

Complete Summary

GUIDELINE TITLE

Screening for lipid disorders in adults: U.S. Preventive Services Task Force recommendation statement.

BIBLIOGRAPHIC SOURCE(S)

U.S. Preventive Services Task Force. Screening for lipid disorders in adults: U.S. Preventive Services Task Force recommendation statement. Rockville (MD): Agency for Healthcare Research and Quality (AHRQ); 2008 Jun. 13 p. [17 references]

GUIDELINE STATUS

This is the current release of the guideline.

This guideline updates a previous version: Berg AO. Screening adults for lipid disorders. Recommendations and rationale. Am J Prev Med 2001 Apr;20(3 Suppl):73-6. [12 references]

COMPLETE SUMMARY CONTENT

SCOPE
 METHODOLOGY - including Rating Scheme and Cost Analysis
 RECOMMENDATIONS
 EVIDENCE SUPPORTING THE RECOMMENDATIONS
 BENEFITS/HARMS OF IMPLEMENTING THE GUIDELINE RECOMMENDATIONS
 IMPLEMENTATION OF THE GUIDELINE
 INSTITUTE OF MEDICINE (IOM) NATIONAL HEALTHCARE QUALITY REPORT
 CATEGORIES
 IDENTIFYING INFORMATION AND AVAILABILITY
 DISCLAIMER

SCOPE

DISEASE/CONDITION(S)

- Lipid disorders
- Coronary heart disease

GUIDELINE CATEGORY

Prevention
 Risk Assessment
 Screening

CLINICAL SPECIALTY

Family Practice
Internal Medicine
Preventive Medicine

INTENDED USERS

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

GUIDELINE OBJECTIVE(S)

- To summarize the U.S. Preventive Services Task Force (USPSTF) recommendations and supporting scientific evidence on screening for lipid disorders in adults
- To update the 2001 USPSTF recommendations on screening for lipid disorders in adults

TARGET POPULATION

Adults aged 20 years and older who have not previously been diagnosed with dyslipidemia

INTERVENTIONS AND PRACTICES CONSIDERED

Screening for lipid disorders using measurement of total cholesterol and high-density lipoprotein cholesterol on nonfasting or fasting blood samples.

Note: Measurement of low-density lipoprotein cholesterol and triglycerides are also considered.

MAJOR OUTCOMES CONSIDERED

Key Question 1: How frequent is elevated total cholesterol in men younger than age 35 and women younger than age 40, and what proportion have an overall 10-year risk of cardiac events of 10% or greater?

Key Question 2: What evidence supports the use of triglyceride levels as part of an initial screening panel?

Key Question 3: What are the optimal screening intervals in the general population and in patients at high risk for coronary heart disease (CHD) events?

Key Question 4: What risk factors should be used to select patients for drug therapy?

Key Question 5: What is the current evidence about the harms of drug therapy for lipid disorders?

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) and the U.S. Preventive Services Task Force (USPSTF): A selective review of the literature was prepared by Oregon Evidence-based Practice Center (EPC) for use by the USPSTF (see the "Availability of Companion Documents" field). In this selective update, new evidence available since the publication of the USPSTF 2001 recommendations on screening for lipid disorders in adults was reviewed. This document should be read in conjunction with the full systematic evidence review conducted for the USPSTF in 2001 (see the "Availability of Companion Documents" field), the final report of National Cholesterol Education Project Adult Treatment Panel III (ATP III), and the 2004 ATP III update. These other reports provide more detailed and thorough analysis than can be provided here. The main findings of this update, focusing on discrepancies between the USPSTF recommendations and ATP III and summarized in Table 1 of the 2008 Evidence Review, should be viewed in this context.

