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High-Priority Evidence Gaps For Clinical Preventive Services

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U.S. PREVENTIVE SERVICES
TASK FORCE

SIXTH ANNUAL REPORT TO CONGRESS

U.S. Preventive Services
TASK FORCE

EXECUTIVE SUMMARY

The U.S. Preventive Services Task Force (USPSTF or Task Force) is an independent, volunteer panel of national experts in prevention and evidence-based medicine. The Task Force works to improve the health of all Americans by making evidence-based recommendations about clinical preventive services and health promotion. The Task Force comprehensively assesses evidence and makes recommendations about the effectiveness of screening tests, counseling about healthful behaviors, and preventive medications for infants, children, adolescents, adults, older adults, and pregnant women.

The Patient Protection and Affordable Care Act of 2010 charges the USPSTF with providing an annual report to Congress that identifies gaps in the scientific evidence base and recommends priority areas for future research.

In this sixth annual report, the USPSTF has identified six recent topics for which the current evidence was insufficient for the Task Force to make a recommendation. Future research in these areas can help fill these gaps and would likely result in important new recommendations that will help to improve the health of Americans.

Clinical Preventive Services That Deserve Further Research:

1. Screening for Autism Spectrum Disorder in Young Children
2. Screening for Chlamydia and Gonorrhea in Men
3. Tobacco Smoking Cessation (Electronic Nicotine Delivery Systems) in Adults
4. Vitamin Supplementation (Nutrients and Multivitamins) to Prevent Cancer and Cardiovascular Disease
5. Aspirin Use to Prevent Cardiovascular Disease and Colorectal Cancer
6. Screening for Skin Cancer in Adults

In the Affordable Care Act, Congress also requested that the USPSTF identify evidence gaps that prevent it from making recommendations for specific populations or age groups. In this report, the USPSTF has highlighted the following three key evidence gaps.

Evidence Gaps Relating to Specific Populations That Deserve Further Research:

1. Screening for Breast Cancer in African American Women
2. Screening for Cervical Cancer in Hispanic and African American Women
3. Screening for Colorectal Cancer in African Americans and American Indians/Alaska Natives

The USPSTF will continue to independently evaluate the evidence on clinical preventive services to empower health care professionals, health care systems, and the American people to make informed decisions about their health and health care.

The USPSTF hopes that identifying evidence gaps and highlighting them as priority areas for research will inspire public and private researchers to collaborate and target their efforts to generate new knowledge and address important health priorities.

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Appendices

"The American Academy of Physician Assistants (AAPA) understands that preventing illness is one of the most important things that physician assistants do to promote the health of their patients. AAPA works with the USPSTF to provide our more than 50,000 members with the authoritative information they need to effectively and systematically implement preventive services into their practice."

– American Academy of Physician Assistants

I. INTRODUCTION

The U.S. Preventive Services Task Force (USPSTF or Task Force) is an independent body of national experts in prevention and evidence-based medicine. Since its inception more than 25 years ago, the Task Force has worked to improve the health of all Americans by making evidence-based recommendations about clinical preventive services and health promotion. These recommendations include screening tests, counseling about healthful behaviors, and preventive medications.

The mission of the USPSTF is to improve the health of all Americans by making evidence-based recommendations about clinical preventive services and health promotion.

The Patient Protection and Affordable Care Act, Sec. 4003 (F), describes the duties of the USPSTF, which include:

> *The submission of yearly reports to Congress and related agencies identifying gaps in research such as preventive services that receive an insufficient evidence statement, and recommending priority areas that deserve further examination, including areas related to populations and age groups not adequately addressed by current recommendations.*

The USPSTF has prepared this report in response to this requirement to update Congress and the research community about key evidence gaps in clinical preventive services.

II. BACKGROUND

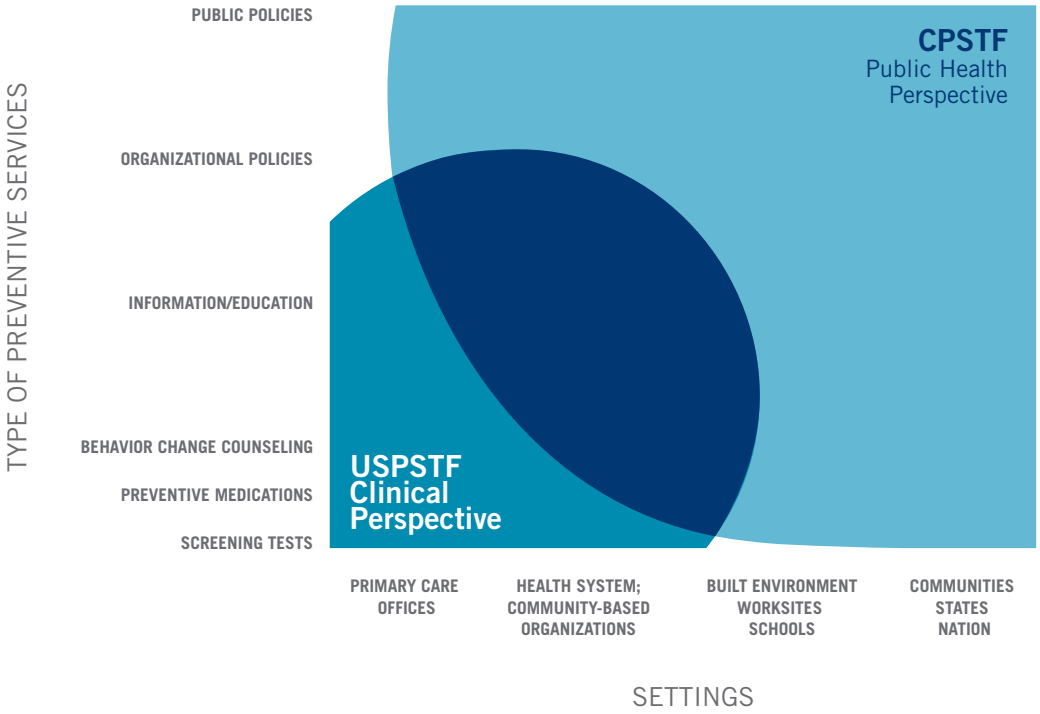
Clinical preventive services can have tremendous value in improving the health of the Nation. When provided appropriately, they can identify diseases at earlier stages when they are more treatable, or reduce a person's risk for developing a disease altogether. However, some clinical preventive services can fail to provide the expected benefit or even cause harm. To make informed decisions, health care professionals, patients, and families need access to trustworthy, objective information about the benefits and harms of clinical preventive services.

Task Force recommendations focus on interventions to prevent or decrease the severity of disease, and they apply only to people without obvious signs or symptoms of the disease or health condition under consideration. USPSTF recommendations address services offered in the primary care setting or services to which patients can be referred by primary care professionals. The Task Force makes recommendations to help primary care clinicians, patients, and families decide together whether a particular preventive service is right for an individual's needs.

Since 1998, the Agency for Healthcare Research and Quality has been authorized by Congress to convene the Task Force and to provide ongoing scientific, administrative, and dissemination support.

Complementing the work of the USPSTF, preventive services at the community level are addressed by the Community Preventive Services Task Force (CPSTF), which was established in 1996 by the U.S. Department of Health and Human Services. The CPSTF assists agencies, organizations, and individuals at all levels (national, State, community, school, worksite, and health care system) by providing evidence-based recommendations about community prevention programs and policies that are effective in increasing longevity and improving the quality of life of all Americans. The work of the CPSTF is supported by the Centers for Disease Control and Prevention. A diagram outlining the complementary domains of the USPSTF and the CPSTF is shown in **Figure 1**.

Figure 1. Complementary Work of the U.S. Preventive Services Task Force and the Community Preventive Services Task Force



Who Serves on the Task Force?

The Task Force is made up of 16 independent, nonfederal members who serve 4-year terms, led by a chair and two vice chairs (see **Appendix F** for current members). Members are nationally recognized experts in prevention and evidence-based medicine and represent the diverse disciplines of primary care, including behavioral health, family medicine, geriatrics, internal medicine, nursing, obstetrics and gynecology, and pediatrics. These prevention specialists provide important insights because Task Force recommendations are addressed to primary care clinicians and apply to individuals who visit them. All members volunteer their time to serve on the USPSTF. Most Task Force members are active clinicians who see patients regularly; many are respected researchers and distinguished professors, and all are dedicated to improving the health of Americans.

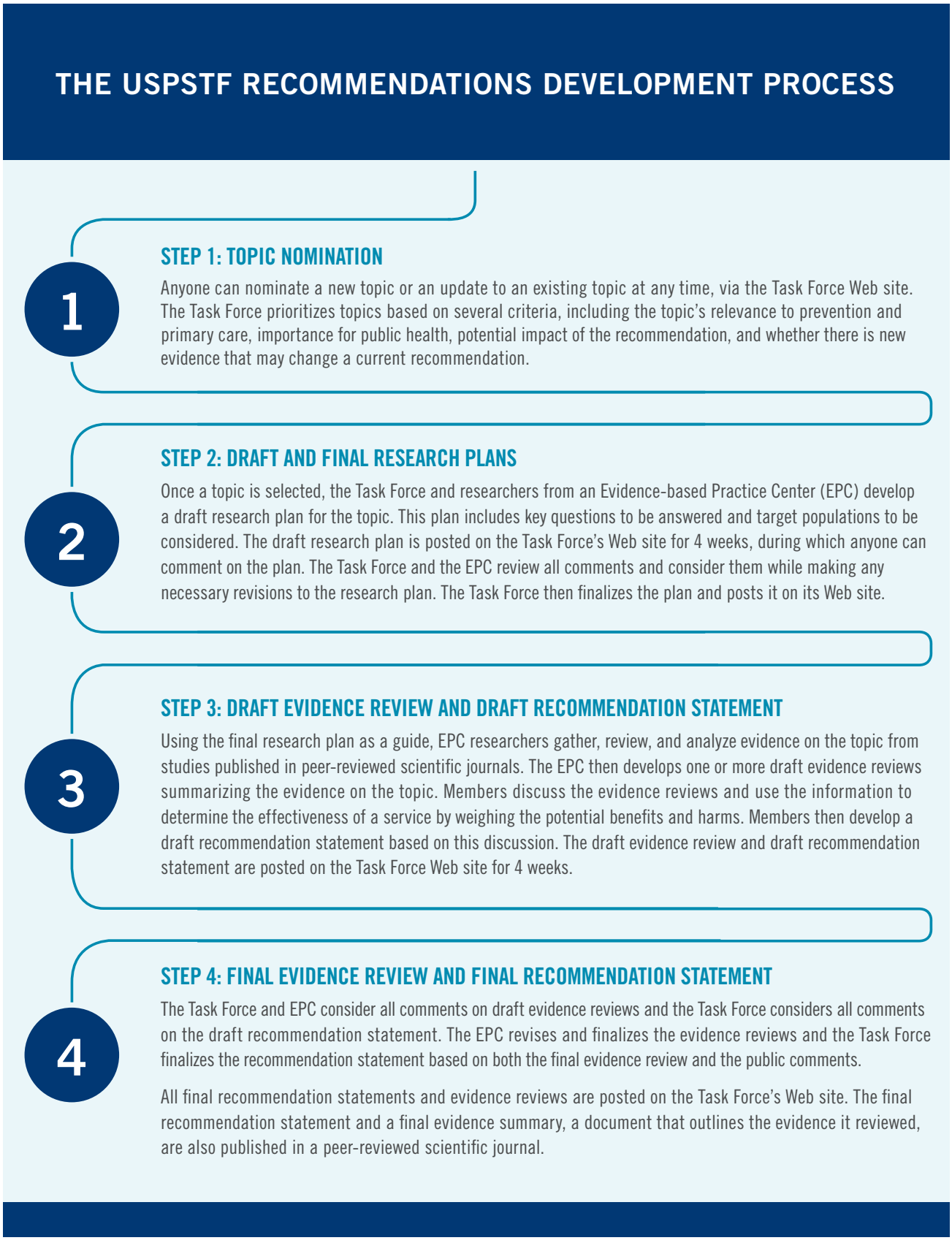
Primary care specializes in understanding and delivering the full spectrum of a patient's preventive needs.

