestation).

Key Question 4: Three trials reporting on the harms of screening were included.

Key Question 5: Seven articles were found to address the harms of treatment.

METHODS USED TO ASSESS THE QUALITY AND STRENGTH OF THE EVIDENCE

Expert Consensus

RATING SCHEME FOR THE STRENGTH OF THE EVIDENCE

Not applicable

METHODS USED TO ANALYZE THE EVIDENCE

Systematic Review with Evidence Tables

DESCRIPTION OF THE METHODS USED TO ANALYZE THE EVIDENCE

Note from the National Guideline Clearinghouse (NGC): A systematic evidence review was prepared by the Oregon Evidence-based Practice Center (EPC) for use by the U.S. Preventive Services Task Force (USPSTF) (see the "Availability of Companion Documents" field).

Article Review and Data Abstraction

Two investigators applied the inclusion/exclusion criteria to each article and marked articles for exclusion as soon as any one exclusion criteria was met. They then rated the quality of all articles meeting inclusion criteria, using the USPSTF's study-design specific criteria (Appendix B in the Evidence Synthesis [see the "Availability of Companion Documents" field), which resulted in additional excluded articles for quality reasons. Listings of excluded articles along with the reason for exclusion are in Appendix D Table 1 in the Evidence Synthesis (see the "Availability of Companion Documents" field).

There are 13 studies included in this review: seven from the 2003 USPSTF review and six located from searches or outside sources. One primary reviewer abstracted relevant information such as study setting, population, screening method, and outcomes into standardized evidence tables for each included article (Appendix C in the Evidence Synthesis [see the "Availability of Companion Documents" field]). A second reviewer checked the abstraction process for accuracy.

Literature Synthesis

EPC staff members were unable to conduct quantitative synthesis for any key question due to the heterogeneity of the screening methods and interventions.

Instead, they qualitatively summarized their findings in the results text and summary tables. For Key Question 3, they stratified the evidence by those trials comparing treatment versus no treatment and trials comparing treatments.

METHODS USED TO FORMULATE THE RECOMMENDATIONS

Balance Sheets
Expert Consensus

DESCRIPTION OF METHODS USED TO FORMULATE THE RECOMMENDATIONS

The U.S. Preventive Services Task Force (USPSTF) systematically reviews the evidence concerning both the benefits and harms of widespread implementation of a preventive service. It then assesses the certainty of the evidence and the magnitude of the benefits and harms. On the basis of this assessment, the USPSTF assigns a letter grade to each preventive service signifying its recommendation about provision of the service (see Table below). An important, but often challenging, step is determining the balance between benefits and harms to estimate "net benefit" (that is, benefits minus harms).

Table 1. U.S. Preventive Services Task Force Recommendation Grid*

Certainty of Net Benefit	Magnitude of Net Benefit			
	Substantial	Moderate	Small	Zero/Negative
High	A	B	C	D
Moderate	B	B	C	D
Low	Insufficient			

**A*, *B*, *C*, *D*, and *I (Insufficient)* represent the letter grades of recommendation or statement of insufficient evidence assigned by the U.S. Preventive Services Task Force after assessing certainty and magnitude of net benefit of the service (see the "Rating Scheme for the Strength of the Recommendations" field.

The overarching question that the Task Force seeks to answer for every preventive service is whether evidence suggests that provision of the service would improve health outcomes if implemented in a general primary care population. For screening topics, this standard could be met by a large randomized, controlled trial (RCT) in a representative asymptomatic population with follow-up of all members of both the group "invited for screening" and the group "not invited for screening."

Direct RCT evidence about screening is often unavailable, so the Task Force considers indirect evidence. To guide its selection of indirect evidence, the Task Force constructs a "chain of evidence" within an analytic framework. For each key question, the body of pertinent literature is critically appraised, focusing on the following 6 questions:

1. Do the studies have the appropriate research design to answer the key question(s)?

2. To what extent are the existing studies of high quality? (i.e., what is the internal validity?)
3. To what extent are the results of the studies generalizable to the general U.S. primary care population and situation? (i.e., what is the external validity?)
4. How many studies have been conducted that address the key question(s)? How large are the studies? (i.e., what is the precision of the evidence?)
5. How consistent are the results of the studies?
6. Are there additional factors that assist us in drawing conclusions (e.g., presence or absence of dose-response effects, fit within a biologic model)?

