Recommendations For Well-Women Care

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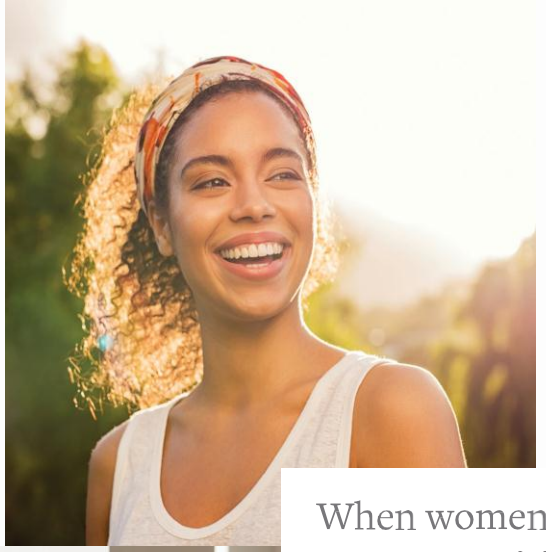

When women are **healthy,** communities **thrive.**

WPSI

Women's Preventive Services Initiative

In 2016 ACOG launched the women's preventive services initiative(***WPSI***).

The WPSI recommends:

Women at least receive on preventive care visit per year, beginning in adolescence , continuing across the life span.

Additional well-women visit may be needed to obtain all necessary services depending on :

- ✓ Age
- ✓ Health status
- ✓ Reproductive health needs
- ✓ Pregnancy status
- ✓ Risk factor

Well-women preventive services may include

- Assessment of physical and psychosocial function
- Primary and secondary prevention and screening risk factor assessment
- Immunization
- Counseling
- Education
- Preconception care
- Paternal care

In heath care , the focus is shifting from disease to prevention .

Prevention care includes:

- ✓Reproductive life planning
- ✓Optimization of nutrition and exercise
- ✓Screening and management of chronic disease
- ✓Immunization
- ✓Management of infectious disease
- ✓Attention to psychological and behavioral heath.

Thyroid disease

- Recommendation for screening asymptomatic women for thyroid disorders in women range from every 5 years starting at age 35 to 50 years and periodic in elder women.

LOW-DOSE ASPIRIN TO PREVENT CARDIOVASCULAR DISEASE AND COLORECTAL CANCER

Rationale: Cardiovascular disease is the leading cause of morbidity and mortality in the United States.

USPSTF recommendation: Initiate low-dose aspirin for the primary prevention of CVD and colorectal cancer in adults aged 50–59 years who have a 10% or greater 10-year CVD risk, are not at increased risk of bleeding, have a life expectancy of at least 10 years, and are willing to take low-dose aspirin daily for at least 10 years.

Ages and frequency (when available)	Low-dose aspirin for adults aged 50–59 years who have a 10% or greater 10-year CVD risk
Clinical practice	The USPSTF recommends initiating low-dose aspirin use in adults aged 50–59 years who have a 10% or greater 10-year CVD risk, are not at increased risk of bleeding, have a life expectancy of at least 10 years, and are willing to take low-dose aspirin daily for at least 10 years. Aspirin use in adults aged 60–69 years who have a 10% or greater 10-year CVD risk should be an individualized decision made in consultation with the health care provider.
Risk assessment	A 10-year risk of first atherosclerotic CVD event (nonfatal myocardial infarction, coronary heart disease death, and fatal or nonfatal stroke) can be determined by a calculator derived from the American College of Cardiology/ American Heart Association (http://tools.acc.org/ASCVD-Risk-Estimator/). The calculator is derived from the only U.S.-based, externally validated equations that report risk as a combination of cerebrovascular and coronary heart disease events. Risks of GI bleeding include older age, upper GI tract pain, GI ulcers, concurrent anticoagulation or NSAID use, and uncontrolled hypertension.

BLOOD PRESSURE SCREENING

Rationale: High blood pressure is a major contributing risk factor to heart failure, heart attack, stroke, and chronic kidney disease. Screening for and treatment of high blood pressure reduces the incidence of cardiovascular events.

USPSTF recommendation: Screen for high blood pressure in adults aged 18 years or older and obtain measurements outside of the clinical setting for diagnostic confirmation before starting treatment.

Bright Futures recommendation: Children should have their blood pressure routinely measured beginning at 3 years of age.