Data Sources

The 2001 systematic evidence review prepared for the USPSTF (see the "Availability of Companion Documents" field) was based on searches of MEDLINE (1994 to December 1999) and the Cochrane Controlled Trials Registry through December 1, 1999. For this update, EPC staff searched the Cochrane Library (2004, Issue 4), MEDLINE (1966-February Week 1 2005), EMBASE (1980-February 4, 2005), PREMEDLINE (through February 9, 2005), and dossiers submitted by manufacturers of statins (see Appendix 1 of the 2008 Evidence Review [see "Availability of Companion Documents" field]). To identify key articles about the epidemiology, natural history, and detection of lipid levels and lipid disorders, EPC staff relied on the reference lists of the 2002 National Cholesterol Education Project Adult Treatment Panel III (ATP III) Final Report and the 2004 update to ATP III, as well as recent systematic reviews, supplemented by a title and abstract search of MEDLINE and PREMEDLINE. All searches were restricted to articles published in English.

Study Selection

EPC staff reviewed randomized trials of at least a 1-year duration that examined drug therapy with statins among patients without previously known CHD, and measured clinical end points including total mortality, coronary heart disease (CHD) mortality, and nonfatal myocardial infarction (MI). To be included, the trial

had to address primary prevention in the general population or in a subset of the general population identified on the basis of risk factors for CHD. Observational studies of the epidemiology of lipid disorders, screening to detect lipid disorders, risk factors for CHD, and the harms of statin therapy were also included.

NUMBER OF SOURCE DOCUMENTS

Not stated

METHODS USED TO ASSESS THE QUALITY AND STRENGTH OF THE EVIDENCE

Weighting According to a Rating Scheme (Scheme Given)

RATING SCHEME FOR THE STRENGTH OF THE EVIDENCE

The U.S. Preventive Services Task Force (USPSTF) grades the **quality of the overall evidence** on a 3-point scale (good, fair, or poor).

Good

Evidence includes consistent results from well-designed, well-conducted studies in representative populations that directly assess effects on health outcomes.

Fair

Evidence is sufficient to determine effects on health outcomes, but the strength of the evidence is limited by the number, quality, or consistency of the individual studies; generalizability to routine practice; or indirect nature of evidence on health outcomes.

Poor

Evidence is insufficient to assess the effects on health outcomes because of limited number or power of studies, important flaws in their design or conduct, gaps in the chain of evidence, or lack of information on important health outcomes.

METHODS USED TO ANALYZE THE EVIDENCE

Review of Published Meta-Analyses
Systematic Review with Evidence Tables

DESCRIPTION OF THE METHODS USED TO ANALYZE THE EVIDENCE

Note from the National Guideline Clearinghouse (NGC) and the U.S. Preventive Services Task Force (USPSTF): A selective review of the literature was prepared by Oregon Evidence-based Practice Center (EPC) for use by the USPSTF (see the "Availability of Companion Documents" field). In this selective update, new evidence available since the publication of the USPSTF 2001

recommendations on screening for lipid disorders in adults was reviewed. This document should be read in conjunction with the full systematic evidence review conducted for the USPSTF in 2001 (see the "Availability of Companion Documents" field), the final report of National Cholesterol Education Project Adult Treatment Panel III (ATP III), and the 2004 ATP III update. These other reports provide more detailed and thorough analysis than can be provided here. The main findings of this update, focusing on discrepancies between the USPSTF recommendations and ATP III and summarized in Table 1 of the 2008 Evidence Review, should be viewed in this context.

Data Extraction and Quality Assessment

EPC staff used text and internal validity ratings from a previous review of statins to summarize the results of recent statin trials and of the safety of statins. They used standard USPSTF methods to rate the internal validity of trials and epidemiologic studies included in this update but not in the statins review (See Appendix 2 of the 2007 Evidence Review [see the "Availability of Companion Documents" field]).

Data Synthesis and Analysis

EPC staff summarized new evidence relevant to discrepancies between USPSTF and ATP III recommendations in the context of earlier evidence from the 2001 evidence review conducted for the USPSTF, the final report of ATP III, and the 2004 ATP III update.