The next step in the Task Force process is to use the evidence from the key questions to assess whether there would be net benefit if the service were implemented. In 2001, the USPSTF published an article that documented its systematic processes of evidence evaluation and recommendation development. At that time, the Task Force's overall assessment of evidence was described as good, fair, or poor. The Task Force realized that this rating seemed to apply only to how well studies were conducted and did not fully capture all of the issues that go into an overall assessment of the evidence about net benefit. To avoid confusion, the USPSTF has changed its terminology. Whereas individual study quality will continue to be characterized as good, fair, or poor, the term *certainty* will now be used to describe the Task Force's assessment of the overall body of evidence about net benefit of a preventive service and the likelihood that the assessment is correct. Certainty will be determined by considering all 6 questions listed above; the judgment about certainty will be described as high, moderate, or low.

In making its assessment of certainty about net benefit, the evaluation of the evidence from each key question plays a primary role. It is important to note that the Task Force makes recommendations for real-world medical practice in the United States and must determine to what extent the evidence for each key question—even evidence from screening RCTs or treatment RCTs—can be applied to the general primary care population. Frequently, studies are conducted in highly selected populations under special conditions. The Task Force must consider differences between the general primary care population and the populations studied in RCTs and make judgments about the likelihood of observing the same effect in actual practice.

It is also important to note that 1 of the key questions in the analytic framework refers to the potential harms of the preventive service. The Task Force considers the evidence about the benefits and harms of preventive services separately and equally. Data about harms are often obtained from observational studies because harms observed in RCTs may not be representative of those found in usual practice and because some harms are not completely measured and reported in RCTs.

Putting the body of evidence for all key questions together as a chain, the Task Force assesses the certainty of net benefit of a preventive service by asking the 6 major questions listed above. The Task Force would rate a body of convincing evidence about the benefits of a service that, for example, derives from several RCTs of screening in which the estimate of benefits can be generalized to the general primary care population as "high" certainty (see the "Rating Scheme for the Strength of Recommendations" field). The Task Force would rate a body of

evidence that was not clearly applicable to general practice or has other defects in quality, research design, or consistency of studies as "moderate" certainty. Certainty is "low" when, for example, there are gaps in the evidence linking parts of the analytic framework, when evidence to determine the harms of treatment is unavailable, or when evidence about the benefits of treatment is insufficient. Table 4 in the methodology document listed below (see "Availability of Companion Documents" field) summarizes the current terminology used by the Task Force to describe the critical assessment of evidence at all 3 levels: individual studies, key questions, and overall certainty of net benefit of the preventive service.

Sawaya GF et al., Update on the methods of the U.S. Preventive Services Task Force: estimating certainty and magnitude of net benefit. Ann Intern Med. 2007;147:871-875 [5 references].

RATING SCHEME FOR THE STRENGTH OF THE RECOMMENDATIONS

What the United States Preventive Services Task Force (USPSTF) Grades Mean and Suggestions for Practice

Grade	Grade Definitions	Suggestions for Practice
A	The USPSTF recommends the service. There is high certainty that the net benefit is substantial.	Offer or provide this service.
B	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.	Offer or provide this service.
C	The USPSTF recommends against routinely providing the service. There may be considerations that support providing the service in an individual patient. There is moderate or high certainty that the net benefit is small.	Offer/provide this service only if there are other considerations in support of the offering/providing the service in an individual patient.
D	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.
I Statement	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.	Read "Clinical Considerations" section of USPSTF Recommendation Statement (see "Major Recommendations" field). If offered, patients should understand the uncertainty about the balance of benefits and harms.