Ages and frequency (when available)	13–21 years of age: Annually 22–39 years of age: At least every 3–5 years 40 years of age or older or individuals with risk factors: Annually
Clinical practice	This recommendation applies to women and adolescents aged 13 years or older without known hypertension. The USPSTF recommends that adults aged 18–39 years with normal blood pressure (<130/85 mm Hg) who do not have other risk factors should be screened every 3–5 years. Adults aged 40 years or older and those who are at increased risk of high blood pressure should be screened annually. Rescreening should include properly measured office blood pressure and, if blood pressure is elevated, confirmation of the diagnosis of hypertension with ambulatory blood pressure measurements. Bright Futures recommends blood pressure screening routinely at well-child visits beginning at age 3 years.
Risk assessment	For adults, risk factors include high-normal blood pressure (130–139/ 85–89 mm Hg), overweight or obesity, and African American race. For adolescents, risk factors include persistently elevated blood pressure (120–130/80 mm Hg), obesity, sleep-disordered breathing, chronic kidney disease, and preterm birth. Prevalence is higher in boys and Hispanic and non-Hispanic African American children.

DIABETES SCREENING

Rationale: Type 2 diabetes mellitus is a metabolic disorder characterized by insulin resistance and relative insulin deficiency, which results in hyperglycemia. Diabetes mellitus is a modifiable risk factor for cardiovascular disease and other adverse health outcomes.

USPSTF recommendation: Screen for abnormal blood glucose as part of cardiovascular risk assess- ment in adults aged 40–70 years who are overweight or obese. Clinicians should offer or refer patients with abnormal blood glucose to intensive behavioral counseling interventions to promote a healthful diet and physical activity.

WPSI recommendation: In addition to the USPSTF recommendation, also screen asymptomatic non- pregnant women with a history of gestational diabetes who have not been previously diagnosed with diabetes when not pregnant.

Ages and frequency (when available)	40–70 years of age and overweight or obese: Every 3 years ≥13 years of age with previous gestational diabetes: Every 3 years for at least 10 years after pregnancy
Clinical practice	This recommendation applies to overweight or obese women aged 40–70 years who do not have symptoms of diabetes and are overweight or obese, and to women of any age who have been previously diagnosed with gestational diabetes. The optimal rescreening interval for adults with an initial normal glucose test result is not known, although studies suggest that rescreening every 3 years may be a reasonable approach. For women with previous gestational diabetes, screening should occur every 3 years for at least 10 years after pregnancy.
Risk assessment	Individuals at increased risk include those with a family history of diabetes, or a history of gestational diabetes or polycystic ovarian syndrome, or are mem- bers of certain racial/ethnic groups (African Americans, American Indians or Alaskan Natives, Asian Americans, Hispanics or Latinas, or Native Hawaiians or Pacific Islanders). These individuals may be at increased risk of diabetes at a younger age or at a lower BMI. Clinicians should consider early screening in individuals with one or more of these characteristics.

LIPID SCREENING AND STATIN USE TO PREVENT CARDIOVASCULAR AND COLORECTAL CANCER

Rationale: Cardiovascular disease is the leading cause of morbidity and mortality in the United States.

USPSTF recommendation: Universal lipid screening in adults aged 40–75 years and calculation of 10-year risk of a cardiovascular event. Alow-to-moderate-dose statin (lipid lowering medication) should be provided for the prevention of CVD events and mortality to adults without a history of CVD, one or more CVD risk factors (ie, dyslipidemia, diabetes, hypertension, or smoking), or 10-year risk of
a cardiovascular event of 10% or greater. The USPSTF cited insufficient evidence to recommend statins for adults aged 22–39 or more than 75 years.

Bright Futures recommendation: Lipid screening only with risk factors between 13 years and 16 years of age, and once between 17 years and 21 years of age

Ages and frequency (when available)	13–16 years of age: No routine lipid screening. Screening only with risk factors (familial dyslipidemia, risk factors, or high-risk conditions) 17–21 years of age: Screen lipids once during age interval 22–39 years of age: No routine lipid screening; screening based on clinical judgment 40–75 years of age: Periodic assessment of CVD risk; measurement of lipid levels every 5 years >75 years of age: No routine lipid screening; screening based on clinical judgment
Clinical practice	This recommendation applies to women without known CVD. Lipid screening includes measurement of total cholesterol, LDL-C, and HDL-C levels. The USPSTF recommends using a low-to-moderate-dose statin for the preven- tion of CVD events and mortality when all the following three criteria are met: 1. Age 40–75 years 2. Have one or more CVD risk factors (ie, dyslipidemia, diabetes, hyperten- sion, or smoking) 3. Have a calculated 10-year risk of a CVD event of 10% or greater. Clinicians may choose to offer a statin to adults who have a calculated 10-year risk of 7.5%–10% and otherwise meet criteria.
Risk assessment	*Dyslipidemia* is defined as an LDL-C level >130 mg/dL or HDL-C <40 mg/dL (to convert HDL-C values to mmol/L, multiply by 0.0259). A10-year risk of first atherosclerotic CVD event (nonfatal myocardial infarc- tion, coronary heart disease death, and fatal or nonfatal stroke) can be deter- mined by a calculator derived from the American College of Cardiology/ American Heart Association

HEALTHFUL DIET AND PHYSICAL ACTIVITY COUNSELING

Rationale: Ahealthful diet and physical activity can benefit all individuals, although those with risk factors for CVD benefit most.

