



RECOMMENDATIONS FOR WELL-WOMAN CARE

CLINICAL SUMMARY TABLES

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Recommendations for Well-Woman Care – Clinical Summary Tables

Recommendations for Well-Woman Care – Clinical Summary Tables were developed by the Women’s Preventive Services Initiative (WPSI) with research support from the Pacific Northwest Evidence Based Practice Center. The *Clinical Summary Tables* summarize preventive services recommended by the [WPSI](#), [U.S. Preventive Services Task Force \(USPSTF\)](#), and [Bright Futures](#). These recommendations should not be viewed as a rigid body of rules. The recommendations are general and intended to be adapted to many different situations, taking into account the needs and resources particular to the locality, the institution, or the type of practice. Variations and innovations that improve the quality of patient care are encouraged rather than restricted. The purpose of these guidelines will be well served if they provide a firm basis on which local norms may be built.

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Alcohol Misuse Screening and Counseling	
<p>Rationale: Approximately one third of the population is affected by alcohol misuse, which is the third leading cause of preventable deaths in the United States.</p> <p>USPSTF Recommendation: Screen adults aged 18 years or older for alcohol misuse and provide persons engaged in risky or hazardous drinking with brief behavioral counseling interventions to reduce alcohol misuse.</p> <p>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.</p>	
Age and Frequency	≥13 years at least annually
Clinical Practice	Numerous screening instruments can detect alcohol misuse in adults with acceptable sensitivity and specificity. These include AUDIT, Abbreviated AUDIT-C, and single-question screening, such as asking, “How many times in the past year have you had 5 (for men) or 4 (for women and all adults older than 65 years) or more drinks in a day?”
Risk Assessment	Not applicable.
References	<ul style="list-style-type: none"> • Moyer VA. Screening and behavioral counseling interventions in primary care to reduce alcohol misuse: U.S. Preventive Services Task Force recommendation statement. <i>Ann Intern Med.</i> 2013; 159(3):210-8. doi: 10.7326/0003-4819-159-3-201308060-00652. PMID: 23698791 • http://pediatrics.aappublications.org/content/136/3/e718

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Low-dose Aspirin to Prevent Cardiovascular Disease and Colorectal Cancer	
<p>Rationale: Cardiovascular disease (CVD) is the leading cause of morbidity and mortality in the United States.</p> <p>USPSTF Recommendation: Initiate low-dose aspirin for the primary prevention of CVD and colorectal cancer in adults aged 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.</p>	
Ages and frequency	Low-dose aspirin for 50 to 59 years who have a 10% or greater 10-year CVD risk
Clinical practice	USPSTF recommends initiating low-dose aspirin use in adults aged 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. Aspirin use in adults aged 60 to 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	10-year risk for 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 (ACC/AHA) (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 for gastrointestinal (GI) bleeding include older age, upper GI tract pain, GI ulcers, concurrent anticoagulation or nonsteroidal anti-inflammatory drug use, and uncontrolled hypertension.
References	<ul style="list-style-type: none"> • Bibbins-Domingo K. Aspirin use for the primary prevention of cardiovascular disease and colorectal cancer: U.S. Preventive Services Task Force recommendation statement. <i>Ann Intern Med.</i> 2016; 164(12):836-45. doi: 10.7326/m16-0577. PMID: 27064677. • https://www.uspreventiveservicestaskforce.org/Page/Document/UpdateSummaryFinal/aspirin-to-prevent-cardiovascular-disease-and-cancer • Goff DC, Lloyd-Jones DM, Bennett G, Coady S, D’Agostino RB, Gibbons R, et al. 2013 ACC/AHA guideline on the assessment of cardiovascular risk: a report of the American College of Cardiology/American Heart Association Task Force on Practice Guidelines. <i>J Am Coll Cardiol.</i> 2014;63:2935-59.