USPSTF Levels of Certainty Regarding Net Benefit

Definition: The U.S. Preventive Services Task Force defines certainty as "likelihood that the USPSTF assessment of the net benefit of a preventive service is correct." The net benefit is defined as benefit minus harm of the preventive service as implemented in a general, primary care population. The USPSTF assigns a certainty level based on the nature of the overall evidence available to assess the net benefit of a preventive service.

Level of Certainty	Description
High	The 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.
Moderate	The available evidence is sufficient to determine the effects of the preventive service on health outcomes, but confidence in the estimate is constrained by factors such 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.
Low	The available evidence is insufficient to assess effects on health outcomes. Evidence is insufficient because of: • The limited number or size of studies • Important flaws in study design or methods • Inconsistency of findings across individual studies • Gaps in the chain of evidence • Findings not generalizable to routine primary care practice • A lack of information on important health outcomes More information may allow an estimation of effects on health outcomes.

COST ANALYSIS

A formal cost analysis was not performed and published cost analyses were not reviewed.

METHOD OF GUIDELINE VALIDATION

Comparison with Guidelines from Other Groups
External Peer Review
Internal Peer Review

DESCRIPTION OF METHOD OF GUIDELINE VALIDATION

Peer Review. Before the U.S. Preventive Services Task Force (USPSTF) makes its final determinations about recommendations on a given preventive service, the Evidence-based Practice Center and the Agency for Healthcare Research and Quality send a draft systematic evidence review to 4 to 6 external experts and to federal agencies. They ask the experts to examine the review critically for accuracy and completeness and to respond to a series of specific questions about the document. After assembling these external review comments and documenting the proposed response to key comments, the topic team presents this information to the Task Force in memo form. In this way, the Task Force can consider these external comments and a final version of the systematic review before it votes on its recommendations about the service. Draft recommendations are then circulated for comment from reviewers representing professional societies, voluntary organizations and Federal agencies. These comments are discussed before the whole U.S. Preventive Services Task Force before final recommendations are confirmed.

Recommendations of Others. Recommendations regarding screening for gestational diabetes were discussed from the following groups: American College of Obstetricians and Gynecologists (ACOG), American Diabetes Association (ADA), and the American Academy of Family Physicians (AAFP).

RECOMMENDATIONS

MAJOR RECOMMENDATIONS

The US Preventive Services Task Force (USPSTF) grades its recommendations (A, B, C, D, or I) and identifies the Levels of Certainty regarding Net Benefit (High, Moderate, and Low). The definitions of these grades can be found at the end of the "Major Recommendations" field.

Summary of Recommendations and Evidence

The USPSTF concludes that the current evidence is insufficient to assess the balance of benefits and harms of screening for gestational diabetes mellitus (GDM), either before or after 24 weeks gestation. **This is an I statement**.

Clinical Considerations

Patient Population Under Consideration

This recommendation concerns pregnant women who have not previously been diagnosed with diabetes.

Suggestions for Practice Regarding the I Statement

Until there is better evidence, clinicians should discuss screening for GDM with their patients and make case-by-case decisions. Discussions should include information about the uncertainty of benefits and harms as well as the frequency of positive screening test results.

Assessment of Risk

Women who are obese, older than 25 years of age, have a family history of diabetes, have a history of previous GDM, or are of certain ethnic groups (Hispanic, American Indian, Asian, or African-American) are at increased risk of developing GDM.

Screening Tests

In the United States, the most common screening test is an initial 50-gram 1-hour glucose challenge test (GCT). If the result of the GCT is abnormal, variably defined as either greater than 130 mg/dL or 140 mg/dL, the patient undergoes a 100-gram 3-hour oral glucose tolerance test (OGTT). Two or more abnormal values on the OGTT are considered a diagnosis of GDM.

Time of Screening

Most screening is conducted between 24 and 28 weeks gestation. There is little evidence about the value of earlier screening.

Treatment

Treatment usually includes recommendations for physical activity and dietary modification. In addition, treatment sometimes includes medication (either insulin or oral hypoglycemic agents), support from diabetes educators and nutritionists, and increased surveillance in prenatal care. The extent to which these interventions improve health outcomes is uncertain.