METHODS USED TO FORMULATE THE RECOMMENDATIONS

Balance Sheets
Expert Consensus

DESCRIPTION OF METHODS USED TO FORMULATE THE RECOMMENDATIONS

When the overall quality of the evidence is judged to be good or fair, the U.S. Preventive Services Task Force (USPSTF) proceeds to consider the magnitude of net benefit to be expected from implementation of the preventive service. Determining net benefit requires assessing both the magnitude of benefits and the magnitude of harms and weighing the two.

The USPSTF classifies benefits, harms, and net benefits on a 4-point scale: "substantial," "moderate," "small," and "zero/negative."

"Outcomes tables" (similar to 'balance sheets') are the USPSTF's standard resource for estimating the magnitude of benefit. These tables, prepared by the topic teams for use at USPSTF meetings, compare the condition specific outcomes expected for a hypothetical primary care population with and without use of the preventive service. These comparisons may be extended to consider only people of specified age or risk groups or other aspects of implementation. Thus, outcomes tables allow the USPSTF to examine directly how the preventive services affect benefits for various groups.

When evidence on harms is available, the topic teams assess its quality in a manner like that for benefits and include adverse events in the outcomes tables. When few harms data are available, the USPSTF does not assume that harms are small or nonexistent. It recognizes a responsibility to consider which harms are likely and judge their potential frequency and the severity that might ensue from implementing the service. It uses whatever evidence exists to construct a general confidence interval on the 4-point scale (e.g., substantial, moderate, small, and zero/negative).

Value judgments are involved in using the information in an outcomes table to rate either benefits or harms on the USPSTF's 4-point scale. Value judgments are also needed to weigh benefits against harms to arrive a rating of net benefit.

In making its determinations of net benefit, the USPSTF strives to consider what it believes are the general values of most people. It does this with greater confidence for certain outcomes (e.g., death) about which there is little disagreement about undesirability, but it recognizes that the degree of risk people are willing to accept to avert other outcomes (e.g., cataracts) can vary considerably. When the USPSTF perceives that preferences among individuals vary greatly, and that these variations are sufficient to make trade-off of benefits and harms a 'close-call', then it will often assign a C recommendation (see the "Recommendation Rating Scheme" field). This recommendation indicates the decision is likely to be sensitive to individual patient preferences.

The USPSTF uses its assessment of the evidence and magnitude of net benefit to make recommendations. The general principles the USPSTF follows in making recommendations are outlined in Table 5 of the companion document cited below. The USPSTF liaisons on the topic team compose the first drafts of the recommendations and rationale statements, which the full panel then reviews and edits. Recommendations are based on formal voting procedures that include explicit rules for determining the views of the majority.

From: Harris RP, Helfand M, Woolf SH, Lohr KN, Mulrow, CD, Teutsch SM, Atkins D. Current methods of the U.S. Preventive Services Task Force: a review of the process. Methods Work Group, Third U.S. Preventive Services Task Force. *Am J Prev Med* 2001 Apr;20(3S):21-35.

RATING SCHEME FOR THE STRENGTH OF THE RECOMMENDATIONS

The U.S. Preventive Services Task Force (USPSTF) grades its recommendations according to one of five classifications (A, B, C, D, or I), reflecting the strength of evidence and magnitude of net benefit (benefits minus harms).

A

The U.S. Preventive Services Task Force (USPSTF) strongly recommends that clinicians provide [the service] to eligible patients. (The USPSTF found good evidence that [the service] improves important health outcomes and concludes that benefits substantially outweigh harms.)

B

The USPSTF recommends that clinicians provide [the service] to eligible patients. (The USPSTF found at least fair evidence that [the service] improves health outcomes and concludes that benefits outweigh harms.)

C

The USPSTF makes no recommendation for or against routine provision of [the service]. (The USPSTF found at least fair evidence that [the service] can improve health outcomes but concludes that the balance of benefits and harms is too close to justify a general recommendation.)

D

The USPSTF recommends against routinely providing [the service] to asymptomatic patients. (The USPSTF found at least fair evidence that [the service] is ineffective or that harms outweigh benefits.)

