

Doug Campos-Outcalt, MD,
MPA

Department of Family
and Community Medicine,
University of Arizona
College of Medicine, Phoenix
dougco@u.arizona.edu

USPSTF scales back approach to lipid screening for women

The USPSTF recommendation for women diverges from those of the NIH and the American Heart Association

When patients reached a certain age (36 for men, 46 for women), it used to mean that it was time, in the eyes of the United States Preventive Services Task Force (USPSTF), to screen for lipid disorders. But that's changed for female patients.

The USPSTF's latest recommendations (TABLE 1) on screening for lipid disorders in adults¹ call for screening women only when coronary heart disease (CHD) risk factors are present, regardless of their age. (See TABLE 2 for a list of CHD risk factors.) That's a major shift from the 2001 recommendation, which stated that *all* women over age 45 should be screened and women ages 20 to 45 should be screened if they were at elevated risk.

The recommendations for men remain the same: All men older than 35 should be screened, as should men who are between the ages of 20 and 35 who have other CHD risks.

■ A different approach from NIH and AHA

The revised updated recommendation for women over age 45 was based on 2 systematic evidence reviews^{2,3} that concluded, while treatment clearly benefits women with other risk factors, benefit has not been proven for women who are

otherwise CHD risk free.

The recommendation for women conflicts with those of the National Institutes of Health and the American Heart Association; both recommend screening all adults starting at age 20—regardless of risk.

■ Screening those without risk isn't ruled out

It is important to note that the task force is not recommending against screening in women (or men between the ages of 20 and 35) who do not have other CHD risks. The task force makes a C recommendation with wording that states, "The USPSTF makes no recommendation for or against routine provision of [the service]. The USPSTF found at least fair evidence that [the service] can improve health outcomes but concludes that the balance of benefits and harms is too close to justify a general recommendation" (TABLE 3).

The task force chose not to use the new wording for a C recommendation, adopted in 2007, which reads, "The USPSTF recommends against routinely providing the service. There may be considerations that support providing the service in an individual patient. There is at least moderate certainty that the net benefit is small."

IN THIS ARTICLE

■ USPSTF screening recommendation categories

Page 742

It is also important to realize that a large proportion of women have another CHD risk and will not fall into the C category recommendation.

■ No need to look at triglycerides initially

The task force recommends screening with a fasting or nonfasting serum sample for total cholesterol and high-density lipoprotein cholesterol. The task force does not recommend including a triglyceride level because there is mixed and inclusive evidence that triglyceride levels are independently associated with CHD risk and scant evidence that treating isolated elevated triglyceride levels reduces the occurrence of CHD events. This approach also conflicts with other organizations that recommend screening with fasting lipid profiles that include a triglyceride level.

The task force states that an abnormal initial screen should be confirmed by a repeat test and, if confirmed, a fasting lipid panel should be obtained. Wide adoption of the task force recommendations would result in considerable savings in cost and patient inconvenience by avoiding complete fasting lipid panels as the initial screen.

The optimal frequency of screening is not established and the task force states that every 5 years is reasonable, although more frequent testing might be considered for those with high normal values, and less frequent intervals for those with optimal cholesterol levels and healthy lifestyles.

■ Treatment: Look beyond lifestyle

The screening recommendations are accompanied by a discussion of clinical considerations and a description of an approach to treatment for those with lipid disorders. The main point the task force makes is that all CHD risks should be addressed, and that lifestyle changes alone rarely reduce elevated cholesterol to an optimal level. (For more on the treat-

TABLE 1

USPSTF lipid disorder screening recommendations at a glance

Screening men

- The United States Preventive Services Task Force (USPSTF) strongly recommends screening men ages 35 and older for lipid disorders.

Grade A recommendation

- The USPSTF recommends screening men ages 20 to 35 for lipid disorders if they are at increased risk for coronary heart disease (CHD).

Grade B recommendation

Screening women at increased risk

- The USPSTF strongly recommends screening women ages 45 and older for lipid disorders if they are at increased risk for CHD.

Grade A recommendation

- The USPSTF recommends screening women ages 20 to 45 for lipid disorders if they are at increased risk for CHD.