USPSTF members are appointed by the Director of the Agency for Healthcare Research and Quality. Members are screened to ensure that they have no substantial conflicts of interest that could impair the scientific integrity of the work of the Task Force. For each preventive service under review and consideration, the financial, professional, and intellectual activities of Task Force members are evaluated to identify any real or potential conflicts of interest. In the unusual case where a conflict is identified for a member regarding a specific topic, the member is recused from participating in the development of the recommendation for that topic.

How the Task Force Makes Recommendations

The Task Force makes recommendations based on a rigorous review of existing peer-reviewed evidence. It does not conduct research studies, but rather reviews and assesses published research. The Task Force follows a multistep process when developing each of its recommendations (see **Figure 2**).

Figure 2. Steps the USPSTF Takes to Make a Recommendation



The process starts with the USPSTF and researchers from an Evidence-based Practice Center (EPC) developing a research plan for the topic. The research plan includes key questions to be answered and target populations to be considered. The draft research plan is posted on the USPSTF Web site for public comment for 4 weeks, during which time anyone can comment on the plan, including stakeholders and members of the general public. The USPSTF and the EPC review all comments and consider them in revising the research plan.

Using the final research plan as a guide, EPC researchers gather, review, and analyze evidence on the topic from studies published in peer-reviewed scientific journals. The EPC summarizes this evidence in a comprehensive evidence report, which is then reviewed by external subject matter experts. In 2013, the Task Force began posting draft evidence reports for public comment for 4 weeks, during which time scientists, researchers, health care professionals, and members of the general public are able to comment. All comments related to the draft evidence report are reviewed by the researchers at the EPC, and the evidence report is revised as necessary.

Task Force members use the evidence report as the basis for their assessment of the effectiveness of the preventive service under consideration. They consider the balance of both the potential benefits and harms when making their recommendations.

Potential benefits of clinical preventive services include reduction of risk factors to prevent disease, early identification of disease leading to earlier treatment, and, ultimately, improved health outcomes such as quality of life and length of life. Harms of preventive services can include adverse effects of the service itself, as well as the harms of inaccurate test results that may lead to a cascade of additional followup tests (some of which are invasive and could cause harm), unnecessary treatments, or false reassurance. Potential harms also include side effects or complications of treatments. When appropriate and when evidence exists, the Task Force evaluates the benefits and harms based on age, sex, and risk factors for the disease.

The Task Force makes its recommendations based on its assessment of the effectiveness of each clinical preventive service. The Task Force does not consider costs in its appraisal of the effectiveness of a service. The USPSTF also recognizes that insurance coverage decisions involve additional considerations beyond a scientific assessment of the clinical benefit and harms.

The Task Force assigns each of its recommendations a letter grade (A, B, C, or D) or issues an "I" statement based on the certainty of the evidence and the balance of benefits and harms of the preventive service (see **Table 1**). Clinical preventive services assigned a grade of "A" or "B" are those for which the USPSTF has determined that the benefits of the service substantially outweigh its harms. The Task Force recommends that clinicians offer and patients consider taking advantage of these services. For services assigned a "C" grade, the net benefit is small. The USPSTF recommends that health care professionals selectively offer these services to patients based on professional judgment and patient preferences. Services assigned a "D" grade are those for which there is no overall benefit, or the harms outweigh the benefits. The Task Force recommends that clinicians not promote these services and that patients avoid them. The Task Force issues an "I" statement when the evidence is insufficient to determine the balance of benefits and harms.

After carefully considering the evidence presented in the draft evidence report, the USPSTF develops a draft recommendation statement based upon the potential benefits and harms of the clinical preventive service. The Task Force posts the draft recommendation statement and the draft evidence report for public comment for 4 weeks. The Task Force requests feedback on the completeness of the evidence, its interpretation of the evidence, and the clarity and usefulness of the draft recommendation statement. Members of the Task Force review all comments received on the draft recommendation statement and then revise the recommendation statement. The final recommendation statement is posted on the USPSTF Web site along with the final evidence report and supporting materials. The final recommendation statement and an evidence summary based on the full evidence review are also published in a peer-reviewed medical journal. To ensure that stakeholders and the public are informed about the recommendations and understand them, the Task Force works with partner organizations on dissemination and implementation activities.

Table 1. Meaning of USPSTF Grades

Grade	Definition
A	The USPSTF recommends the service. There is high certainty that the net benefit is substantial.
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.
C	The USPSTF recommends selectively offering or providing this service to individual patients based on professional judgment and patient preferences. There is at least moderate 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.
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.

III. MAJOR ACTIVITIES OF THE USPSTF IN 2015–2016

The Task Force focuses on making its work as transparent as possible so that stakeholders and the public better understand and have more confidence in the approach of the Task Force. This also ensures that its work is open, credible, independent, and unbiased, and is recognized as such. By expanding opportunities for the public and stakeholders to engage in the process, the Task Force believes that its recommendations are more accurate and relevant.

The Task Force has an open process to solicit input from the public, experts, professional organizations, and policymakers for all of its recommendations.

As a result of these efforts, stakeholders and the public can:

- Nominate new members to serve on the Task Force
- Nominate new topics for Task Force consideration or request an update of an existing topic
- Provide comments on all draft research plans
- Provide comments on all draft evidence reports
- Provide comments on all draft recommendation statements

Over the past year, the members of the Task Force continued working on a full portfolio of topics. The current USPSTF library includes 128 specific recommendations (see **Appendix I** for a complete listing of all current USPSTF recommendations). Between October 2015 and October 2016, the Task Force:

- Received 22 nominations for new topics and 3 nominations to reconsider or update existing topics
- Posted 11 draft research plans for public comment
- Posted 12 draft recommendation statements and draft evidence reports for public comment
- Published 21 final recommendation statements on 12 topics in peer-reviewed journals (see **Table 2**)

Table 2. Final Recommendation Statements Published by the USPSTF, October 2015 to October 2016

Topic	Recommendation
Aspirin Use to Prevent Cardiovascular Disease and Colorectal Cancer: Preventive Medication	The USPSTF recommends initiating low-dose aspirin use for the primary prevention of cardiovascular disease (CVD) and colorectal cancer (CRC) in adults ages 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. (Grade B) The decision to initiate low-dose aspirin use for the primary prevention of CVD and CRC in adults ages 60 to 69 years who have a 10% or greater 10-year CVD risk should be an individual one. Persons who 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 are more likely to benefit. Persons who place a higher value on the potential benefits than the potential harms may choose to initiate low-dose aspirin. (Grade C) The USPSTF concludes that the current evidence is insufficient to assess the balance of benefits and harms of initiating aspirin use for the primary prevention of CVD and CRC in adults younger than age 50 years. (I statement) The USPSTF concludes that the current evidence is insufficient to assess the balance of benefits and harms of initiating aspirin use for the primary prevention of CVD and CRC in adults age 70 years or older. (I statement)
Autism Spectrum Disorder: Screening in Young Children	The USPSTF concludes that the current evidence is insufficient to assess the balance of benefits and harms of screening for autism spectrum disorder in young children for whom no concerns of the disorder have been raised by their parents or a clinician. (I statement)
Breast Cancer: Screening	The USPSTF recommends biennial screening mammography for women ages 50 to 74 years. (Grade B) The decision to start screening mammography in women prior to age 50 years should be an individual one. Women who place a higher value on the potential benefit than the potential harms may choose to begin biennial screening between the ages of 40 and 49 years. (Grade C) The USPSTF concludes that the current evidence is insufficient to assess the balance of benefits and harms of screening mammography in women age 75 years or older. (I statement) The USPSTF concludes that the current evidence is insufficient to assess the benefits and harms of digital breast tomosynthesis as a primary screening method for breast cancer. (I statement) The USPSTF concludes that the current evidence is insufficient to assess the balance of benefits and harms of adjunctive screening for breast cancer using breast ultrasonography, magnetic resonance imaging, digital breast tomosynthesis, or other methods in women identified to have dense breasts on an otherwise negative screening mammogram. (I statement)
Chronic Obstructive Pulmonary Disease: Screening	The USPSTF recommends against screening for chronic obstructive pulmonary disease in asymptomatic adults. (Grade D)