I

The USPSTF concludes that the evidence is insufficient to recommend for or against routinely providing [the service]. (Evidence that [the service] is effective is lacking, of poor quality, or conflicting and the balance of benefits and harms cannot be determined.)

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 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 and professional and disease-based health organizations with interests in the topic. 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 for screening for lipid disorders from the following groups were discussed: National Cholesterol Education Program's Adult Treatment Panel III, sponsored by the National Institutes of Health and endorsed by the American Heart Association; the American Academy of Family Physicians; and the American College of Obstetricians and Gynecologists.

RECOMMENDATIONS

MAJOR RECOMMENDATIONS

The U.S. Preventive Services Task Force (USPSTF) grades its recommendations (**A, B, C, D, or I**) and the quality of the overall evidence for a service (**good, fair, poor**). The definitions of these grades can be found at the end of the "Major Recommendations" field.

Summary of Recommendations

Screening Men

The U.S. Preventive Services Task Force (USPSTF) strongly recommends screening men aged 35 and older for lipid disorders. **This is a grade A recommendation.**

The USPSTF recommends screening men aged 20 to 35 for lipid disorders if they are at increased risk for coronary heart disease. **This is a grade B recommendation.**

Screening Women at Increased Risk

The USPSTF strongly recommends screening women aged 45 and older for lipid disorders if they are at increased risk for coronary heart disease. **This is a grade A recommendation.**

The USPSTF recommends screening women aged 20 to 45 for lipid disorders if they are at increased risk for coronary heart disease. **This is a grade B recommendation.**

Screening of Young Men and All Women Not at Increased Risk

The USPSTF makes no recommendation for or against routine screening for lipid disorders in men aged 20 to 35, or in women aged 20 and older who are not at increased risk for coronary heart disease. **This is a grade C recommendation.**

Clinical Considerations

- Lipid disorders, also called dyslipidemias, are abnormalities of lipoprotein metabolism and include elevations of total cholesterol, low-density lipoprotein cholesterol (LDL-C), or triglycerides (TG), or deficiencies of high-density lipoprotein cholesterol (HDL-C). These disorders can be acquired or familial (e.g., familial hypercholesterolemia). This recommendation applies to adults aged 20 and older who have not previously been diagnosed with dyslipidemia.
- Increased risk, for the purposes of this recommendation, is defined by the presence of any one of the risk factors listed below. The greatest risk for coronary heart disease (CHD) is conferred by a combination of multiple listed factors. While the USPSTF did not use a specific numerical risk to bound this recommendation, the framework used by the USPSTF in making these recommendations relies on a 10-year risk of cardiovascular events:
 - Diabetes
 - Previous personal history of CHD or non-coronary atherosclerosis (e.g., abdominal aortic aneurysm, peripheral artery disease, carotid artery stenosis)
 - A family history of cardiovascular disease before age 50 in male relatives or age 60 in female relatives
 - Tobacco use
 - Hypertension
 - Obesity (body mass index [BMI] ≥ 30)
- The preferred screening tests for dyslipidemia are total cholesterol and HDL-C on non-fasting or fasting samples. There is currently insufficient evidence of the benefit of including TG as a part of the initial tests used to screen routinely for dyslipidemia. Abnormal screening test results should be confirmed by a repeated sample on a separate occasion, and the average of both results should be used for risk assessment.
- Measuring total cholesterol alone is acceptable for screening if available laboratory services cannot provide reliable measurements of HDL-C; measuring both total cholesterol and HDL-C is more sensitive and specific for assessing coronary heart disease risk than measuring total cholesterol alone. In conjunction with HDL-C, the addition of either LDL-C or total cholesterol would provide comparable information, but measuring LDL-C requires a fasting sample and is more expensive. Direct LDL-C testing, which does not require a fasting sample measurement, is now available; however, calculated LDL (total cholesterol minus HDL minus TG/5) is the validated measurement used in trials for risk assessment and treatment decisions. In patients with dyslipidemia identified by screening, complete lipoprotein analysis is useful.
- The optimal interval for screening is uncertain. On the basis of other guidelines and expert opinion, reasonable options include every 5 years, shorter intervals for people who have lipid levels close to those warranting therapy, and longer intervals for those not at increased risk who have had repeatedly normal lipid levels.
- An age to stop screening has not been established. Screening may be appropriate in older people who have never been screened; repeated screening is less important in older people because lipid levels are less likely to increase after age 65. However, because older adults have an increased baseline risk for coronary heart disease, they stand to gain greater absolute benefit from the treatment of dyslipidemia, compared with younger adults.
- Treatment decisions should take into account a person's overall risk of heart disease rather than lipid levels alone. Overall risk assessment should include the presence and severity of the following risk factors: age, gender, diabetes, elevated blood pressure, family history (in younger adults), and smoking.