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Blood Pressure Screening	
<p>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.</p> <p>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.</p> <p>Bright Futures Recommendation: Children should have their blood pressure routinely measured beginning at 3 years of age.</p>	
Ages and frequency	<p>13 to 21 years: annual</p> <p>22 to 39 years: at least every 3 to 5 years</p> <p>≥40 years or risk factors: annual</p>
Clinical practice	<p>This recommendation applies to women and adolescents aged 13 years or older without known hypertension.</p> <p>USPSTF recommends that adults aged 18 to 39 years with normal blood pressure (<130/85 mm Hg) who do not have other risk factors should be screened every 3 to 5 years. Adults aged 40 years or older and those who are at increased risk for 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.</p> <p>Bright Futures recommends blood pressure screening routinely at well child visits beginning at age 3.</p>
Risk assessment	<p>For adults, risk factors include high-normal blood pressure (130-139/85-89 mm Hg); overweight or obesity; and African American race.</p> <p>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.</p>
References	<ul style="list-style-type: none"> • Siu AL. Screening for high blood pressure in adults: U.S. Preventive Services Task Force recommendation statement. <i>Ann Intern Med.</i> 2015; 163(10):778-86. doi: 10.7326/m15-2223. PMID: 26458123. • https://www.uspreventiveservicestaskforce.org/Page/Document/RecommendationStatementFinal/high-blood-pressure-in-adults-screening • Hagan JF, Shaw JS, Duncan PM, eds. <i>Bright Futures: Guidelines for Health Supervision of Infants, Children, and Adolescents.</i> 4th ed. Elk Grove Village, IL: American Academy of Pediatrics; 2017. • https://www.aap.org/en-us/Documents/periodicity_schedule.pdf • Flynn JT, Kaelber DC, Baker-Smith GM, et al.; American Academy of Pediatrics Subcommittee on Screening and Management of High Blood Pressure in Children. Clinical Practice Guideline for Screening and Management of High Blood Pressure in Children and Adolescents. <i>Pediatrics</i> 2017; 140(3): e20171904 available at: http://pediatrics.aappublications.org/content/140/3/e20171904

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Contraception	
<p>Rationale: Contraceptive methods enable women to actively prevent unintended pregnancy and control the timing of a desired pregnancy.</p> <p>WPSI Recommendation: Access to the full range of female-controlled contraceptives to prevent unintended pregnancy and improve birth outcomes. Contraceptive care includes contraceptive counseling, initiation of contraceptive use, and follow-up care.</p>	
Ages and frequency	≥13 years and as needed for women capable of pregnancy
Clinical Practice	<p>Provision of the full range of female-controlled U.S. Food and Drug Administration-approved contraceptive methods, and access to contraceptive counseling, effective family planning practices, and sterilization procedures as part of contraceptive care. Services include initiation of contraceptive use, and follow-up care (e.g., management, evaluation, changes to and removal or discontinuation of the contraceptive method).</p> <p>Counseling should emphasize patient-centered decision making and allow for discussion of the full range of contraceptive options to identify the appropriate contraceptive methods to optimize compliance and effectiveness as determined by a woman and her health care provider.</p>
Risk Assessment	Not applicable
References	<ul style="list-style-type: none"> • Women’s Preventive Services Initiative. <i>Recommendations for Preventive Services for Women: Final report to the U.S. Department of Health and Human Services, Health Resources & Services Administration</i>. Washington, DC: 2016. • http://pediatrics.aappublications.org/content/134/4/e1244 • CDC Medical Eligibility Criteria, https://www.cdc.gov/reproductivehealth/contraception/contraception_guidance.htm