Topic	Recommendation
Colorectal Cancer: Screening	The USPSTF recommends screening for colorectal cancer starting at age 50 years and continuing until age 75 years. The risks and benefits of different screening methods vary. (Grade A) The decision to screen for colorectal cancer in adults ages 76 to 85 years should be an individual one, taking into account the patient's overall health and prior screening history. (Grade C)
Depression: Screening in Adults	The USPSTF recommends screening for depression in the general adult population, including pregnant and postpartum women. Screening should be implemented with adequate systems in place to ensure accurate diagnosis, effective treatment, and appropriate followup. (Grade B)
Depression: Screening in Children and Adolescents	The USPSTF recommends screening for major depressive disorder in adolescents ages 12 to 18 years. Screening should be implemented with adequate systems in place to ensure accurate diagnosis, effective treatment, and appropriate followup. (Grade B) The USPSTF concludes that the current evidence is insufficient to assess the balance of benefits and harms of screening for major depressive disorder in children age 11 years or younger. (I statement)
Impaired Visual Acuity: Screening in Older Adults	The USPSTF concludes that the current evidence is insufficient to assess the balance of benefits and harms of screening for impaired visual acuity in older adults. (I statement)
Latent Tuberculosis Infection: Screening in Adults	The USPSTF recommends screening for latent tuberculosis infection in populations at increased risk. (Grade B)
Lipid Disorders: Screening in Children and Adolescents	The USPSTF concludes that the current evidence is insufficient to assess the balance of benefits and harms of screening for lipid disorders in children and adolescents 20 years or younger. (I statement)
Skin Cancer: Screening in Adults	The USPSTF concludes that the current evidence is insufficient to assess the balance of benefits and harms of visual skin examination by a clinician to screen for skin cancer in adults. (I statement)
Syphilis Infection: Screening in Nonpregnant Adults and Adolescents	The USPSTF recommends screening for syphilis infection in persons who are at increased risk for infection. (Grade A)

The Task Force continued efforts to disseminate its recommendations by working with a group of partner organizations (see **Appendix G**) representing primary care clinicians, consumer organizations, and other stakeholders involved in delivering primary care. These partners help ensure that Task Force recommendations are meaningful to the groups they represent. Partners are also a powerful vehicle for ensuring that America's primary care workforce remains up to date on USPSTF recommendations.

In addition, through liaisons with Federal agencies (see **Appendix H**), the Task Force has access to a wide range of experts in prevention and disease. This helps ensure that its recommendations are comprehensive and reflect the best available science.

In order to help the public understand what Task Force recommendations mean, the Task Force continued to produce plain language fact sheets for its recommendations. The fact sheets highlight that evidence-based recommendations are only one part of informed decisionmaking, and encourage people to consider Task Force recommendations within the context of their health status, their values and preferences for health and health care, and advice from a trusted health care professional. The fact sheets contain links to resources for learning more about each topic and encourage people to have informed discussions about clinical preventive services with their doctor or nurse.

IV. CLINICAL PREVENTIVE SERVICES THAT DESERVE FURTHER RESEARCH

The Task Force issues evidence-based recommendations about clinical preventive services in order to improve the health of all Americans. The Task Force focuses on health conditions that have a high burden of suffering, with potentially important public health implications, based on the expected effectiveness of the preventive service to reduce suffering. If implemented appropriately and effectively, Task Force recommendations can improve the health of the Nation. However, significant gaps in key areas of knowledge limit the full realization of these benefits.

By requiring this annual report, Congress has recognized the opportunity for new research to provide the necessary evidence base upon which the USPSTF can build more extensive recommendations. Congress has specifically charged the Task Force with identifying and reporting each year on areas where current evidence is insufficient to make a recommendation on the use of a clinical preventive service, with special attention to those areas where evidence is needed to make recommendations for specific populations and age groups.

For this annual report, the USPSTF reviewed recent recommendations for which it had insufficient evidence to make a recommendation for or against providing the preventive service and has identified six priority areas where more research is needed (**Table 3**). The Task Force has also identified three evidence gaps related to specific populations and age groups. Future research in the following areas can help fill these gaps and would likely result in important new recommendations that will help to improve the health of Americans.

"By providing our members with reliable, high-quality, evidence-based recommendations, the USPSTF helps the American Academy of Family Physicians work toward our mission of improving the health of patients, families, and communities. We join the Task Force in its call for more research to address the important evidence gaps highlighted in this report so our members can continue to be guided by the best available evidence when making important decisions about clinical preventive services."

– American Academy of Family Physicians

Table 3. Key Research Gaps for Clinical Preventive Services

Clinical Preventive Services That Deserve Further Research	Gaps Where Research Is Needed
Screening for Autism Spectrum Disorder in Young Children	• Effectiveness of screening all children without signs or symptoms, including in populations with low socioeconomic status and in racial/ethnic minority populations • Effect of screening on intermediate and long-term health outcomes • Effect of treatment on patient outcomes for children whose autism is detected through universal screening programs
Screening for Chlamydia and Gonorrhea in Men	• Effectiveness of different screening strategies for identifying men who are at increased risk for infection • Subgroups for whom screening may be effective • Effectiveness of screening in reducing the spread of chlamydia and gonorrhea, as well as cotesting for other sexually transmitted infections and different screening intervals
Tobacco Smoking Cessation (Electronic Nicotine Delivery Systems [ENDS]) in Adults	• Effectiveness of ENDS on achieving smoking abstinence • Side effects of ENDS • Safety, benefits, and harms of ENDS • Effect of ENDS use (and co-use with tobacco) on subsequent tobacco use, especially in people trying to quit
Vitamin Supplementation (Nutrients and Multivitamins) to Prevent Cancer and Cardiovascular Disease	• Effectiveness of vitamin supplementation (single nutrient or nutrient pair) in the general population, including women and minority groups • Benefit of targeting supplementation toward people who are high-risk for nutrient deficiency rather than the general population • New and innovative research methods for examining effects of nutrients that account for the unique complexities of nutritional research • Standardized methods to determine blood nutrient levels • Thresholds for sufficiency and insufficiency
Aspirin Use to Prevent Cardiovascular Disease and Colorectal Cancer	• Role of aspirin therapy in racial/ethnic subpopulations • Benefits and harms of aspirin therapy in adults younger than age 50 years or older than age 70 years • Differential effects of sex, race/ethnicity, age, and genetic factors on risk for colorectal cancer and the effect of screening • Longer-term followup of cardiovascular disease prevention trials that report cancer incidence and death outcomes
Screening for Skin Cancer in Adults	• Effectiveness of the clinical visual skin examination • Possible harms of skin cancer screening, particularly for overdiagnosis and overtreatment

Screening for Autism Spectrum Disorder in Young Children

Autism spectrum disorder (ASD) is a developmental disorder involving social interaction and communication impairments and repetitive behaviors that affects about 1 in 68 children in the United States.

Existing research has focused on screening and diagnostic tools for children with signs or symptoms and treatment for children diagnosed with ASD. In order for the USPSTF to have enough evidence to issue a recommendation, good-quality studies are needed to better understand the following key issues:

- Whether earlier identification through universal screening (screening all children without signs or symptoms) improves intermediate and long-term health outcomes
- The effectiveness of screening in populations with low socioeconomic status and in racial/ethnic minority populations, where access to care may be more limited
- The effectiveness of treatment of young children with ASD identified through screening, including the impact on patient-centered outcomes

Screening for Chlamydia and Gonorrhea in Men

Chlamydia and gonorrhea are the most commonly reported sexually transmitted infections in the United States. More than 1.4 million cases of chlamydia and more than 330,000 cases of gonorrhea were reported to the Centers for Disease Control and Prevention in 2012. Good-quality studies are still needed to help understand the following:

- The effectiveness and population impact of different screening strategies for identifying men who are at increased risk for infection
- Subgroups for whom screening may be effective, including men who have sex with men, sexually active males younger than age 24 years, and men living in high-prevalence communities
- The effectiveness of screening in reducing the spread of chlamydia and gonorrhea, as well as cotesting for other sexually transmitted infections and different screening intervals

Tobacco Smoking Cessation (Electronic Nicotine Delivery Systems) in Adults

Tobacco use is the leading preventable cause of disease, disability, and death in the United States. Cigarette smoking results in more than 480,000 premature deaths each year and accounts for about 1 in every 5 deaths. An estimated 42.1 million U.S. adults (about 18% of the population) currently smoke. About 69% of adults who smoke daily report interest in quitting, and roughly 43% attempted to quit in the previous year.

The overall benefit of medications and behavioral counseling to promote quitting smoking is well-established. However, the USPSTF did not find enough evidence to determine the effect of using electronic nicotine delivery systems (ENDS, or e-cigarettes) to quit smoking. Therefore, good-quality studies are still needed to understand the following:

- The effectiveness of ENDS on achieving smoking abstinence
- The side effects of ENDS
- The safety, benefits, and harms of ENDS
- The effect of ENDS use (and co-use with tobacco) on subsequent tobacco use, especially in people trying to quit

Vitamin Supplementation (Nutrients and Multivitamins) to Prevent Cancer and Cardiovascular Disease

Many dietary supplements are promoted to prevent cancer and cardiovascular disease. The use of dietary supplements is common in the United States—49% of adults used at least one dietary supplement between 2007 and 2010; 32% reported using a multivitamin–multimineral supplement.

The USPSTF identified a need for studies on combined multivitamin supplements in people similar to the U.S. general population as a critical gap in the evidence. Good-quality studies are needed to help understand the following:

- The effectiveness of vitamin supplementation (single nutrient or nutrient pair) in the general population, including women and minority groups
- Whether targeting supplementation toward people identified as high-risk for nutrient deficiency rather than the general population is beneficial
- Whether there are new and innovative research methods for examining effects of nutrients that account for the unique complexities of nutritional research
- Standardized methods to determine blood nutrient levels
- Thresholds for sufficiency and insufficiency

Aspirin Use to Prevent Cardiovascular Disease and Colorectal Cancer

Cardiovascular disease and cancer are the leading causes of death for adults in the United States. In 2011, more than half of all deaths in the United States were caused by cardiovascular disease or cancer. Colorectal cancer is the third most commonly diagnosed cancer in men and women and is a leading cause of cancer death.

The USPSTF has identified several important research gaps that could potentially identify other populations that may benefit from using aspirin to prevent cardiovascular disease and colorectal cancer, including the following:

- The role of aspirin therapy in racial/ethnic subpopulations
- The benefits and harms of aspirin therapy in adults younger than age 50 years or older than age 70 years
- The differential effects of sex, race/ethnicity, age, and genetic factors on risk for colorectal cancer and the effect of screening
- Longer-term followup of cardiovascular disease prevention trials that report cancer incidence and death outcomes

Screening for Skin Cancer in Adults

Skin cancer is the most common type of cancer in the United States. Some types of skin cancer, such as basal and squamous cell carcinoma, are more common but are treatable and rarely lead to death or substantial illness. However, melanoma, which is much less common than the other types of skin cancer, is more likely to result in death. An estimated 76,400 adults in the United States will develop melanoma and 10,000 will die from the disease in 2016.