Risk calculators that incorporate specific information on multiple risk factors provide a more accurate estimation of cardiovascular risk than tools that simply count numbers of risk factors.

- Drug therapy is usually more effective than diet alone in improving lipid profiles, but choice of treatment should consider overall risk, costs of treatment, and patient preferences. Guidelines for treating lipid disorders are available from the National Cholesterol Education Program of the National Institutes of Health (<http://www.nhlbi.nih.gov/about/ncep/>).
- Although lifestyle modifications (diet and physical activity) are appropriate initial therapies for most patients, a minority achieves substantial reductions in lipid levels from changes in diet alone; drugs are frequently needed to achieve therapeutic goals, especially for those at increased risk for coronary heart disease. Lipid-lowering treatments should be accompanied by interventions addressing all modifiable risk factors for heart disease, including smoking cessation, treatment of blood pressure, diabetes, and obesity, as well as promotion of a healthy diet and regular physical activity. Long-term adherence to therapies should be emphasized.

Definitions:

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B

The USPSTF recommends that clinicians provide [the service] to eligible patients. (The USPSTF found at least fair evidence that [the service] improves health outcomes and concludes that benefits outweigh harms.)

C

The USPSTF makes no recommendation for or against routine provision of [the service]. (The US Preventive Services Task Force found at least fair evidence that [the service] can improve health outcomes but concludes that the balance of benefits and harms is too close to justify a general recommendation.)

D

The USPSTF recommends against routinely providing [the service] to asymptomatic patients. (The USPSTF found at least fair evidence that [the service] is ineffective or that harms outweigh benefits.)

I

The USPSTF concludes that the evidence is insufficient to recommend for or against routinely providing [the service]. (Evidence that [the service] is effective is lacking, of poor quality, or conflicting and the balance of benefits and harms cannot be determined.)

The USPSTF grades the **quality of the overall evidence** for a service on a 3-point scale (good, fair, or poor).

Good

Evidence includes consistent results from well-designed, well-conducted studies in representative populations that directly assess effects on health outcomes.

Fair

Evidence is sufficient to determine effects on health outcomes, but the strength of the evidence is limited by the number, quality, or consistency of the individual studies; generalizability to routine practice; or indirect nature of evidence on health outcomes.

Poor

Evidence is insufficient to assess the effects on health outcomes because of limited number or power of studies, important flaws in their design or conduct, gaps in the chain of evidence, or lack of information on important health outcomes.

CLINICAL ALGORITHM(S)

None provided

EVIDENCE SUPPORTING THE RECOMMENDATIONS

TYPE OF EVIDENCE SUPPORTING THE RECOMMENDATIONS

The type of evidence supporting each recommendation is identified in the "Major Recommendations" field.