USPSTF recommendation: Offer or refer adults who are overweight or obese and have additional CVD risk factors to intensive behavioral counseling interventions to promote a healthful diet and physical activity for CVD prevention.

Ages and frequency (when available)	18 years of age and older, overweight or obese with additional CVD risk factors
Clinical practice	The USPSTF recommends offering or referring adults who are overweight or obese and have additional CVD risk factors to intensive behavioral counseling interventions to promote a healthful diet and physical activity for CVD preven- tion. Many interventions are effective, particularly those that combine coun- seling on healthful diet and physical activity and have multiple contacts over extended periods. Healthful diet and physical activity counseling for adults without known CVD risk factors should be determined on an individual basis.
Risk assessment	Major risk factors for CVD include obesity, hypertension, dyslipidemia, abnor- mal blood glucose levels, and diabetes.

OBESITY SCREENING

Rationale: More than 30% of adult women in the United States are obese. Obesity increases risks of cardiovascular disease, type 2 diabetes mellitus, cancer, gallstones, and disability.

USPSTF recommendation: Screen for obesity at age 6 years and older and offer or refer obese individuals to comprehensive, intensive behavioral interventions to improve weight status.

Bright Futures recommendation: Children should have their BMI calculated and classified at every well-child visit.

Ages and frequency (when available)	13 years and older: Annually
Clinical practice	Height and weight are typically measured at most routine visits. *Overweight* is defined as a BMI of 25–29 and *obesity* is defined as a BMI of 30 or higher. The USPSTF recommends offering or referring patients with a BMI of 30 or higher to intensive, multicomponent behavioral interventions. These interventions can lead to weight loss, as well as improved glucose tolerance and other physiologic risk factors for cardiovascular disease.
Risk assessment	Not applicable

FOLIC ACID SUPPLEMENTATION

Rationale: Neural tube defects are major birth defects of the brain and spine that occur early in pregnancy due to improper closure of the embryonic neural tube, which may lead to a range of disabilities or death. Daily folic acid supplementation in the prepregnancy and early pregnancy period can prevent neural tube defects.

USPSTF recommendation: All women who are capable of pregnancy should take a daily supplement containing 0.4–0.8 mg (400–800 micrograms) of folic acid.

Ages and frequency (when available)	≥13 years of age
Clinical practice	Because one half of all pregnancies are unplanned, this recommendation applies to women who are capable of pregnancy. The critical period for supplementation starts at least 1 month before pregnancy and continues through the first 2–3 months of pregnancy. The USPSTF recommendation does not apply to women who have had a previous pregnancy affected by neural tube defects or who are at very high risk because of other factors and may be advised to take higher doses of folic acid.
Risk assessment	Factors that increase risk of neural tube defects include a personal or family history of neural tube defects, use of antiseizure medications, maternal diabetes, obesity, and mutations in folate-related enzymes.

DEPRESSION SCREENING

Rationale: Depression is among the leading causes of disability and is common in patients seeking care in the primary care setting and among pregnant and postpartum women.

USPSTF recommendations: Screen for major depressive order in adolescents aged 12–17 years and all adults, including pregnant and postpartum women.

Ages and frequency (when available)	≥13 years of age: At least annually
Clinical practice	Commonly used depression screening instruments include the Patient Health Questionnaire and the Hospital Anxiety and Depression Scales in adults; the Geriatric Depression Scale in older adults; and the Edinburgh Postnatal Depression Scale in postpartum and pregnant women. Positive screening results should lead to additional assessments that consider severity of depression and comorbid psychological problems, alternate diagnoses, and medical conditions. Screening should be implemented with adequate systems in place to ensure accurate diagnosis, effective treatment, and appropriate follow-up.
Risk assessment	Risk factors in older adults include disability and poor health status related to medical illness, complicated grief, chronic sleep disturbance, loneliness, and history of depression. Risk factors during pregnancy and postpartum include poor self-esteem, childcare stress, prenatal anxiety, life stress, decreased social support, single or unpartnered relationship status, history of depression, difficult infant temperament, previous postpartum depression, lower socioeconomic status, and unintended pregnancy.