Other Approaches to Prevention

Nearly all pregnant women should be encouraged to achieve moderate weight gain based on their pre-pregnancy body mass index (BMI) and to participate in physical activity.

Definitions:

What the United States Preventive Services Task Force (USPSTF) Grades Mean and Suggestions for Practice

Grade	Grade Definitions	Suggestions for Practice
A	The USPSTF recommends the service. There is high certainty that the net benefit is substantial.	Offer or provide this service.
B	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.	Offer or provide this service.
C	The USPSTF recommends against routinely providing the service. There may be considerations that support providing the service in an	Offer/provide this service only if there are other considerations in support of the offering/providing the service in an individual patient.

Grade	Grade Definitions	Suggestions for Practice
	individual patient. There is moderate or high certainty that the net benefit is small.	
D	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.
I Statement	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.	Read "Clinical Considerations" section of USPSTF Recommendation Statement (see "Major Recommendations" field). If offered, patients should understand the uncertainty about the balance of benefits and harms.

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Level of Certainty	Description
High	The 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.
Moderate	The available evidence is sufficient to determine the effects of the preventive service on health outcomes, but confidence in the estimate is constrained by factors such 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.
Low	The available evidence is insufficient to assess effects on health outcomes. Evidence is insufficient because of: • The limited number or size of studies

Level of Certainty	Description
	• Important flaws in study design or methods • Inconsistency of findings across individual studies • Gaps in the chain of evidence • Findings not generalizable to routine primary care practice • A lack of information on important health outcomes More information may allow an estimation of effects on health outcomes.

CLINICAL ALGORITHM(S)

None provided

EVIDENCE SUPPORTING THE RECOMMENDATIONS

TYPE OF EVIDENCE SUPPORTING THE RECOMMENDATIONS

The type of supporting evidence is not specifically stated for each recommendation.

BENEFITS/HARMS OF IMPLEMENTING THE GUIDELINE RECOMMENDATIONS

POTENTIAL BENEFITS

Benefits of Detection and Early Treatment

Screening Before 24 Weeks Gestation

The evidence is poor to determine whether there are benefits to screening women at this time in pregnancy.

Screening After 24 Weeks Gestation

Although screening and early treatment of gestational diabetes mellitus (GDM) reduces macrosomia, and although 1 trial suggests the possibility of other health benefits, the overall evidence is poor to determine whether maternal or fetal complications are reduced by screening.

POTENTIAL HARMS

Harms of Detection and Early Treatment

There is fair evidence that short-term anxiety occurs in some women with positive screening results; longer term psychological or other harms have not been documented. The majority of positive screening test results are probably false positives. Consequently, it is likely that many women and medical practices are being inconvenienced unnecessarily by screening.

QUALIFYING STATEMENTS

QUALIFYING STATEMENTS

- The U.S. Preventive Services Task Force (USPSTF) makes recommendations about preventive care services for patients without recognized signs or symptoms of the target condition.
- Recommendations are based on a systematic review of the evidence of the benefits and harms and an assessment of the net benefit of the service.
- The USPSTF recognizes that clinical or policy decisions involve more considerations than this body of evidence alone. Clinicians and policy-makers should understand the evidence but individualize decision making to the specific patient or situation.

IMPLEMENTATION OF THE GUIDELINE

DESCRIPTION OF IMPLEMENTATION STRATEGY

The experiences of the first and second U.S. Preventive Services Task Force (USPSTF), as well as that of other evidence-based guideline efforts, have highlighted the importance of identifying effective ways to implement clinical recommendations. Practice guidelines are relatively weak tools for changing clinical practice when used in isolation. To effect change, guidelines must be coupled with strategies to improve their acceptance and feasibility. Such strategies include enlisting the support of local opinion leaders, using reminder systems for clinicians and patients, adopting standing orders, and audit and feedback of information to clinicians about their compliance with recommended practice.