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Depression Screening	
<p>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.</p> <p>USPSTF Recommendations: Screen for major depressive disorder in adolescents aged 12 to 18 years and all adults, including pregnant and postpartum women.</p>	
Ages and frequency	≥13 years at least annually, and in all pregnant and postpartum women
Clinical Practice	<p>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.</p> <p>Positive screening results should lead to additional assessments that consider severity of depression and comorbid psychological problems, alternate diagnoses, and medical conditions.</p> <p>Screening should be implemented with adequate systems in place to ensure accurate diagnosis, effective treatment, and appropriate follow-up.</p>
Risk Assessment	<p>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/unpartnered relationship status, history of depression, difficult infant temperament, previous postpartum depression, lower socioeconomic status, and unintended pregnancy.</p>
References	<ul style="list-style-type: none"> • Siu AL. Screening for depression in children and adolescents: US Preventive Services Task Force recommendation statement. <i>Pediatrics</i>. 2016; 137(3):e20154467. doi: 10.1542/peds.2015-4467. PMID: 26908686. • Siu AL, Bibbins-Domingo K, Grossman DC, et al. Screening for depression in adults: US Preventive Services Task Force recommendation statement. <i>JAMA</i>. 2016; 315(4):380-7. doi: 10.1001/JAMA.2015.18392. PMID: 26813211.

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Diabetes Screening	
<p>Rationale: Type 2 diabetes mellitus is a metabolic disorder characterized by insulin resistance and relative insulin deficiency, resulting in hyperglycemia. Diabetes mellitus is a modifiable risk factor for cardiovascular disease and other adverse health outcomes.</p> <p>USPSTF Recommendation: Screen for abnormal blood glucose as part of cardiovascular risk assessment in adults aged 40 to 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.</p> <p>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.</p>	
Ages and frequency	<p>40-70 years overweight or obese: every 3 years</p> <p>≥13 years with previous gestational diabetes: every 3 years for at least 10 years after pregnancy</p>
Clinical practice	<p>This recommendation applies to overweight or obese women aged 40 to 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.</p> <p>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.</p>
Risk assessment	<p>Persons at increased risk include those with a family history of diabetes, a history of gestational diabetes or polycystic ovarian syndrome, or are members 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 for diabetes at a younger age or at a lower body mass index. Clinicians should consider screening earlier in persons with one or more of these characteristics.</p>
References	<ul style="list-style-type: none"> • Siu AL. Screening for abnormal blood glucose and type 2 diabetes mellitus: U.S. Preventive Services Task Force recommendation statement. <i>Ann Intern Med.</i> 2015; 163(11):861-8. doi: 10.7326/m15-2345. PMID: 26501513. • https://www.uspreventiveservicestaskforce.org/Page/Document/UpdateSummaryFinal/screening-for-abnormal-blood-glucose-and-type-2-diabetes • Women’s Preventive Services Initiative. <i>Recommendations for Preventive Services for Women: Final Report to the U.S. Department of Health and Human Services, Health Resources & Services Administration.</i> Washington, DC: 2017. [in press]

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Folic Acid Supplementation	
<p>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, and may lead to a range of disabilities or death. Daily folic acid supplementation in the pre-pregnancy and early pregnancy period can prevent neural tube defects.</p> <p>USPSTF Recommendation: All women who are capable of pregnancy take a daily supplement containing 0.4 to 0.8 mg (400 to 800 µg) of folic acid.</p>	
Ages and frequency	≥13 years
Clinical Practice	<p>Since 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 conception and continues through the first 2 to 3 months of pregnancy.</p> <p>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 due to other factors who may be advised to take higher doses of folic acid.</p>
Risk Assessment	Factors that increase risk for 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.
References	<ul style="list-style-type: none"> • Bibbins-Domingo K, Grossman DC, Curry SJ, et al. Folic acid supplementation for the prevention of neural tube defects: US Preventive Services Task Force recommendation statement. <i>JAMA</i>. 2017; 317(2):183-9. doi: 10.1001/JAMA.2016.19438. PMID: 28097362. • https://www.uspreventiveservicestaskforce.org/Page/Document/RecommendationStatementFinal/folic-acid-for-the-prevention-of-neural-tube-defects-preventive-medication#Pod5