BENEFITS/HARMS OF IMPLEMENTING THE GUIDELINE RECOMMENDATIONS

POTENTIAL BENEFITS

Benefits of Detection and Early Treatment

There is good evidence that lipid-lowering drug therapy substantially decreases the incidence of coronary heart disease in persons with abnormal lipids. The absolute benefits of lipid-lowering treatment depend on a person's underlying risk for coronary heart disease. Men over the age of 35 and women over the age of 45 who are at increased risk will realize a substantial benefit from treatment; younger adults with multiple risk factors for coronary disease, including

dyslipidemia, will realize a moderate benefit from treatment; and younger men and women without risk factors for coronary heart disease will realize a small benefit from treatment, as seen in the risk reduction in 10-year coronary heart disease (CHD) event rate.

POTENTIAL HARMS

Harms of Detection and Early Treatment

There is good evidence that the harms from screening and treatment are small and include possible labeling and the adverse effects associated with lipid-lowering therapy (e.g., rhabdomyolysis).

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

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 lipid disorders in adults: U.S. Preventive Services Task Force recommendation statement. Rockville (MD): Agency for Healthcare Research and Quality (AHRQ); 2008 Jun. 13 p. [17 references]

ADAPTATION

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

DATE RELEASED

1996 (revised 2008 Jun)

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 U.S. Preventive Services Task Force do not necessarily reflect policy of the U.S. Department of Health and Human Services (DHHS) or its 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.*

**Steven Teutsch, MD, MPH was recused from voting on this topic.*

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 an important financial conflict for each topic being discussed. Task Force members with conflicts can participate in discussions about evidence, but members abstain from voting on recommendations about the topic in question.

From: Harris RP, Helfand M, Woolf SH, Lohr KN, Mulrow, CD, Teutsch SM, Atkins D. Current methods of the U.S. Preventive Services Task Force: a review of the process. Methods Work Group, Third U.S. Preventive Services Task Force. *Am J Prev Med* 2001 Apr;20(3S):21-35.

GUIDELINE STATUS

This is the current release of the guideline.

This guideline updates a previous version: Berg AO. Screening adults for lipid disorders. Recommendations and rationale. *Am J Prev Med* 2001 Apr;20(3 Suppl):73-6. [12 references]

GUIDELINE AVAILABILITY

Electronic copies: Available from the [U.S. Preventive Services Task Force \(USPSTF\) Web site](http://www.ahrq.gov/clinic/uspstf.htm).

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).

AVAILABILITY OF COMPANION DOCUMENTS

The following are available:

Evidence Reviews:

- Helfand M, Carson S. Screening for Lipid Disorders in Adults: Selective Update of 2001 U.S. Preventive Services Task Force Review. Evidence Synthesis No. 49. Rockville, MD: Agency for Healthcare Research and Quality, April 2008. AHRQ Publication no. 08-05114-EF-1. Electronic copies: from the [U.S. Preventive Services Task Force \(USPSTF\) Web site](http://www.ahrq.gov/clinic/uspstf.htm).

- Pignone MP, Phillips CJ, Lannon CM, Mulrow CD, Teutsch SM, Lohr KN, Whitener BL. Screening for lipid disorders. Rockville (MD): Agency for Healthcare Research and Quality (AHRQ), 2001. (Systematic evidence review; no. 4) [243 references] Electronic copies: from the [U.S. Preventive Services Task Force \(USPSTF\) Web site](#).

Background Article:

- Harris RP, Helfand M, Woolf SH, Lohr KN, Mulrow, CD, Teutsch SM, Atkins D. Current methods of the U.S. Preventive Services Task Force: a review of the process. Methods Work Group, Third U.S. Preventive Services Task Force. Am J Prev Med 2001 Apr;20(3S):21-35. Electronic copies: Available from the [USPSTF Web site](#).

The following are 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. 256 p. Electronic copies available from the [AHRQ 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:

- Men: Stay Healthy at Any Age – Checklist for Your Next Checkup. Rockville (MD): Agency for Healthcare Research and Quality. AHRQ Pub. No. 07-IP006-A. February 2007. Electronic copies: Available from the [USPSTF Web site](#).
- Women: Stay Healthy at Any Age – Checklist for Your Net 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](#).

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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