The USPSTF identified a need for good-quality studies to help understand the following:

- The effectiveness of the clinical visual skin examination
- The possible harms of skin cancer screening, particularly for overdiagnosis and overtreatment (i.e., when patients are diagnosed or treated for skin cancer that would have never caused them any harm)

V. EVIDENCE GAPS RELATING TO SPECIFIC POPULATIONS THAT DESERVE FURTHER RESEARCH

Several clinical preventive services have been well studied for the general population, but important evidence gaps prevent the USPSTF from making recommendations for certain populations and age groups. This is often because these groups are not well represented in health research. Prime examples of such groups are older adults, children, and racial/ethnic minority groups. Greater inclusion of these populations in research will help the USPSTF issue recommendations that can be used to improve the quality of preventive care for these groups and to eliminate disparities in health care.

Screening for Breast Cancer in African American Women

White women have historically had higher breast cancer incidence rates than African American women; however, incidence rates between the two groups are now comparable. Despite having comparable incidence rates, African American women have higher rates of death from breast cancer than white women. Disparities may be, in part, due to differences in disease epidemiology. African American women are disproportionally affected by more aggressive and treatment-resistant forms of breast cancer. These types of cancer may be least likely to benefit from screening, because they can grow so rapidly that they develop and spread between screenings. The difference in death rate may also be due to socioeconomic differences and health system failures. Multiple studies have shown an association between being African American and experiencing delays in receiving health care services for cancer, not receiving appropriate treatment, or not receiving treatment at all. African American women are also not well represented in mammography screening trials.

There is a need for high-quality evidence to determine whether the recommendations on screening for breast cancer should be different for African American women than for the overall population of women. Studies are needed to determine whether screening African American women more often or earlier than the general population would result in more benefit and less harms.

Screening for Cervical Cancer in Hispanic and African American Women

Cervical cancer incidence and deaths have declined in the United States since the introduction of cervical cancer screening. However, incidence rates vary by age and race/ethnicity, both of which are associated with low income and poor access to health care and health insurance. Hispanic and African American women have higher cervical cancer incidence and death rates compared to other racial/ethnic groups in the United States. About half of all invasive cervical cancer cases are diagnosed in women who have never been screened or have not been screened in the last 5 years. An additional 10% of cases occur in women who did not have appropriate followup for an abnormal Pap smear.

There is a need for high-quality evidence on how to increase access to screening and treatment for women who are at increased risk. There is also a need for evidence on how human papillomavirus vaccination status should be used to inform subsequent cervical cancer screening.

Screening for Colorectal Cancer in African Americans and American Indians/Alaska Natives

African American adults have the highest colorectal cancer incidence and death rates compared to other racial/ethnic groups. Although the causes for these disparities are unclear, there appear to be several factors that contribute to the higher incidence and mortality in African Americans, including biological factors in disease presentation; lower rates of screening; and inequalities in screening, followup of abnormal screening tests, and treatment.

American Indians/Alaska Natives also have higher incidence and death rates compared to some other racial/ethnic groups. From 2001 to 2010, colorectal cancer incidence and death rates have declined among men and women of all racial/ethnic groups except American Indians/Alaska Natives. Colorectal cancer incidence rates have remained relatively stable among American Indian/Alaska Native men. Colorectal cancer death rates have also remained relatively stable among American Indians/Alaska Natives (American Cancer Society 2014).

There is a need for high-quality evidence on how to increase access to recommended screening, followup, and treatment for African Americans and American Indians/Alaska Natives. Research is also needed to determine the effectiveness of different screening strategies for these diverse populations.

VI. PRIOR REPORTS TO CONGRESS AND PROGRESS IN EVIDENCE GAPS

Since 2011, the Task Force has prepared for Congress an annual report on critical evidence gaps in the field of clinical preventive services (see **Appendices A, B, C, D,** and **E**). The Task Force encourages Congress to continue promoting research in the areas in which these evidence gaps remain. Researchers have responded by embarking on important work to address some of the areas where there previously was not enough evidence. For example:

1. **New evidence led the USPSTF to update its recommendation on screening for hepatitis C virus (HCV) infection from "insufficient evidence" to "recommended."** In its 2004 recommendation on screening for HCV infection in high-risk adults, the USPSTF issued an "I" statement for insufficient evidence. When the USPSTF updated its recommendation in 2013, it was able to determine that the benefits of screening outweighed the harms in populations at higher risk for infection. Based on the new evidence, the USPSTF changed its previous recommendation to recommend screening for HCV infection in people at high risk for infection and also one-time screening in people born between 1945 and 1965 (Grade B).
2. **New evidence led the USPSTF to update its recommendation on screening for hepatitis B virus (HBV) infection from "not recommended" to "recommended."** In 2004, the USPSTF recommended against screening for chronic HBV infection in asymptomatic people in the general population. When the recommendation was updated in 2014, the USPSTF focused on high-risk populations. Based on new evidence, the USPSTF determined that the benefits of screening outweighed the harms and recommended screening for HBV infection in people at high risk (Grade B).
3. **New evidence led the USPSTF to update its recommendation on screening for lung cancer from "insufficient evidence" to "recommended."** In 2004, the USPSTF concluded that there was not enough evidence to recommend for or against screening for lung cancer. In its 2013 recommendation, based on new evidence, the USPSTF determined that annual screening provided a substantial net benefit in adults ages 55 to 80 years who are at high risk for lung cancer (Grade B).

In addition, the USPSTF, the Agency for Healthcare Research and Quality, and the National Institutes of Health (NIH) are working together to enhance coordination in identifying key evidence gaps that may be addressed by research efforts through future funding opportunities. The NIH Office of Disease Prevention provides leadership for the development, coordination, and implementation of prevention research in collaboration with NIH Institutes and Centers and other Federal partners. These activities include partnering with the USPSTF, communicating USPSTF "I" statements to the NIH research community, and monitoring the prevention research portfolios of the NIH Institutes and Centers (Murray 2015).

VII. NEXT STEPS FOR THE USPSTF IN 2017

In the coming 12 months, it is expected that the USPSTF will:

- Continue its work on more than 40 topics that are in progress
- Continue work on 3 new topics nominated for consideration through the public topic nomination process
- Post 10 draft research plans and 10 draft recommendation statements and evidence reports for public comment
- Publish 10 final recommendation statements
- Continue to coordinate closely with the CPSTF to improve the Nation's ability to benefit from the full spectrum of prevention
- Prepare a seventh annual report for Congress on high-priority evidence gaps

The USPSTF appreciates the opportunity to report on its activities, to highlight critical evidence gaps, and to recommend important new areas for research in clinical preventive services. The members of the Task Force look forward to their ongoing work to improve the health of all Americans.

REFERENCES

American Cancer Society. Colorectal Cancer Facts & Figures 2014-2016. Atlanta: American Cancer Society; 2014.

Murray DM, Kaplan RM, Ngo-Metzger Q, et al. Enhancing coordination among the U.S. Preventive Services Task Force, Agency for Healthcare Research and Quality, and National Institutes of Health. *Am J Prev Med.* 2015;49(3 Suppl 2):S166-73.

"Research supported by the National Institutes of Health (NIH) provides most of the evidence that the USPSTF uses to guide development of its preventive service recommendations. As part of its systematic reviews, the USPSTF identifies gaps in prevention research. The NIH Office of Disease Prevention works with NIH Institutes and Centers to review those gaps annually to identify areas that might warrant expanded research effort or investment. In this way, the NIH and USPSTF work independently yet synergistically to improve the Nation's health."

– National Institutes of Health, Office of Disease Prevention

APPENDICES

APPENDIX A: SUMMARY OF FIFTH ANNUAL REPORT TO CONGRESS ON HIGH-PRIORITY EVIDENCE GAPS FOR CLINICAL PREVENTIVE SERVICES (2015)

The Patient Protection and Affordable Care Act of 2010 charges the USPSTF with making an annual report to Congress that identifies gaps in the evidence base and recommends priority areas that deserve further examination. In its previous four reports to Congress, the Task Force identified screening tests, behavioral interventions, and preventive medications with significant evidence gaps deserving further research. Given the expected pace of research, it is too soon to expect that many of the gaps identified in the Task Force's previous annual reports would have been addressed by clinical researchers. The Task Force therefore encourages Congress to continue promoting research to address these gaps.

In this annual report, the USPSTF prioritized evidence gaps related to the care of women. Research in these areas would generate much needed evidence for important new recommendations to improve the health and health care of women in the United States.

Prioritized Evidence Gaps for Improving the Health of Women Through Research on Clinical Preventive Services:

1. Screening for Intimate Partner Violence, Illicit Drug Use, and Mental Health Conditions
2. Screening for Thyroid Dysfunction
3. Screening for Vitamin D Deficiency, Vitamin D and Calcium Supplementation to Prevent Fractures, and Screening for Osteoporosis
4. Screening for Cancer
5. Implementing Clinical Preventive Services

The USPSTF will continue to independently evaluate the evidence on clinical preventive services to empower health care professionals, health care systems, and the American people to make informed decisions about their health and health care.

The USPSTF believes that identifying evidence gaps and highlighting them as priority areas for research will inspire public and private researchers to collaborate and target their efforts to generate new knowledge and address important health priorities.

To view the full report, visit: http://www.uspreventiveservicestaskforce.org/Page/Name/fifth-annual-report-to-congress-on-high-priority-evidence-gaps-for-clinical-preventive-services.

APPENDIX B: SUMMARY OF FOURTH ANNUAL REPORT TO CONGRESS ON HIGH-PRIORITY EVIDENCE GAPS FOR CLINICAL PREVENTIVE SERVICES (2014)

The Patient Protection and Affordable Care Act of 2010 charges the USPSTF with making an annual report to Congress that identifies gaps in the evidence base and recommends priority areas that deserve further examination. In its previous three reports to Congress, the Task Force identified screening tests, behavioral interventions, and preventive medications with significant evidence gaps deserving further research. Given the expected pace of research, it is too soon to expect that many of the gaps identified in the Task Force's previous annual reports would have been addressed by clinical researchers. The Task Force therefore encourages Congress to continue promoting research to address these gaps.

In this annual report, the USPSTF prioritized evidence gaps related to the care of children and adolescents. More research in these areas would likely result in important new recommendations that will help improve the health and health care of young Americans, with lasting benefits through adulthood.