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Healthful Diet and Physical Activity Counseling	
<p>Rationale: A healthful diet and physical activity can benefit all individuals, although those with risk factors for cardiovascular disease (CVD) benefit most.</p> <p>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.</p>	
Ages and frequency	≥18 overweight or obese with additional CVD risk factors
Clinical practice	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 prevention. Many interventions are effective, particularly those that combine counseling 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 cardiovascular disease include obesity, hypertension, dyslipidemia, abnormal blood glucose levels, and diabetes.
References	<ul style="list-style-type: none"> • LeFevre ML. Behavioral counseling to promote a healthful diet and physical activity for cardiovascular disease prevention in adults with cardiovascular risk factors: US Preventive Services Task Force recommendation statement. <i>Ann Intern Med.</i> 2014; 161(8):587-93. doi: 10.7326/m14-1796. PMID: 25155419. • https://www.uspreventiveservicestaskforce.org/Page/Document/RecommendationStatementFinal/healthy-diet-and-physical-activity-counseling-adults-with-high-risk-of-cvd • US Preventive Services Task Force. Behavioral counseling to promote a healthful diet and physical activity for cardiovascular disease prevention in adults without cardiovascular risk factors. US Preventive Services Task Force recommendation statement. <i>JAMA.</i> 2017;318(2):167–174. doi:10.1001/jama.2017.7171 • https://www.uspreventiveservicestaskforce.org/Page/Document/RecommendationStatementFinal/healthful-diet-and-physical-activity-for-cardiovascular-disease-prevention-in-adults-without-known-risk-factors-behavioral-counseling

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Interpersonal and Domestic Violence Screening	
<p>Rationale: Interpersonal and domestic violence are common among women in the United States, but often remain undetected.</p> <p>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.</p>	
Ages and frequency	≥13 years at least annually
Clinical Practice	<p>Interpersonal and domestic violence includes physical violence, sexual violence, stalking and psychological aggression (including coercion), reproductive coercion, neglect, and the threat of violence, abuse, or both.</p> <p>Multiple brief screening questionnaires are accurate in identifying interpersonal 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.</p>
Risk Assessment	Although all women are at potential risk for abuse, factors that elevate risk include young age, substance abuse, relationship difficulties, and economic hardships, among others.
References	<ul style="list-style-type: none"> Women’s Preventive Services Initiative. <i>Recommendations for preventive services for women: final report to the U.S. Department of Health and Human Services, Health Resources & Services Administration</i>. Washington, DC: 2016.

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Lipid Screening and Statin Use to Prevent CVD and Colorectal Cancer	
<p>Rationale: Cardiovascular disease (CVD) is the leading cause of morbidity and mortality in the United States.</p> <p>USPSTF Recommendation: Universal lipid screening in adults age 40 to 75 and calculation of 10-year risk of a cardiovascular event. A low- to moderate-dose statin (lipid lowering medication) should be provided for the prevention of CVD events and mortality to adults without a history of cardiovascular disease (CVD), one or more CVD risk factors (i.e. dyslipidemia, diabetes, hypertension, or smoking), and 10-year risk of a cardiovascular event of 10% or greater.</p> <p>Bright Futures recommendation: Lipid screening once between 9 and 11 years of age, and once between 17 and 21 years of age</p>	
Ages and frequency	<p>9 to 11 years: once during age interval</p> <p>18 to 21 years: once during age interval</p> <p>40 to 75 years: periodic assessment of CVD risk; measurement of lipid levels every 5 years</p>
Clinical practice	<p>This recommendation applies to women without known CVD. Lipid screening includes measurement of total cholesterol, low-density lipoprotein cholesterol (LDL-C), and high-density lipoprotein cholesterol (HDL-C) levels.</p> <p>USPSTF recommends using a low- to moderate-dose statin for the prevention of CVD events and mortality when all the following criteria are met: 1) age 40 to 75 years; 2) have one or more CVD risk factors (i.e., dyslipidemia, diabetes, hypertension, or smoking); and 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% to 10% and otherwise meet criteria.</p>
Risk assessment	<p>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).</p> <p>10-year risk for 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 (ACC/AHA) (http://tools.acc.org/ASCVD-Risk-Estimator/).</p>
References	<ul style="list-style-type: none"> • US Preventive Services Task Force. Statin use for the primary prevention of cardiovascular disease in adults: US Preventive Services Task Force recommendation statement. <i>JAMA</i>. 2016;316(19):1997-2007. doi:10.1001/jama.2016.15450 • https://www.uspreventiveservicestaskforce.org/Page/Document/UpdateSummaryFinal/statin-use-in-adults-preventive-medication1 • Hagan JF, Shaw JS, Duncan PM, eds. <i>Bright Futures: Guidelines for Health Supervision of Infants, Children, and Adolescents</i>. 4th ed. Elk Grove Village, IL: American Academy of Pediatrics; 2017. • https://www.aap.org/en-us/Documents/periodicity_schedule.pdf