In the case of preventive services guidelines, implementation needs to go beyond traditional dissemination and promotion efforts to recognize the added patient and clinician barriers that affect preventive care. These include clinicians' ambivalence about whether preventive medicine is part of their job, the psychological and practical challenges that patients face in changing behaviors, lack of access to health care or of insurance coverage for preventive services for some patients, competing pressures within the context of shorter office visits, and the lack of organized systems in most practices to ensure the delivery of recommended preventive care.

Dissemination strategies have changed dramatically in this age of electronic information. While recognizing the continuing value of journals and other print formats for dissemination, the Agency for Healthcare Research and Quality will make all U.S. Preventive Services Task Force (USPSTF) products available through its Web site. The combination of electronic access and extensive material in the public domain should make it easier for a broad audience of users to access U.S. Preventive Services Task Force materials and adapt them for their local needs. Online access to U.S. Preventive Services Task Force products also opens up new possibilities for the appearance of the annual, pocket-size *Guide to Clinical Preventive Services*.

To be successful, approaches for implementing prevention have to be tailored to the local level and deal with the specific barriers at a given site, typically requiring the redesign of systems of care. Such a systems approach to prevention has had notable success in established staff-model health maintenance organizations, by addressing organization of care, emphasizing a philosophy of prevention, and altering the training and incentives for clinicians. Staff-model plans also benefit from integrated information systems that can track the use of needed services and generate automatic reminders aimed at patients and clinicians, some of the most consistently successful interventions. Information systems remain a major challenge for individual clinicians' offices, however, as well as for looser affiliations of practices in network-model managed care and independent practice associations, where data on patient visits, referrals, and test results are not always centralized.

IMPLEMENTATION TOOLS

Patient Resources
Personal Digital Assistant (PDA) Downloads
Pocket Guide/Reference Cards
Staff Training/Competency Material

For information about availability, see the "Availability of Companion Documents" and "Patient Resources" fields below.

INSTITUTE OF MEDICINE (IOM) NATIONAL HEALTHCARE QUALITY REPORT CATEGORIES

IOM CARE NEED

Staying Healthy

IOM DOMAIN

Effectiveness
Patient-centeredness

IDENTIFYING INFORMATION AND AVAILABILITY

BIBLIOGRAPHIC SOURCE(S)

U.S. Preventive Services Task Force. Screening for gestational diabetes mellitus: U.S. Preventive Services Task Force recommendation statement. Ann Intern Med 2008 May 20;148(10):759-65. PubMed

ADAPTATION

Not applicable: The guideline was not adapted from another source.

DATE RELEASED

1996 (revised 2008 May)

GUIDELINE DEVELOPER(S)

United States Preventive Services Task Force - Independent Expert Panel

GUIDELINE DEVELOPER COMMENT

The U.S. Preventive Services Task Force (USPSTF) is a Federally-appointed panel of independent experts. Conclusions of the USPSTF do not necessarily reflect policy of the U.S. Department of Health and Human Services (DHHS) or DHHS agencies.

SOURCE(S) OF FUNDING

United States Government

GUIDELINE COMMITTEE

U.S. Preventive Services Task Force (USPSTF)

COMPOSITION OF GROUP THAT AUTHORED THE GUIDELINE

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**Members of the Task Force at the time this recommendation was finalized. For a list of current Task Force members, go to www.ahrq.gov/clinic/uspstfab.htm.*

FINANCIAL DISCLOSURES/CONFLICTS OF INTEREST

The U.S. Preventive Services Task Force has an explicit policy concerning conflict of interest. All members disclose at each meeting if they have a significant financial, professional/business, or intellectual conflict for each topic being

discussed. Task Force members with conflicts may be recused from discussing or voting on recommendations about the topic in question.

GUIDELINE STATUS

This is the current release of the guideline.

This guideline updates a previous version: U.S. Preventive Services Task Force (USPSTF). Screening for gestational diabetes mellitus: recommendations and rationale. Obstet Gynecol 2003 Feb;101(2):393-5.

GUIDELINE AVAILABILITY

Electronic copies: Available from the U.S. Preventive Services Task Force (USPSTF) Web site and the Annals of Internal Medicine Web site.