Priorities for Improving the Health of Children and Adolescents Through Research on Clinical Preventive Services:

1. Mental Health Conditions and Substance Abuse
2. Obesity and Cardiovascular Health
3. Behavior and Development
4. Infectious Diseases
5. Cancer Prevention
6. Injury and Child Maltreatment
7. Vision Disorders

The USPSTF will continue to independently evaluate the evidence on clinical preventive services to empower health care professionals, health care systems, and the American people to make informed decisions about their health and health care.

The USPSTF believes that identifying evidence gaps and highlighting them as priority areas for research will inspire public and private researchers to collaborate and target their efforts to generate new knowledge and address important health priorities.

To view the full report, visit: http://www.uspreventiveservicestaskforce.org/Page/Name/fourth-annual-report-to-congress-on-high-priority-evidence-gaps-for-clinical-preventive-services.

APPENDIX C: SUMMARY OF THIRD ANNUAL REPORT TO CONGRESS ON HIGH-PRIORITY EVIDENCE GAPS FOR CLINICAL PREVENTIVE SERVICES (2013)

The Patient Protection and Affordable Care Act of 2010 charged the USPSTF with making an annual report to Congress that identifies gaps in the evidence base and recommends priority areas that deserve further examination.

In its first and second annual reports to Congress, the Task Force identified screening tests, behavioral interventions, and preventive medications with significant evidence gaps deserving further research. Given the expected pace of research, it is too soon to expect that many of the gaps identified in the USPSTF's first two annual reports would have been addressed. The USPSTF, therefore, encourages Congress to continue promoting research to address these gaps.

In the third annual report, issued in November 2013, the USPSTF prioritized evidence gaps related to the care of older adults. More research in these areas would likely result in important new recommendations that will help improve the health and health care of older Americans.

High-Priority Evidence Gaps for Clinical Preventive Services: Focus on Older Adults

1. Screening for Cognitive Impairment and Dementia
2. Screening for Physical and Mental Well-Being of Older Adults
3. Preventing Falls and Fractures
4. Screening for Vision and Hearing Problems
5. Avoiding the Unintended Harms of Medical Procedures and Testing in Older Adults

The USPSTF will continue to independently evaluate the evidence on clinical preventive services to empower health care professionals, health care systems, and the American people to make informed decisions about their health and health care.

The USPSTF believes that identifying these evidence gaps and prioritizing these areas for research will inspire public and private researchers to collaborate and target their efforts to generate new knowledge and fill current evidence gaps.

To view the full report, visit: http://www.uspreventiveservicestaskforce.org/Page/Name/third-annual-report-to-congress-on-high-priority-evidence-gaps-for-clinical-preventive-services.

APPENDIX D: SUMMARY OF SECOND ANNUAL REPORT TO CONGRESS ON HIGH-PRIORITY EVIDENCE GAPS FOR CLINICAL PREVENTIVE SERVICES (2012)

The Patient Protection and Affordable Care Act of 2010 charged the USPSTF with making an annual report to Congress that identifies gaps in the evidence base and recommends priority areas that deserve further examination. In its second annual report, issued November 2012, the USPSTF identified specific topics from its previous year of work as having important evidence gaps that may be addressed through research. More research in these areas would likely result in important new recommendations that will help to improve the health of Americans.

Clinical Preventive Services That Deserve Further Research:

1. Screening for Chronic Kidney Disease
2. Screening for Cervical Cancer With Human Papillomavirus (HPV) Tests
3. Screening for Prostate Cancer

In the Affordable Care Act, Congress also requested that the USPSTF identify evidence gaps that prevent it from making recommendations for specific populations or age groups. In this report, the USPSTF highlighted three key areas.

Evidence Gaps Relating to Specific Populations and Age Groups That Deserve Further Research:

1. Screening for Chronic Kidney Disease in African American Adults
2. Screening for Prostate Cancer in African American Men
3. Counseling About Sun-Protective Behaviors in Families With Children Under Age 10 to Reduce the Risk for Skin Cancer

The USPSTF believes that identifying these evidence gaps and prioritizing these areas for research will inspire public and private researchers to collaborate and target their efforts to generate new knowledge and fill current evidence gaps.

To view the full report, visit: http://www.uspreventiveservicestaskforce.org/Page/Name/second-annual-report-to-congress-on-high-priority-evidence-gaps-for-clinical-preventive-services.

APPENDIX E: SUMMARY OF FIRST ANNUAL REPORT TO CONGRESS ON HIGH-PRIORITY EVIDENCE GAPS FOR CLINICAL PREVENTIVE SERVICES (2011)

The Patient Protection and Affordable Care Act of 2010 charged the USPSTF with making an annual report to Congress to identify gaps in the evidence base and recommend priority areas that deserve further examination. The first annual report from the USPSTF was delivered to Congress in October 2011. In this report, the USPSTF identified the following high-priority evidence gaps that can be addressed through targeted research:

Screening Tests That Deserve Further Research:

1. Screening for Coronary Heart Disease With New and Old Technologies
2. Screening for Colorectal Cancer With New Modalities
3. Screening for Hepatitis C
4. Screening for Hip Dysplasia in Newborns

Behavioral Intervention Research Topics That Deserve Further Research:

1. Moderate- to Low-Intensity Counseling for Obesity
2. Interventions in Primary Care to Prevent Child Abuse and Neglect
3. Screening for Illicit Drug Use in Primary Care

In the Affordable Care Act, Congress also requested that the USPSTF identify evidence gaps that prevent it from making recommendations that target specific populations or age groups. In its 2011 report, the USPSTF highlighted the following key areas.

Evidence Gaps Relating to Specific Population and Age Groups That Deserve Further Research:

1. Screening for Osteoporosis in Men
2. Screening and Treatment for Depression in Children
3. Screening and Counseling for Alcohol Misuse in Adolescents
4. Aspirin Use to Prevent Heart Attacks and Strokes in Adults Age 80 and Older

By identifying these evidence gaps and prioritizing these areas for research, the USPSTF hopes to have inspired public and private researchers to focus their efforts in these areas so that the USPSTF can develop definitive recommendations on these important topics in the near future.

To view the full report, visit: http://www.uspreventiveservicestaskforce.org/Page/Name/first-annual-report-to-congress-on-high-priority-evidence-gaps-for-clinical-preventive-services.

APPENDIX F: 2016 MEMBERS OF THE USPSTF

Kirsten Bibbins-Domingo, Ph.D., M.D., M.A.S. (Chair)

David Grossman, M.D., M.P.H. (Vice Chair)

Susan J. Curry, Ph.D. (Vice Chair)

Karina W. Davidson, Ph.D., M.A.Sc.

John W. Epling, Jr., M.D., M.S.Ed.

Francisco García, M.D., M.P.H.

Alex R. Kemper, M.D., M.P.H., M.S.

Alexander H. Krist, M.D., M.P.H.

Ann E. Kurth, Ph.D., R.N., M.S.N., M.P.H.

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Carol M. Mangione, M.D., M.S.P.H.

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Michael P. Pignone, M.D., M.P.H

Michael Silverstein, M.D., M.P.H.

Chien-Wen Tseng, M.D., M.P.H., M.S.E.E.

APPENDIX G: 2016 USPSTF DISSEMINATION AND IMPLEMENTATION PARTNER ORGANIZATIONS

AARP
America's Health Insurance Plans
American Academy of Family Physicians
American Association of Nurse Practitioners
American Academy of Pediatrics
American Academy of Physician Assistants
American College of Obstetricians and Gynecologists
American College of Physicians
American College of Preventive Medicine
American Medical Association
American Osteopathic Association
American Psychological Association
Canadian Task Force on Preventive Health Care
Community Preventive Services Task Force
Consumers Union
National Association of Pediatric Nurse Practitioners
National Business Group on Health
National Committee for Quality Assurance
Patient-Centered Outcomes Research Institute

APPENDIX H: 2016 FEDERAL LIAISONS TO THE USPSTF

Centers for Disease Control and Prevention
Centers for Medicare & Medicaid Services
Community Preventive Services Task Force
Department of Defense/Military Health System
Food and Drug Administration
Health Resources and Services Administration
Indian Health Service
National Cancer Institute
National Institutes of Health
Office of Disease Prevention and Health Promotion
Substance Abuse and Mental Health Services Administration
Veterans Health Administration

APPENDIX I: COMPLETE LISTING OF ALL USPSTF RECOMMENDATIONS AS OF OCTOBER 2016

Grade	Title
A	**Bacteriuria: Screening in Pregnant Women** The USPSTF recommends screening for asymptomatic bacteriuria with urine culture in pregnant women at 12 to 16 weeks of gestation or at the first prenatal visit, if later.
A	**Cervical Cancer: Screening in Women Ages 21 to 65 (Cytology) or 30 to 65 (Cytology With HPV Testing) Years** The USPSTF recommends screening for cervical cancer in women ages 21 to 65 years with cytology (Pap smear) every 3 years or, for women ages 30 to 65 years who want to lengthen the screening interval, screening with a combination of cytology and human papillomavirus (HPV) testing every 5 years.
A	**Colorectal Cancer: Screening in Adults Ages 50 to 75 Years** The USPSTF recommends screening for colorectal cancer starting at age 50 years and continuing until age 75 years. The risks and benefits of different screening methods vary.
A	**Folic Acid: Supplementation in Women Planning or Capable of Pregnancy** The USPSTF recommends that all women planning or capable of pregnancy take a daily supplement containing 0.4 to 0.8 mg (400 to 800 µg) of folic acid.
A	**Gonococcal Ophthalmia Neonatorum: Preventive Medication for Newborns** The USPSTF recommends prophylactic ocular topical medication for all newborns for the prevention of gonococcal ophthalmia neonatorum.
A	**Hepatitis B Virus: Screening in Pregnant Women** The USPSTF recommends screening for hepatitis B virus infection in all pregnant women at their first prenatal visit.
A	**HIV: Screening in Adolescents and Adults Ages 15 to 65 Years** The USPSTF recommends screening for HIV infection in adolescents and adults ages 15 to 65 years. Younger adolescents and older adults who are at increased risk should also be screened.
A	**HIV: Screening in Pregnant Women** The USPSTF recommends screening all pregnant women for HIV, including those in labor who are untested and whose HIV status is unknown.
A	**Hypertension: Screening in Adults** The USPSTF recommends screening for high blood pressure in adults age 18 years and older. The USPSTF recommends obtaining measurements outside of the clinical setting for diagnostic confirmation before starting treatment.
A	**Lipid Disorders: Screening in Men Age 35 Years and Older** The USPSTF recommends screening for lipid disorders in men age 35 years and older.