INTERPERSONAL AND DOMESTIC VIOLENCE SCREENING

Rationale: Interpersonal and domestic violence are common among women in the United States but often remain undetected.

WPSI recommendation: Screen adolescents and women for interpersonal and domestic violence at least annually. When needed, provide or refer for initial intervention services that include but are not limited to counseling, education, harm reduction strategies, and referral to appropriate supportive services.

Ages and frequency (when available)	≥13 years of age: At least annually
Clinical practice	Interpersonal and domestic violence includes physical violence; sexual violence; stalking and psychological aggression (including coercion); repro- ductive coercion; neglect; and the threat of violence or abuse, or both. Multiple brief screening questionnaires are accurate in identifying inter- personal and domestic violence in women. Screening should occur at least annually, although the frequency and intensity of screening may vary depending on a patient's situation.
Risk assessment	Although all women are at potential risk of abuse, factors that elevate risk include young age, substance abuse, relationship difficulties, and economic hardships, among others.

OSTEOPOROSIS SCREENING

Rationale: Approximately one half of all postmenopausal women will have an osteoporosis-related fracture during their lifetime. Osteoporotic fractures, particularly hip fractures, are associated with chronic pain and disability, loss of independence, decreased quality of life, and increased mortality.

USPSTF recommendation: Screen for osteoporosis with bone measurement testing to prevent osteoporotic fractures in women aged 65 years and older and in younger women who are at increased risk.

Ages and frequency (when available)	≥65 years of age for all women 50–64 years of age for women at increased risk There is no benefit from repeating bone measurement testing between 4 years and 8 years after initial screening, and a minimum of 2 years may be needed to reliably measure a change in BMD.
Clinical practice	This recommendation is intended for women without previous osteoporotic fractures. The USPSTF recommends women aged 65 and older have bone measurement testing to identify osteoporosis, which is a risk factor for fragility fractures. Women between the ages of 50 years and 64 years with equivalent or greater 10-year fracture risks based on specific risk factors also should be tested. Women identified with low-bone density can reduce their risk of fractures with osteoporosis medications. Bone measurement testing with central DXA is the most commonly used and studied method for the diagnosis of osteoporosis. Measurement of BMD at central bone sites (hip and lumbar spine) is the established standard for diagnosis of osteoporosis and for guiding decisions about treatment. Use of DXA and quantitative ultrasonography at peripheral sites (such as wrist, forearm, and calcaneus) are alternative methods.
Risk assessment	Postmenopausal women younger than 65 years who have at least one risk factor (parental history of hip fracture, smoking, white race, excess alcohol consumption, low-body weight) can be evaluated with a clinical risk assessment tool. Several tools to estimate risk are available for clinicians.

PREVENTION OF FALLS

Rationale: Falls are common and a leading cause of injury in women aged 65 years and older.

USPSTF recommendation: Exercise to prevent falls in community-dwelling adults aged 65 years and older who are at increased risk of falls.

Ages and frequency (when available)	≥65 years of age: Annually
Clinical practice	The USPSTF recommends exercise interventions to prevent falls in community-dwelling adults aged 65 years or older who are at increased risk of falls. Effective exercise interventions include supervised individual and group classes that include gait, balance, and functional training components. Clini- cians may selectively offer multifactorial interventions for fall prevention that include combinations of exercise, psychological interventions, nutrition ther- apy, education, medication management, urinary incontinence management, environmental modification, and referrals to physical or occupational therapy, social or community services, or specialists (eg, ophthalmologist, neurologist, or cardiologist).
Risk assessment	Risk factors to identify older adults who are at increased risk of falls include age; history of falls; and impairments in mobility, gait, and balance. Clinicians also could use assessments of gait and mobility to help determine risk.

SUBSTANCE USE SCREENING AND COUNSELING

Rationale: Illicit drug use and abuse are serious problems in the United States, ranking among the 10 leading preventable risk factors for years of healthy life lost to death and disability.

Bright Futures recommendation: Substance use should be evaluated as part of an age-appropriate comprehensive history. Reviewing the adolescent's environment can identify risk and protective factors for the development of alcohol or drug abuse.

Ages and frequency (when available)	13–21 years of age: Annually
Clinical practice	Ask about alcohol and substance use. Although many adolescents do not discuss substance use with their physicians, the most common reason is because they were never asked. Screening tools such as CRAFFT accurately identify a diagnosis of substance problem use, abuse, or dependence.
Risk assessment	Risk factors include substance use by a family member; poor parental super- vision; household disruption; low-academic achievement or academic aspira- tions, or both; and untreated ADHD.