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Obesity Screening	
<p>Rationale: Over 30% of adult women in the United States are obese. Obesity increases risks for cardiovascular disease, type 2 diabetes mellitus, cancer, gallstones, and disability.</p> <p>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.</p> <p>Bright Futures Recommendation: Children should have BMI calculated and classified at every well child visit.</p>	
Ages and frequency	≥13 years annually
Clinical practice	<p>Height and weight are typically measured at most routine visits. Overweight is defined as a body mass index (BMI) of 25-29 kg/m² and obesity as BMI of 30 kg/m² or higher.</p> <p>USPSTF recommends offering or referring patients with a BMI of 30 kg/m² 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.</p>
Risk assessment	Not applicable.
References	<ul style="list-style-type: none"> • Grossman DC, Bibbins-Domingo K, Curry SJ, et al. Screening for obesity in children and adolescents: US Preventive Services Task Force recommendation statement. <i>JAMA</i>. 2017; 317(23):2417-26. doi: 10.1001/JAMA.2017.6803. PMID: 28632874. • Moyer VA. Screening for and management of obesity in adults: US Preventive Services Task Force recommendation statement. <i>Ann Intern Med</i>. 2012;157:373-378. • https://www.uspreventiveservicestaskforce.org/Page/Document/UpdateSummaryFinal/obesity-in-adults-screening-and-management • Hagan JF, Shaw JS, Duncan PM, eds. <i>Bright Futures: Guidelines for Health Supervision of Infants, Children, and Adolescents</i>. 4th ed. Elk Grove Village, IL: American Academy of Pediatrics; 2017. • https://www.aap.org/en-us/Documents/periodicity_schedule.pdf

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Osteoporosis Screening	
<p>Rationale: Approximately 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.</p> <p>USPSTF Recommendation: Screen for osteoporosis with bone measurement testing to prevent osteoporotic fractures in women age 65 years and older and in younger women who are at increased risk.</p>	
Ages and frequency	<p>≥65 years for all women</p> <p>50 to 64 years for women at increased risk</p> <p>There is no benefit from repeating bone measurement testing between 4 and 8 years after initial screening and a minimum of 2 years may be needed to reliably measure a change in bone mineral density (BMD).</p>
Clinical practice	<p>This recommendation is intended for women without previous osteoporotic fractures.</p> <p>USPSTF recommends women age 65 and older have bone measurement testing to identify osteoporosis, which is a risk factor for fragility fractures. Women between the ages of 50 and 64 years with equivalent or greater 10-year fracture risks based on specific risk factors should also be tested. Women identified with low bone density can reduce their risk of fractures with osteoporosis medications.</p> <p>Bone measurement testing with central dual-energy x-ray absorptiometry (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 ultrasound (QUS) at peripheral sites (such as wrist, forearm, and calcaneus) are alternative methods.</p>
Risk assessment	<p>Postmenopausal women younger than age 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.</p>
References	<ul style="list-style-type: none"> • Calonge N, Bibbins-Domingo K, Cantu A, et al. Screening for osteoporosis: US Preventive Services Task Force recommendation statement. <i>Ann Intern Med.</i> 2011; 154(5):356-64. doi: 10.7326/0003-4819-154-5-201103010-00307. PMID: 21242341. • US Preventive Services Task Force. Screening for osteoporosis to prevent fractures: US Preventive Services Task Force recommendation statement. [in press] • https://www.uspreventiveservicestaskforce.org/Page/Document/draft-recommendation-statement/osteoporosis-screening1