Grade	Title
A	**Lipid Disorders: Screening in Women Age 45 Years and Older at Increased Risk for Coronary Heart Disease** The USPSTF recommends screening for lipid disorders in women age 45 years and older who are at increased risk for coronary heart disease.
A	**Rh(D) Blood Typing: Screening in Pregnant Women at First Pregnancy-Related Visit** The USPSTF strongly recommends Rh(D) blood typing and antibody testing for all pregnant women during their first visit for pregnancy-related care.
A	**Syphilis: Screening in Nonpregnant Adults and Adolescents** The USPSTF recommends screening for syphilis infection in persons who are at increased risk for infection.
A	**Syphilis: Screening in Pregnant Women** The USPSTF recommends screening for syphilis infection in all pregnant women.
A	**Tobacco Smoking Cessation: Behavioral and Pharmacotherapy Interventions for Nonpregnant Adults** The USPSTF recommends that clinicians ask all adults about tobacco use, advise them to stop using tobacco, and provide behavioral interventions and U.S. Food and Drug Administration–approved pharmacotherapy for cessation to adults who use tobacco.
A	**Tobacco Smoking Cessation: Behavioral Interventions for Pregnant Women** The USPSTF recommends that clinicians ask all pregnant women about tobacco use, advise them to stop using tobacco, and provide behavioral interventions for cessation to pregnant women who use tobacco.
B	**Abdominal Aortic Aneurysm: Screening in Men Ages 65 to 75 Years Who Smoke** The USPSTF recommends one-time screening for abdominal aortic aneurysm by ultrasonography in men ages 65 to 75 years who have ever smoked.
B	**Abnormal Blood Glucose and Type 2 Diabetes Mellitus: Screening in Adults** The USPSTF recommends screening for abnormal blood glucose as part of cardiovascular risk assessment in adults ages 40 to 70 years who are overweight or obese. Clinicians should offer or refer patients with abnormal glucose to intensive behavioral counseling interventions to promote a healthful diet and physical activity.
B	**Alcohol Misuse: Screening and Counseling for Adults** The USPSTF recommends screening in adults age 18 years or older for alcohol misuse and providing persons engaged in risky or hazardous drinking with brief behavioral counseling interventions to reduce alcohol misuse.
B	**Aspirin Use to Prevent Cardiovascular Disease and Colorectal Cancer: Preventive Medication for Adults Ages 50 to 59 Years** The USPSTF recommends initiating low-dose aspirin use for the primary prevention of cardiovascular disease (CVD) and colorectal cancer in adults ages 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.

Grade	Title
B	**Aspirin to Prevent Morbidity and Mortality From Preeclampsia: Preventive Medication for Pregnant Women** The USPSTF recommends the use of low-dose aspirin (81 mg/day) as preventive medication after 12 weeks of gestation in women who are at high risk for preeclampsia.
B	**BRCA-Related Cancer: Risk Assessment, Genetic Counseling, and Genetic Testing in Women at Increased Risk** The USPSTF recommends screening in women who have family members with breast, ovarian, tubal, or peritoneal cancer with one of several screening tools designed to identify a family history that may be associated with an increased risk for potentially harmful mutations in breast cancer susceptibility genes (*BRCA1* or *BRCA2*). Women with positive screening results should receive genetic counseling and, if indicated after counseling, BRCA testing.
B	**Breast Cancer: Preventive Medications for Women at Increased Risk** The USPSTF recommends that clinicians engage in shared, informed decisionmaking with women who are at increased risk for breast cancer about medications to reduce their risk. For women who are at increased risk for breast cancer and at low risk for adverse medication effects, clinicians should offer to prescribe risk-reducing medications, such as tamoxifen or raloxifene.
B	**Breast Cancer: Screening With Mammography in Women Ages 50 to 74 Years*** The USPSTF recommends biennial screening mammography for women ages 50 to 74 years.
B	**Breastfeeding: Interventions for Pregnant Women and New Mothers** The USPSTF recommends interventions during pregnancy and after birth to promote and support breastfeeding.
B	**Chlamydia and Gonorrhea: Screening in Women Age 24 Years and Younger and in Older Women Who Are at Increased Risk** The USPSTF recommends screening for chlamydia and gonorrhea in sexually active women age 24 years and younger and in older women who are at increased risk for infection.
B	**Dental Caries: Preventive Medication for Children Age 5 Years and Younger** The USPSTF recommends that primary care clinicians prescribe oral fluoride supplementation starting at age 6 months for children whose water supply is deficient in fluoride. The USPSTF recommends that primary care clinicians apply fluoride varnish to the primary teeth of all infants and children starting at the age of primary tooth eruption.
B	**Depression: Screening in Children and Adolescents** The USPSTF recommends screening for major depressive disorder in adolescents ages 12 to 18 years. Screening should be implemented with adequate systems in place to ensure accurate diagnosis, effective treatment, and appropriate followup.
B	**Depression: Screening in Adults** The USPSTF recommends screening for depression in the general adult population, including pregnant and postpartum women Screening should be implemented with adequate systems in place to ensure accurate diagnosis, effective treatment, and appropriate followup.

* The Department of Health and Human Services, in implementing the Affordable Care Act under the standard it sets out in revised Section 2713(a)(5) of the Public Health Service Act and Section 9(h)(v)(229) of the 2015 Consolidated Appropriations Act, utilizes the 2002 USPSTF recommendation on breast cancer screening (available at http://www.uspreventiveservicestaskforce.org/Page/Document/UpdateSummaryFinal/breast-cancer-screening-2002).

Grade	Title
B	**Falls Prevention: Interventions for Community-Dwelling Adults Age 65 Years and Older at Increased Risk** The USPSTF recommends exercise or physical therapy to prevent falls in community-dwelling adults age 65 years and older who are at increased risk for falls.
B	**Falls Prevention: Vitamin D in Community-Dwelling Adults Age 65 Years and Older at Increased Risk** The USPSTF recommends vitamin D supplementation to prevent falls in community-dwelling adults age 65 years and older who are at increased risk for falls.
B	**Gestational Diabetes Mellitus: Screening in Pregnant Women After 24 Weeks of Gestation** The USPSTF recommends screening for gestational diabetes mellitus in asymptomatic pregnant women after 24 weeks of gestation.
B	**Healthful Diet and Physical Activity for Cardiovascular Disease Prevention: Counseling for Adults With Cardiovascular Risk Factors** The USPSTF recommends offering or referring adults who are overweight or obese and have additional cardiovascular risk factors to intensive behavioral counseling interventions to promote a healthful diet and physical activity for cardiovascular disease prevention.
B	**Hepatitis B Virus: Screening in Nonpregnant Adolescents and Adults** The USPSTF recommends screening for hepatitis B virus infection in nonpregnant adolescents and adults who are at high risk for infection.
B	**Hepatitis C Virus: Screening in Adults at High Risk and Adults Born Between 1945 and 1965** The USPSTF recommends screening for hepatitis C virus infection in adults at high risk for infection. The USPSTF also recommends offering one-time screening for hepatitis C virus infection to adults born between 1945 and 1965.
B	**Intimate Partner Violence: Screening in Women of Childbearing Age** The USPSTF recommends that clinicians screen women of childbearing age for intimate partner violence, such as domestic violence, and provide or refer women who screen positive to intervention services.
B	**Latent Tuberculosis Infection: Screening in Adults** The USPSTF recommends screening for latent tuberculosis infection in populations at increased risk.
B	**Lipid Disorders in Adults: Screening in Men Ages 20 to 35 Years at Increased Risk for Coronary Heart Disease** The USPSTF recommends screening for lipid disorders in men ages 20 to 35 years who are at increased risk for coronary heart disease.
B	**Lipid Disorders: Screening in Women Ages 20 to 45 Years at Increased Risk for Coronary Heart Disease** The USPSTF recommends screening for lipid disorders in women ages 20 to 45 years who are at increased risk for coronary heart disease.

Grade	Title
B	**Lung Cancer: Screening in Adults** The USPSTF recommends annual screening for lung cancer with low-dose computed tomography in adults ages 55 to 80 years who have a 30 pack-year smoking history and currently smoke or have quit within the past 15 years. Screening should be discontinued once a person has not smoked for 15 years or develops a health problem that substantially limits life expectancy or the ability or willingness to have curative lung surgery.
B	**Obesity: Screening and Management in Adults** The USPSTF recommends screening for obesity in all adults. Clinicians should offer or refer patients with a body mass index of 30 kg/m^2 or greater to intensive, multicomponent behavioral interventions.
B	**Obesity: Screening in Children and Adolescents Ages 6 to 18 Years** The USPSTF recommends that clinicians screen for obesity in children age 6 years and older and offer or refer them to comprehensive, intensive behavioral interventions to promote improvement in weight status.
B	**Osteoporosis: Screening in Women Age 65 Years and Older and Younger Women at Increased Risk** The USPSTF recommends screening for osteoporosis in women age 65 years and older and in younger women whose fracture risk is equal to or greater than that of a 65-year-old white woman who has no additional risk factors.
B	**Rh(D) Blood Typing: Antibody Testing in Unsensitized Rh(D)-Negative Pregnant Women** The USPSTF recommends repeated Rh(D) antibody testing for all unsensitized Rh(D)-negative women at 24 to 28 weeks of gestation, unless the biological father is known to be Rh(D)-negative.
B	**Sexually Transmitted Infections: Counseling for Sexually Active Adolescents and Adults at Increased Risk** The USPSTF recommends intensive behavioral counseling for all sexually active adolescents and for adults who are at increased risk for sexually transmitted infections.
B	**Skin Cancer: Counseling for Children, Adolescents, and Young Adults Ages 10 to 24 Years** The USPSTF recommends counseling children, adolescents, and young adults ages 10 to 24 years who have fair skin about minimizing their exposure to ultraviolet radiation to reduce risk for skin cancer.
B	**Tobacco Use: Interventions for Children and Adolescents** The USPSTF recommends that primary care clinicians provide interventions, including education or brief counseling, to prevent initiation of tobacco use in school-aged children and adolescents.
B	**Visual Impairment: Screening in Children Ages 3 to 5 Years** The USPSTF recommends screening for vision impairment in all children at least once between the ages of 3 and 5 years to detect the presence of amblyopia or its risk factors.
C	**Abdominal Aortic Aneurysm: Screening in Men Ages 65 to 75 Years Who Do Not Smoke** The USPSTF recommends selectively offering screening for abdominal aortic aneurysm in men ages 65 to 75 years who have never smoked rather than routinely screening all men in this group.