URINARY INCONTINENCE SCREENING

Rationale: Approximately 50% of women in the United States experience urinary incontinence that can adversely affect health, quality of life, and function.

WPSI recommendation: Screen women for urinary incontinence annually and refer for further diagnostic evaluation and treatment if indicated.

Ages and frequency (when available)	Women of all ages and postpartum women: Annually
Clinical practice	Several brief clinician- or self-administered questionnaires accurately identify women with stress, urge, or mixed incontinence and can be used to guide diagnostic evaluations and management. Screening assesses the type and degree of urinary incontinence, situations in which it occurs, and how it affects activities and quality of life. Once women with incontinence are identified, they may undergo individual- ized clinical diagnostic evaluations to determine appropriate treatment and management options, including behavioral, pharmacologic, nonpharmaco- logic, and surgical interventions specific to the type and severity of inconti- nence and patient preferences.
Risk assessment	Although urinary incontinence is common among all groups of women, rates are higher for women with specific risk factors, particularly elderly age, obesity, and previous vaginal delivery. Additional risk factors include hysterec- tomy, cognitive impairment, functional impairment, and other chronic medical conditions.

GONORRHEA AND CHLAMYDIAL INFECTION SCREENING

Rationale: Gonorrhea and chlamydial infection are the most commonly reported sexually transmitted infections in the United States. Gonococcal infections are often asymptomatic in women but may lead to pelvic inflammatory disease and its associated complications, such as ectopic pregnancy, infertility, and chronic pelvic pain.

USPSTF recommendation: Screen for gonorrhea and chlamydial infection in sexually active women who are 24 years or younger and in older women who are at increased risk of infection.

Bright Futures recommendation: Screen all sexually active females 24 years and younger for gonor- rhea and chlamydial infection annually.

Ages and frequency (when available)	13–24 years of age: Annually >24 years of age: Annually if increased risk
Clinical practice	Gonococcal and chlamydial infections are diagnosed with nucleic acid ampli- fication tests using urine, endocervical, or health care provider-collected or patient self-collected vaginal specimens.
Risk assessment	Infection rates are highest in sexually active females aged 15–24 years. Risk factors include new or multiple sex partners, a sex partner with concurrent partners or a sex partner with an STI, inconsistent condom use, previous or concurrent STI, exchanging sex for money or drugs, history of sexual abuse, and patients at public STI clinics.

HEPATITIS B SCREENING

Rationale: Approximately 700,000 to 2.2 million individuals in the United States have chronic HBV infection that can lead to cirrhosis, hepatic decompensation, and hepatocellular carcinoma, and serve as a reservoir for person-to-person transmission of HBV. Screening identifies chronically infected individuals who may benefit from treatment or other interventions, such as surveillance for hepatocellular carcinoma.

USPSTF Recommendations: Screen for HBV infection in adolescents and adults at high risk of infection and in pregnant women at their first prenatal visit.

Ages and frequency (when available)	≥13 years of age (all pregnant women and high-risk adolescents and adults who are not pregnant)
Clinical practice	Chronic HBV infection is determined by immunoassays for detecting HBsAg. Periodic screening may be useful in patients with ongoing risk of HBV transmission who do not receive vaccination. Screening for HBV infection in pregnancy should occur at the first prenatal visit. Women also should be screened at delivery if they have unknown HBsAg status or new or continuing risk factors (such as injection drug use or STI).
Risk assessment	Risk factors include being born in a country with a prevalence of HBV infection ≥2%; lack of vaccination in infancy in individuals born in the United States with parents from a country or region with a prevalence of ≥8%; HIV-positive individuals; injection drug users; household contacts or sexual partners of individuals with HBV infection; travelers to endemic areas who have not completed Hepatitis B vaccination series.

HEPATITIS C SCREENING

Rationale: Hepatitis C virus is the most common chronic blood-borne pathogen in the United States and a leading cause of complications from chronic liver disease. Approximately three fourths of patients in the United States living with HCV infection were born between 1945 and 1965.

USPSTF recommendation: Screen for HCV infection in individuals at high risk of infection. Offer one- time screening for HCV infection to adults born between 1945 and 1965.