Grade B recommendation

Screening young men and all women not at increased risk

- The USPSTF makes no recommendation for or against routine screening for lipid disorders in men between the ages of 20 and 35, or in women ages 20 and older who are not at increased risk for CHD.

Grade C recommendation

TABLE 2

Risk factors for CHD

- Diabetes
- Personal history of coronary heart disease (CHD) or noncoronary atherosclerosis (eg, abdominal aortic aneurysm, peripheral artery disease, and carotid artery stenosis)
- A family history of cardiovascular disease before age 50 in male relatives or age 60 in female relatives
- Tobacco use
- Hypertension
- Obesity (body mass index ≥ 30)

ment of hyperlipidemia, see the National Heart, Lung, and Blood Institute's *Detection, Evaluation, and Treatment of High Blood Cholesterol in Adults [Adult Treatment Panel III]* at <http://www.nhlbi.nih.gov/guidelines/cholesterol/index.htm>.)

■ Time to rethink conventional opinion

The updated task force recommendations are a reminder that many widely used guidelines, including those on the

**IN THE
UNITED STATES,
THE PRESS
CANNOT
BE CENSORED.**

—
**THE INTERNET
CANNOT
BE CENSORED.**

—
**POLITICAL
ADVERTISING
CANNOT
BE CENSORED.**

—
**WHY ARE
SOME MEMBERS
OF CONGRESS &
ACADEMIA
TRYING TO CENSOR
MEDICAL
COMMUNICATIONS?**

Diabetes. Cancer. Obesity. Respiratory disease. America's medical professionals are busier than ever. How can they stay current with medical advances and still improve their patients' well-being?

Information is part of quality care. Yet government controls threaten to keep doctors in the dark about current medical advances.

Restrictions on how much information consumers and doctors can know about current and new treatments reduce their ability to advocate for care.

Using censorship as a policy tool to control healthcare costs is a bad idea! Yet that's what vocal pockets of academic medicine and Congress have in mind.

We are concerned that some members of Congress and Academia are seeking to restrict the content of CME and other industry-sponsored communications without input from practicing physicians.

Information is the first step to care. To learn more, visit cohealthcom.org.

This message brought to you as a public service by the Coalition for Healthcare Communication.

TABLE 3

USPSTF recommendation categories

A—Strongly recommended: The United States Preventive Services Task Force (USPSTF) strongly recommends that clinicians provide the service to eligible patients. The USPSTF found good evidence that the service improves important health outcomes and concludes that benefits substantially outweigh harms.

B—Recommended: The USPSTF recommends that clinicians provide the service to eligible patients. The USPSTF found at least fair evidence that the service improves important health outcomes and concludes that benefits outweigh harms.

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

D—Not recommended: The USPSTF recommends against routinely providing the service to asymptomatic patients. The USPSTF found at least fair evidence that the service is ineffective or that harms outweigh benefits.

I—Insufficient evidence to make a recommendation: The USPSTF concludes that the evidence is insufficient to recommend for or against routinely providing the service. Evidence that the service is effective is lacking, of poor quality, or conflicting, and the balance of benefits and harms cannot be determined.

prevention of CHD, are based on a lack of high-level evidence. Thus, it is not surprising that a rigorously evidence-based analysis, as preformed by the USPSTF, will frequently result in recommendations that are at variance with common practice and conventional opinion. ■

References

1. U.S. Preventive Services Task Force (USPSTF). Screening for lipid disorders in adults: recommendation statement. June 2008. Available at: <http://www.ahrq.gov/clinic/uspstf08/lipid/lipidrs.htm>. Accessed September 26, 2008.
2. Grady D, Chaput L, Kristof M. *Systematic Review of Lipid Lowering Treatment to Reduce Risk of Coronary Heart Disease in Women*. Rockville, Md: Agency for Healthcare Research and Quality; 2003.
3. Helfand M, Carson S. Screening for lipid disorders in adults: selective update of 2001 U.S. Preventive Services Task Force Review. June 2008. AHRQ publication number 08-05114-EF-1. Available at: <http://www.ahrq.gov/clinic/uspstf08/lipid/lipides.pdf>. Accessed September 26, 2008.