Grade	Title
C	**Aspirin to Prevent Cardiovascular Disease and Colorectal Cancer: Preventive Medication for Adults Ages 60 to 69 Years** The decision to initiate low-dose aspirin use for the primary prevention of cardiovascular disease (CVD) and colorectal cancer in adults ages 60 to 69 years who have a 10% or greater 10-year CVD risk should be an individual one. Persons who 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 are more likely to benefit. Persons who place a higher value on the potential benefits than the potential harms may choose to initiate low-dose aspirin.
C	**Breast Cancer: Screening With Mammography in Women Ages 40 to 49 Years*** The decision to start screening mammography in women prior to age 50 years should be an individual one. Women who place a higher value on the potential benefit than the potential harms may choose to begin biennial screening between the ages of 40 and 49 years.
C	**Colorectal Cancer: Screening in Adults Ages 76 to 85 Years** The decision to screen for colorectal cancer in adults ages 76 to 85 years should be an individual one, taking into account the patient's overall health and prior screening history.
C	**Falls Prevention: Multifactorial Risk Assessment With Comprehensive Risk Management for Community-Dwelling Adults Age 65 Years and Older** The USPSTF does not recommend automatically performing an in-depth multifactorial risk assessment in conjunction with comprehensive management of identified risks to prevent falls in community-dwelling adults age 65 years and older because the likelihood of benefit is small. In determining whether this service is appropriate in individual cases, patients and clinicians should consider the balance of benefits and harms on the basis of the circumstances of prior falls, comorbid medical conditions, and patient values.
C	**Healthful Diet and Physical Activity for Cardiovascular Disease Prevention: Counseling for Adults Without Cardiovascular Risk Factors** Although the correlation among healthful diet, physical activity, and the incidence of cardiovascular disease is strong, existing evidence indicates that the health benefit of initiating behavioral counseling in the primary care setting to promote a healthful diet and physical activity is small. Clinicians may choose to selectively counsel patients rather than incorporate counseling into the care of all adults in the general population.
C	**Lipid Disorders: Screening in Men Ages 20 to 35 Years Not at Increased Risk for Coronary Heart Disease** The USPSTF makes no recommendation for or against routine screening for lipid disorders in men ages 20 to 35 years who are not at increased risk for coronary heart disease.
C	**Lipid Disorders: Screening in Women Age 20 Years and Older Not at Increased Risk for Coronary Heart Disease** The USPSTF makes no recommendation for or against routine screening for lipid disorders in women age 20 years and older who are not at increased risk for coronary heart disease.

* The Department of Health and Human Services, in implementing the Affordable Care Act under the standard it sets out in revised Section 2713(a)(5) of the Public Health Service Act and Section 9(h)(v)(229) of the 2015 Consolidated Appropriations Act, utilizes the 2002 USPSTF recommendation on breast cancer screening (available at http://www.uspreventiveservicestaskforce.org/Page/Document/UpdateSummaryFinal/breast-cancer-screening-2002).

Grade	Title
D	**Abdominal Aortic Aneurysm: Screening in Women Who Have Never Smoked** The USPSTF recommends against routine screening for abdominal aortic aneurysm in women who have never smoked.
D	**Bacterial Vaginosis: Screening in Pregnant Women at Low Risk for Preterm Delivery** The USPSTF recommends against screening for bacterial vaginosis in asymptomatic pregnant women who are at low risk for preterm delivery.
D	**Bacteriuria: Screening in Men and Nonpregnant Women** The USPSTF recommends against screening for asymptomatic bacteriuria in men and nonpregnant women.
D	**Beta-Carotene and Vitamin E to Prevent Cancer and Cardiovascular Disease: Supplementation in Adults** The USPSTF recommends against the use of beta-carotene or vitamin E supplements for the prevention of cardiovascular disease or cancer.
D	**BRCA-Related Cancer: Risk Assessment, Genetic Counseling, and Genetic Testing in Women at Low Risk** The UPSTF recommends against routine genetic counseling or BRCA testing for women whose family history is not associated with an increased risk for potentially harmful mutations in the *BRCA1* or *BRCA2* genes.
D	**Breast Cancer: Preventive Medication for Women Not at Increased Risk** The USPSTF recommends against the routine use of medications, such as tamoxifen or raloxifene, for risk reduction of primary breast cancer in women who are not at increased risk for breast cancer.
D	**Carotid Artery Stenosis: Screening in Adults** The USPSTF recommends against screening for asymptomatic carotid artery stenosis in the general adult population.
D	**Cervical Cancer: Screening in Women Older Than Age 65 Years Who Have Had Adequate Prior Screening** The USPSTF recommends against screening for cervical cancer in women older than age 65 years who have had adequate prior screening and are not otherwise at high risk for cervical cancer.
D	**Cervical Cancer: Screening in Women Who Have Had a Hysterectomy** The USPSTF recommends against screening for cervical cancer in women who have had a hysterectomy with removal of the cervix and who do not have a history of a high-grade precancerous lesion (cervical intraepithelial neoplasia grade 2 or 3) or cervical cancer.
D	**Cervical Cancer: Screening in Women Younger Than Age 21 Years** The USPSTF recommends against screening for cervical cancer in women younger than age 21 years.
D	**Cervical Cancer: Screening With HPV Testing in Women Younger Than Age 30 Years** The USPSTF recommends against screening for cervical cancer with human papillomavirus (HPV) testing, alone or in combination with cytology, in women younger than age 30 years.

Grade	Title
D	**Chronic Obstructive Pulmonary Disease: Screening in Adults** The USPSTF recommends against screening for chronic obstructive pulmonary disease in asymptomatic adults.
D	**Coronary Heart Disease: Screening With Electrocardiography in Adults at Low Risk** The USPSTF recommends against screening with resting or exercise electrocardiography for the prediction of coronary heart disease events in asymptomatic adults at low risk for such events.
D	**Genital Herpes: Screening in Adolescents and Adults** The USPSTF recommends against routine serological screening for herpes simplex virus in asymptomatic adolescents and adults.
D	**Genital Herpes: Screening in Pregnant Women** The USPSTF recommends against routine serological screening for herpes simplex virus in asymptomatic pregnant women.
D	**Hormone Therapy With Combined Estrogen and Progestin: Preventive Medication for Postmenopausal Women** The USPSTF recommends against the use of combined estrogen and progestin for the prevention of chronic conditions in postmenopausal women.
D	**Hormone Therapy With Estrogen: Preventive Medication for Postmenopausal Women Who Have Had a Hysterectomy** The USPSTF recommends against the use of estrogen for the prevention of chronic conditions in postmenopausal women who have had a hysterectomy.
D	**Idiopathic Scoliosis: Screening in Adolescents** The USPSTF recommends against routine screening for idiopathic scoliosis in asymptomatic adolescents.
D	**Lead: Screening in Children Ages 1 to 5 Years at Average Risk** The USPSTF recommends against routine screening for elevated blood lead levels in asymptomatic children ages 1 to 5 years who are at average risk.
D	**Lead: Screening in Pregnant Women** The USPSTF recommends against routine screening for elevated blood lead levels in asymptomatic pregnant women.
D	**Ovarian Cancer: Screening in Women** The USPSTF recommends against screening for ovarian cancer in asymptomatic women. Women with known genetic mutations that increase their risk for ovarian cancer (e.g., BRCA mutations) are not included in this recommendation.
D	**Pancreatic Cancer: Screening in Adults** The USPSTF recommends against routine screening for pancreatic cancer with abdominal palpation, ultrasonography, or serologic markers in asymptomatic adults.

Grade	Title
D	**Prostate Cancer: Prostate-Specific Antigen-Based Screening in Men** The USPSTF recommends against prostate-specific antigen-based screening for prostate cancer.
D	**Testicular Cancer: Screening in Adolescents and Adults** The USPSTF recommends against screening for testicular cancer in adolescents or adults.
D	**Vitamin D and Calcium to Prevent Fractures: Low-Dose Supplementation in Postmenopausal Women** The USPSTF recommends against daily supplementation with 400 IU or less of vitamin D and 1,000 mg or less of calcium for the primary prevention of fractures in noninstitutionalized, postmenopausal women.
I	**Abdominal Aortic Aneurysm: Screening in Women Ages 65 to 75 Years Who Have Ever Smoked** The USPSTF concludes that the current evidence is insufficient to assess the balance of benefits and harms of screening for abdominal aortic aneurysm in women ages 65 to 75 years who have ever smoked.
I	**Abuse and Neglect: Screening in Elderly or Vulnerable Adults** The USPSTF concludes that the current evidence is insufficient to assess the balance of benefits and harms of screening for abuse and neglect in all elderly or vulnerable (physically or mentally dysfunctional) adults.
I	**Alcohol Misuse: Screening and Counseling in Adolescents** The USPSTF concludes that the current evidence is insufficient to assess the balance of benefits and harms of screening and behavioral counseling interventions in primary care settings to reduce alcohol misuse in adolescents.
I	**Aspirin Use to Prevent Cardiovascular Disease and Colorectal Cancer: Preventive Medication for Adults Age 70 Years and Older** The USPSTF concludes that the current evidence is insufficient to assess the balance of benefits and harms of initiating aspirin use for the primary prevention of cardiovascular disease and colorectal cancer in adults age 70 years and older.
I	**Aspirin Use to Prevent Cardiovascular Disease and Colorectal Cancer: Preventive Medication for Adults Younger Than Age 50 Years** The USPSTF concludes that the current evidence is insufficient to assess the balance of benefits and harms of initiating aspirin use for the primary prevention of cardiovascular disease and colorectal cancer in adults younger than age 50 years.
I	**Autism Spectrum Disorder: Screening in Young Children** The USPSTF concludes that the current evidence is insufficient to assess the balance of benefits and harms of screening for autism spectrum disorder in young children for whom no concerns of the disorder have been raised by their parents or a clinician.
I	**Bacterial Vaginosis: Screening in Pregnant Women at High Risk for Preterm Delivery** The USPSTF concludes that the current evidence is insufficient to assess the balance of benefits and harms of screening for bacterial vaginosis in asymptomatic pregnant women who are at high risk for preterm delivery.