Ages and frequency (when available)	≥13 years of age at high risk Adults born between 1945 and 1965: One-time screening
Clinical practice	Anti-HCV antibody testing followed by confirmatory polymerase chain reac- tion testing accurately detects chronic HCV infection. Individuals in the birth cohort and those who are at risk because of potential exposure before universal blood screening and are not otherwise at increased risk need be screened only once. Individuals with continued risk of HCV infec- tion (injection drug users) should be screened periodically.
Risk assessment	One-time screening for adults born between 1945 and 1965. Criteria for others include past or current injection drug use; receipt of a blood transfusion before 1992; long-term hemodialysis; being born to an HCV-infected mother; incarceration; intranasal drug use; having an unregulated tattoo; and having other percutaneous exposures (eg, health care workers).

HUMAN IMMUNODEFICIENCY VIRUS SCREENING

Rationale: Screening for HIV infection detects individuals who are unaware of their infection and would otherwise miss the opportunity to benefit from early therapy that can reduce serious AIDS- related events and death as well as disease transmission.

WPSI recommendation: Prevention education and risk assessment for HIV infection in adolescents and adults at least annually throughout the lifespan. Test all women for HIV at least once during their lifetimes, and all pregnant women upon initiation of prenatal care with retesting during pregnancy based on risk factors.

Bright Futures recommendation: Screen once between the ages of 15 years and 18 years; retest annually if increased risk (sexually active, injection drug use, tested for other STIs).

Ages and frequency (when available)	≥13 years of age: Risk assessment and prevention education annually; test if pregnant 15–18 years of age: Test once; retest annually if increased risk or pregnant >18 years of age: Test at least once; retest if increased risk or pregnant
Clinical practice	This recommendation refers to routine HIV screening, which is different from incident-based or exposure-based HIV testing. Annual or more frequent HIV testing is recommended for women who are high risk. Screening is recommended for all pregnant women upon initiation of prenatal care with retesting during pregnancy based on risk factors. Rapid HIV testing is recommended for pregnant women who present in active labor with an undocumented HIV status. Screening can begin at age 15 years unless an individual is identified at an earlier age with risk factors. Screen after age 65 years if ongoing risk.
Risk assessment	Risk factors include injection drug use; unprotected vaginal or anal inter- course; multiple sexual partners; new sexual relationship; sexual partners who are HIV-infected, bisexual, or injection drug users; exchanging sex for drugs or money; victim of sex trafficking; incarceration; other STIs.

LATENT TUBERCULOSIS SCREENING

Rationale: A total of 5–10% of individuals with latent tuberculosis infection progress to active tuber- culosis disease. Identifying and treating latent tuberculosis is a key component of the strategy for reducing the burden of tuberculosis disease.

USPSTF recommendation: Screen for latent tuberculosis infection in populations at increased risk.

Ages and frequency (when available)	≥13 years of age at increased risk
Clinical practice	Screening tests include the Mantoux tuberculin skin test and interferon- gamma release assays.
Risk assessment	Individuals from countries with increased tuberculosis prevalence; living in high-risk congregate settings (e.g., homeless shelters, correctional facilities); exposure to individuals with active tuberculosis such as health care workers and workers in high-risk congregate settings; immunosuppressed individuals.

SEXUALLY TRANSMITTED INFECTIONS COUNSELING

Rationale: Sexually transmitted infections are frequently asymptomatic and can be unknowingly spread to others. Serious sequelae of STIs include pelvic inflammatory disease, infertility, and cancer. Untreated STIs that present during pregnancy or birth may cause perinatal infection, death, and serious physical and mental disabilities.

WPSI recommendation: Directed behavioral counseling should be provided by health care providers or other appropriately trained individuals for sexually active adolescents and adult women at an increased risk of STIs. Health care providers should use a woman's sexual history and risk factors to help identify those at an increased risk of STIs. For adolescents and women not identified as high risk, counseling to reduce the risk of STIs should be considered, as determined by clinical judgement.

Ages and frequency (when available)	13–21 years of age >22 years of age for sexually active women with increased risk of STIs
Clinical practice	Intensive behavioral counseling may be delivered in primary care settings or other sectors of the health care system. Risk-reduction counseling may be offered by community organizations, schools, and health departments, or their affiliated STI clinics. Health care providers should select behavioral counseling interventions based on their effectiveness, appropriateness to the patient population, and feasibil- ity of implementation.
Risk assessment	All sexually active adolescents are at increased risk of STIs and should be counseled. Risk factors may include age >25 years, a recent history of an STI, a new sex partner, multiple partners, a partner with concurrent partners, a partner with an STI, and a lack of or inconsistent condom use. Increased STI prevalence rates are found in women who exchange sex for money or drugs, those with mental illness or a disability, current or former intravenous drug users, those

SYPHILIS SCREENING

Rationale: Although less common than other sexually transmitted infections, syphilis can cause blindness, paresis, tabes dorsalis, and dementia; inflammatory lesions causing cardiovascular or organ dysfunction; and congenital abnormalities when infecting pregnant women. Syphilis infection also increases the risk of acquiring or transmitting HIV infection.