Print copies: Available from the Agency for Healthcare Research and Quality (AHRQ) Publications Clearinghouse. For more information, go to http://www.ahrq.gov/news/pubsix.htm or call 1-800-358-9295 (U.S. only).

AVAILABILITY OF COMPANION DOCUMENTS

The following are available:

Evidence Reviews:

- Hiller TA, Vesco KK, Whitlock EP, Pettitt DJ, Pedula KL, Beil TL. Screening for gestational diabetes mellitus. Evidence Synthesis No. 60. AHRQ Publication No. 08-05115-EF-1. Rockville, Maryland: Agency for Healthcare Research and Quality, March 008. Electronic copies: Available from the U.S. Preventive Services Task Force (USPSTF) Web site.
- Hiller TA, Vesco KK, Pedula KL, Beil TL, Whitlock EP, Pettitt DJ. Screening for gestational diabetes mellitus: a systematic review for the U.S. Preventive Services Task Force. Ann Intern Med 2008 May 20 148(10):766-75. Available from the U.S. Preventive Services Task Force (USPSTF) Web site and the Annals of Internal Medicine Web site.
- Screening for gestational diabetes mellitus: clinical summary of U.S. Preventive Services Task Force recommendations. 2008. Electronic copies: Available in Portable Document Format (PDF) from the U.S. Preventive Services Task Force (USPSTF) Web site.
- A continuing medical education (CME) activity is available from the Annals of Internal Medicine Web site.

Background Articles:

- Barton M et al. How to read the new recommendation statement: methods update from the U.S. Preventive Services Task Force. Ann Intern Med. 2007;147:123-127.
- Guirguis-Blake J et al. Current processes of the U.S. Preventive Services Task Force: refining evidence-based recommendation development. Ann Intern Med. 2007;147:117-122. [2 references]

- Sawaya GF et al., Update on the methods of the U.S. Preventive Services Task Force: estimating certainty and magnitude of net benefit. Ann Intern Med. 2007;147:871-875. [5 references].

Electronic copies: Available from U.S. Preventive Services Task Force (USPSTF) Web site.

The following is also available:

- The guide to clinical preventive services, 2007. Recommendations of the U.S. Preventive Services Task Force. Rockville (MD): Agency for Healthcare Research and Quality (AHRQ), 2007. 228 p. Electronic copies available from the AHRQ Web site.
- A step-by-step guide to delivering clinical preventive services: a systems approach. Rockville (MD): Agency for Healthcare Research and Quality (AHRQ), 2002 May. 189 p. Electronic copies available from the AHRQ Web site. See the related QualityTool summary on the Health Care Innovations Exchange Web site.

Print copies: Available from the Agency for Healthcare Research and Quality Publications Clearinghouse. For more information, go to http://www.ahrq.gov/news/pubsix.htm or call 1-800-358-9295 (U.S. only).

The Electronic Preventive Services Selector (ePSS), available as a PDA application and a web-based tool, is a quick hands-on tool designed to help primary care clinicians identify the screening, counseling, and preventive medication services that are appropriate for their patients. It is based on current recommendations of the USPSTF and can be searched by specific patient characteristics such as age, sex, and selected behavioral risk factors.

PATIENT RESOURCES

The following are available:

- Women: Stay Healthy at Any Age – Checklist for Your Next Checkup. Rockville (MD): Agency for Healthcare Research and Quality. AHRQ Pub. No. 07-IP005-A. February 2007. Electronic copies: Available from the USPSTF Web site.
- Screening for gestational diabetes mellitus during pregnancy: recommendations from the U.S. Preventive Services Task Force. Ann Intern Med 2008 May 20; 148(10):I-60. Available from the Annals of Internal Medicine Web site.

Print copies: Available from the Agency for Healthcare Research and Quality (AHRQ) Publications Clearinghouse. For more information, go to http://www.ahrq.gov/news/pubsix.htm or call 1-800-358-9295 (U.S. only).

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