Grade	Title
I	**Bladder Cancer: Screening in Adults** The USPSTF concludes that the current evidence is insufficient to assess the balance of benefits and harms of screening for bladder cancer in asymptomatic adults.
I	**Breast Cancer: Adjunctive Screening in Women With Dense Breasts*** The USPSTF concludes that the current evidence is insufficient to assess the balance of benefits and harms of adjunctive screening for breast cancer using breast ultrasonography, magnetic resonance imaging, digital breast tomosynthesis, or other methods in women identified to have dense breasts on an otherwise negative screening mammogram.
I	**Breast Cancer: Screening in Women Age 75 Years and Older*** The USPSTF concludes that the current evidence is insufficient to assess the balance of benefits and harms of screening mammography in women age 75 years and older.
I	**Breast Cancer: Screening With Digital Breast Tomosynthesis*** The USPSTF concludes that the current evidence is insufficient to assess the benefits and harms of digital breast tomosynthesis as a primary screening method for breast cancer.
I	**Child Maltreatment: Interventions for Primary Care** The USPSTF concludes that the current evidence is insufficient to assess the balance of benefits and harms of primary care interventions to prevent child maltreatment. The recommendation applies to children who do not have signs or symptoms of maltreatment.
I	**Chlamydia and Gonorrhea: Screening in Men** The USPSTF concludes that the current evidence is insufficient to assess the balance of benefits and harms of screening for chlamydia and gonorrhea in men.
I	**Chronic Kidney Disease: Screening in Adults** The USPSTF concludes that the evidence is insufficient to assess the balance of benefits and harms of routine screening for chronic kidney disease in asymptomatic adults.
I	**Cognitive Impairment: Screening in Older Adults** The USPSTF concludes that the current evidence is insufficient to assess the balance of benefits and harms of screening for cognitive impairment.
I	**Coronary Heart Disease: Risk Assessment With Nontraditional Risk Factors in Adults** The USPSTF concludes that the current evidence is insufficient to assess the balance of benefits and harms of using nontraditional risk factors to screen asymptomatic adults with no history of coronary heart disease to prevent such events. Nontraditional risk factors include high-sensitivity C-reactive protein, ankle-brachial index, leukocyte count, fasting blood glucose level, periodontal disease, carotid intima-media thickness, coronary artery calcification score on electron-beam computed tomography, homocysteine level, and lipoprotein(a) level.

* The Department of Health and Human Services, in implementing the Affordable Care Act under the standard it sets out in revised Section 2713(a)(5) of the Public Health Service Act and Section 9(h)(v)(229) of the 2015 Consolidated Appropriations Act, utilizes the 2002 USPSTF recommendation on breast cancer screening (available at http://www.uspreventiveservicestaskforce.org/Page/Document/UpdateSummaryFinal/breast-cancer-screening-2002).

Grade	Title
I	**Coronary Heart Disease: Screening With Electrocardiography in Adults at Intermediate or High Risk** The USPSTF concludes that the current evidence is insufficient to assess the balance of benefits and harms of screening with resting or exercise electrocardiography for the prediction of coronary heart disease events in asymptomatic adults who are at intermediate or high risk for such events.
I	**Dental Caries: Screening in Children Age 5 Years and Younger** The USPSTF concludes that the current evidence is insufficient to assess the balance of benefits and harms of routine screening for dental caries performed by primary care clinicians in children age 5 years and younger.
I	**Depression: Screening in Children Age 11 Years and Younger** The USPSTF concludes that the current evidence is insufficient to assess the balance of benefits and harms of screening for major depressive disorder in children age 11 years and younger.
I	**Drug Use, Illicit: Primary Care Interventions for Children and Adolescents** The USPSTF concludes that the current evidence is insufficient to assess the balance of benefits and harms of primary care–based behavioral interventions to prevent or reduce illicit drug or nonmedical pharmaceutical use in children and adolescents.
I	**Drug Use, Illicit: Screening in Adolescents, Adults, and Pregnant Women** The USPSTF concludes that the current evidence is insufficient to assess the balance of benefits and harms of screening for illicit drug use in adolescents, adults, and pregnant women.
I	**Gestational Diabetes Mellitus: Screening in Pregnant Women Before 24 Weeks of Gestation** The USPSTF concludes that the current evidence is insufficient to assess the balance of benefits and harms of screening for gestational diabetes mellitus in asymptomatic pregnant women before 24 weeks of gestation.
I	**Glaucoma: Screening in Adults** The USPSTF concludes that the current evidence is insufficient to assess the balance of benefits and harms of screening for primary open-angle glaucoma in adults.
I	**Hearing Loss: Screening in Older Adults** The USPSTF concludes that the current evidence is insufficient to assess the balance of benefits and harms of screening for hearing loss in asymptomatic adults age 50 years and older.
I	**Hip Dysplasia: Screening in Infants** The USPSTF concludes that the evidence is insufficient to recommend routine screening for developmental dysplasia of the hip in infants.
I	**Hypertension: Screening in Children and Adolescents** The USPSTF concludes that the current evidence is insufficient to assess the balance of benefits and harms of screening for primary hypertension in asymptomatic children and adolescents to prevent subsequent cardiovascular disease in childhood or adulthood.

Grade	Title
I	**Iron: Supplementation in Pregnant Women** The USPSTF concludes that the current evidence is insufficient to assess the balance of benefits and harms of routine iron supplementation for pregnant women to prevent adverse maternal health and birth outcomes.
I	**Iron Deficiency Anemia: Screening in Pregnant Women** The USPSTF concludes that the current evidence is insufficient to assess the balance of benefits and harms of screening for iron deficiency anemia in pregnant women to prevent adverse maternal health and birth outcomes.
I	**Iron Deficiency Anemia: Screening in Children Ages 6 to 24 Months** The USPSTF concludes that the current evidence is insufficient to assess the balance of benefits and harms of screening for iron deficiency anemia in children ages 6 to 24 months.
I	**Lead: Screening in Children Ages 1 to 5 Years at Increased Risk** The USPSTF concludes that the evidence is insufficient to recommend for or against routine screening for elevated blood lead levels in asymptomatic children ages 1 to 5 years who are at increased risk.
I	**Lipid Disorders: Screening in Children and Adolescents Age 20 Years and Younger** The USPSTF concludes that the evidence is insufficient to assess the balance of benefits and harms of screening for lipid disorders in children and adolescents age 20 years and younger.
I	**Multivitamins to Prevent Cardiovascular Disease and Cancer: Supplementation in Adults** The USPSTF concludes that the current evidence is insufficient to assess the balance of benefits and harms of the use of multivitamins for the prevention of cardiovascular disease or cancer.
I	**Nutrient Supplements to Prevent Cardiovascular Disease and Cancer: Supplementation in Adults** The USPSTF concludes that the current evidence is insufficient to assess the balance of benefits and harms of the use of single- or paired-nutrient supplements (except beta-carotene and vitamin E) for the prevention of cardiovascular disease or cancer in adults.
I	**Oral Cancer: Screening in Adults** The USPSTF concludes that the current evidence is insufficient to assess the balance of benefits and harms of screening for oral cancer in asymptomatic adults.
I	**Osteoporosis: Screening in Men** The USPSTF concludes that the current evidence is insufficient to assess the balance of benefits and harms of screening for osteoporosis in men.
I	**Peripheral Artery Disease and Cardiovascular Disease Risk Assessment: Screening With the Ankle-Brachial Index in Adults** The USPSTF concludes that the current evidence is insufficient to assess the balance of benefits and harms of screening for peripheral artery disease and cardiovascular disease risk assessment with the ankle-brachial index in adults.

Grade	Title
I	**Skin Cancer: Counseling for Adults Older Than Age 24 Years** The USPSTF concludes that the current evidence is insufficient to assess the balance of benefits and harms of counseling adults older than age 24 years about minimizing risks to prevent skin cancer.
I	**Skin Cancer: Screening in Adults** The USPSTF concludes that the current evidence is insufficient to assess the balance of benefits and harms of visual skin examination by a clinician to screen for skin cancer in adults.
I	**Speech and Language Delay: Screening in Children Age 5 Years and Younger** The USPSTF concludes that the current evidence is insufficient to assess the balance of benefits and harms of screening for speech and language delay and disorders in children age 5 years and younger.
I	**Suicide Risk: Screening in Adolescents, Adults, and Older Adults** The USPSTF concludes that the current evidence is insufficient to assess the balance of benefits and harms of screening for suicide risk in adolescents, adults, and older adults in primary care.
I	**Thyroid Dysfunction: Screening in Nonpregnant Adults** The USPSTF concludes that the current evidence is insufficient to assess the balance of benefits and harms of screening for thyroid dysfunction in nonpregnant, asymptomatic adults.
I	**Tobacco Smoking Cessation: Electronic Nicotine Delivery Systems for Adults, Including Pregnant Women** The USPSTF concludes that the current evidence is insufficient to recommend electronic nicotine delivery systems for tobacco cessation in adults, including pregnant women. The USPSTF recommends that clinicians direct patients who smoke tobacco to other cessation interventions with established effectiveness and safety.
I	**Tobacco Smoking Cessation: Pharmacotherapy Interventions for Pregnant Women** The USPSTF concludes that the current evidence is insufficient to assess the balance of benefits and harms of pharmacotherapy interventions for tobacco cessation in pregnant women.
I	**Visual Acuity: Screening in Older Adults** The USPSTF concludes that the current evidence is insufficient to assess the balance of benefits and harms of screening for impaired visual acuity in older adults.
I	**Visual Impairment: Screening in Children Younger Than Age 3 Years** The USPSTF concludes that the current evidence is insufficient to assess the balance of benefits and harms of screening for vision impairment in children younger than age 3 years.
I	**Vitamin D Deficiency: Screening in Adults** The USPSTF concludes that the current evidence is insufficient to assess the balance of benefits and harms of screening for vitamin D deficiency in asymptomatic adults.

Grade	Title
I	**Vitamin D and Calcium to Prevent Fractures: High-Dose Supplementation in Postmenopausal Women** The USPSTF concludes that the current evidence is insufficient to assess the balance of the benefits and harms of daily supplementation with greater than 400 IU of vitamin D and greater than 1,000 mg of calcium for the primary prevention of fractures in noninstitutionalized, postmenopausal women.
I	**Vitamin D and Calcium to Prevent Fractures: Supplementation in Premenopausal Women or Men** The USPSTF concludes that the current evidence is insufficient to assess the balance of the benefits and harms of combined vitamin D and calcium supplementation for the primary prevention of fractures in premenopausal women or in men.


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