USPSTF recommendations: Screen for syphilis in adolescents and adults at increased risk of infection and in all pregnant women.

Bright Futures recommendation: For high-risk teenagers, screen for syphilis at least once a year.

Ages and frequency (when available)	≥13 years of age (all pregnant women and high-risk adolescents and adults who are not pregnant)
Clinical practice	Screening for syphilis infection is a two-step process involving an initial nontreponemal test (Venereal Disease Research Laboratory or rapid plasma reagin test) followed by a confirmatory treponemal antibody detection test (fluorescent treponemal antibody absorption or *Treponema pallidum* particle agglutination test). All pregnant women should be tested early in their pregnancies. High-risk pregnant women require repeat serologic testing in the third trimester and again at delivery.
Risk assessment	Risk factors include previous syphilis infection or other STIs, incarceration, or drug use; multiple or concurrent sex partners; living in high-prevalence areas; HIV infection; history of incarceration; and exchanging sex for money or drugs.

BREAST CANCER SCREENING

Rationale: Breast cancer is the second leading cause of cancer death among women in the United States.

WPSI Recommendation: Initiate mammography screening no earlier than age 40 years and no later than age 50 years for women at average risk of breast cancer. Screening should continue through at least age 74 years and age alone should not be the basis to discontinue screening.

Ages and frequency (when available)	Begin at ages 40–50 years until at least age 74 years at least biennially and as frequently as annually
Clinical practice	These recommendations are for women at average risk of breast cancer. The decision to screen women before age 50 years and after age 74 years should be an individual one.
Risk assessment	Major risk factors for breast cancer include increasing age, family history of breast or ovarian cancer (especially among first-degree relatives and onset before age 50 years), history of atypical hyperplasia or other nonmalignant high-risk breast lesions, previous breast biopsy, and extremely dense breast tissue. Women considered at high risk of breast cancer (previous breast or ovarian cancer, *BRCA* mutation carriers, previous high-dose radiation to the chest) also should undergo periodic mammography screening and may require additional follow-up that is beyond the scope of this recommendation.

MEDICATIONS TO REDUCE BREAST CANCER RISK

Rationale: Although screening for breast cancer may detect cancer early, screening does not prevent the development of cancer. Use of medications, such as selective estrogen receptor modulators, reduces risk of estrogen receptor (ER)-positive breast cancer.

USPSTF recommendation: Clinicians should offer to prescribe risk-reducing medications for women who are at increased risk of breast cancer and at low risk of adverse medication effects.

Ages and frequency (when available)	≥40 years of age: Assess risk annually
Clinical practice	The USPSTF recommends that clinicians engage in shared, informed decision making with women who are at increased risk of breast cancer about medica- tions to reduce their risk and recommends against their use in women who are not at increased risk of breast cancer.
Risk assessment	Major risk factors for breast cancer include increasing age, family history of breast or ovarian cancer (especially among first-degree relatives and onset before age 50 years), history of atypical hyperplasia or other nonmalignant high-risk breast lesions, previous breast biopsy, and extremely dense breast tissue. Models suggest that women with an estimated 5-year breast cancer risk of 3% or greater are likely to have more benefit than harm, although the balance depends on age, race or ethnicity, the medication used, and whether the patient has a uterus.

RISK ASSESSMENT FOR *BRCA* TESTING

Rationale: Inherited mutations of the *BRCA* gene increases risk of breast, ovarian, and fallopian tube cancer. These mutations occur in an estimated 1 in 300–500 women (0.2%–0.3%) in the general population but are more common within families with previously diagnosed cancer.

USPSTF recommendation: Screen women who have family members with breast, ovarian, tubal, or peritoneal cancer to identify a family history that may be associated with an increased risk of 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.

Ages and frequency (when available)	≥18 years of age: Assess risk periodically
Clinical practice	The USPSTF recommends that primary care providers screen 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 of 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. Women without positive family histories do not require genetic counseling or *BRCA* testing.
Risk assessment	Family history factors associated with increased likelihood of potentially harmful *BRCA* mutations include breast cancer diagnosis before age 50 years, bilateral breast cancer, presence of breast and ovarian cancer, presence of breast cancer in one or more male family members, multiple cases of breast cancer in the family, one or more family members with two primary types of *BRCA*-related cancer, and Ashkenazi Jewish ethnicity. These factors are included in clinical screening tools to identify women for referral to genetic counseling.

CERVICAL CANCER SCREENING

Rationale: Cervical cancer deaths in the United States have decreased since the implementation of widespread cervical cancer screening. Most deaths related to cervical cancer occur in women who have not been adequately screened.

WPSI Recommendation: Cervical cancer screening for average-risk women aged 21–65 years includes cervical cytology (Pap test) every 3 years for women aged 21–29 years, cytology and human papilloma- virus testing every 5 years, or cytology alone every 3 years for women aged 30–65 years.

USPSTF recommendation: Screening for cervical cancer every 3 years with cervical cytology alone in women aged 21–29 years and every 3 years with cervical cytology alone, every 5 years with hrHPV testing alone, or every 5 years with hrHPV testing in combination with cytology (co-testing) in women aged 30–65 years.

Ages and frequency (when available)	21–29 years of age: Cervical cytology alone every 3 years 30–65 years of age: Cervical cytology alone every 3 years; or cytology and human papillomavirus testing every 5 years (WPSI); or hrHPV testing alone every 5 years (USPSTF)
Clinical practice	This recommendation applies to women who have a cervix, regardless of sexual history or HPV vaccination status. Women who have had a hysterectomy with removal of the cervix and do not have a history of a high-grade precancerous lesion or cervical cancer are not at risk of cervical cancer and should not be screened.
Risk assessment	Women who have received a diagnosis of a high-grade precancerous cervical lesion or cervical cancer, women with in utero exposure to diethylstilbestrol, or women who are immunocompromised (such as those who are HIV positive) require individualized follow-up.

COLON CANCER SCREENING

Rationale: Colorectal cancer is most common among adults older than 50 years and early detection with screening can reduce mortality.

USPSTF recommendation: Screen for colorectal cancer starting at age 50 years and continuing until age 75 years.

Ages and frequency (when available)	50–75 years of age: Frequency varies by method
Clinical practice	Screening methods include gFOBT, FIT, or FIT-DNA (multitargeted stool DNA test) every 1–2 years; flexible sigmoidoscopy or CT colonography every 5 years; and colonoscopy every 10 years. The decision to screen for colorectal cancer in adults aged 76–85 years should be an individual one that considers the patient's overall health and prior screening history.
Risk assessment	Black women and those with a family history of colorectal cancer (a first- degree relative with early-onset colorectal cancer or multiple first-degree relatives with the disease) have increased risks of colorectal cancer and may need to be considered for screening at earlier ages.

LUNG CANCER SCREENING

Rationale: Lung cancer is the third most common cancer and the leading cause of cancer death for women in the United States. The most important risk factor for lung cancer is smoking, which results in approximately 85% of cases of lung cancer.

USPSTF recommendation: Screen for lung cancer with low-dose CT in adults aged 55–80 years who have a 30 pack-year smoking history and currently smoke or have quit within the past 15 years.

Ages and frequency (when available)	55–80 years of age: Annually
Clinical practice	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.
Risk assessment	The incidence of lung cancer increases with age and occurs most commonly in individuals aged 55 years or older. Increasing age and cumulative exposure to tobacco smoke are the two most common risk factors for lung cancer. Approxi- mately 37% of adults in the United States are current or former smokers.

SKIN CANCER COUNSELING

Rationale: Skin cancer, including melanoma and nonmelanoma types, is the most common cancer in the United States. Although invasive melanoma accounts for only 2% of all cases of skin cancer, it is responsible for 80% of skin cancer deaths. Exposure to ultraviolet radiation increases risk.

USPSTF recommendation: Counsel fair-skinned young adults, adolescents, children, and parents of young children about minimizing exposure to ultraviolet radiation to reduce risk of skin cancer (ages 6 months–24 years)

Ages and frequency (when available)	13–24 years of age: Annually
Clinical practice	The USPSTF recommends behavioral counseling interventions that target sun protection behaviors to reduce ultraviolet radiation exposure that damages DNA and causes skin cancer. These include the use of broad-spectrum sun- screen with a sun-protection factor of 15 or more; wearing hats, sunglasses, or sun-protective clothing; avoiding sun exposure; seeking shade during midday hours (10 am to 4 pm); and avoiding indoor tanning equipment.
Risk assessment	Radiation exposure during childhood and adolescence increases the risk of skin cancer later in life. Risk is higher for those with fair skin, light hair and eye color, and freckles; those who sunburn easily; use tanning beds; have a history of previous skin cancer; family history of skin cancer; HIV infection; or history of an organ transplant.

Thank you