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Prevention of Falls	
<p>Rationale: Falls are common and a leading cause of injury in women age 65 and older.</p> <p>USPSTF Recommendation: Exercise to prevent falls in community-dwelling adults age 65 years or older who are at increased risk for falls.</p>	
Ages and frequency	≥65 years annually
Clinical practice	USPSTF recommends exercise interventions to prevent falls in community-dwelling adults age 65 years or older who are at increased risk for falls. Effective exercise interventions include supervised individual and group classes that included gait, balance, and functional training components. Clinicians may selectively offer multifactorial interventions for fall prevention that include combinations of exercise, psychological interventions, nutrition therapy, education, medication management, urinary incontinence management, environmental modification, and referrals to physical or occupational therapy, social or community services, or specialists (e.g., ophthalmologist, neurologist, or cardiologist).
Risk assessment	Risk factors to identify older adults who are at increased risk for falls include age; history of falls; and impairments in mobility, gait, and balance. Clinicians could also use assessments of gait and mobility to help determine risk.
References	<ul style="list-style-type: none"> US Preventive Services Task Force. Falls Prevention in Community-Dwelling Older Adults: US Preventive Services Task Force recommendation statement. [in press] https://www.uspreventiveservicestaskforce.org/Page/Document/draft-recommendation-statement/falls-prevention-in-older-adults-interventions1

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Substance Use Screening and Counseling	
<p>Rationale: Illicit drug use and abuse are serious problems in the United States, ranking among the ten leading preventable risk factors for years of healthy life lost to death and disability.</p> <p>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.</p>	
Age and Frequency	13 to 21 years annually
Clinical Practice	<p>Ask about alcohol and substance use. While many adolescents do not discuss substance use with their physicians, the most common reason is because they were never asked.</p> <p>Screening tools, such as CRAFFT, accurately identify a diagnosis of substance problem use, abuse, or dependence.</p>
Risk Assessment	Risk factors include substance use by a family member, poor parental supervision, household disruption, low academic achievement and/or academic aspirations, and untreated attention-deficit/hyperactivity disorder (ADHD).
References	<ul style="list-style-type: none"> • https://brightfutures.aap.org/Bright%20Futures%20Documents/Screening.pdf

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Tobacco Screening and Cessation Counseling	
<p>Rationale: Tobacco use is the leading preventable cause of disease, disability, and death in the United States. In pregnant women, smoking increases the risk for congenital anomalies; perinatal complications; and neonatal or pediatric complications.</p> <p>USPSTF Recommendations: Provide education or brief counseling to prevent initiation of tobacco use in school-aged children and adolescents. Ask all adults, including pregnant women, about tobacco use, advise them to stop using tobacco, and provide behavioral interventions and U.S. Food and Drug Administration–approved pharmacotherapy for smoking cessation.</p>	
Age and Frequency	≥13 years at least annually
Clinical Practice	The 5 A's framework is a strategy for engaging patients in smoking cessation discussions. These include: 1) Asking every patient about tobacco use, 2) Advising them to quit, 3) Assessing their willingness to quit, 4) Assisting them with quitting, and 5) Arranging follow-up.
Risk Assessment	Smoking prevalence is highest for those age 25 to 44 years; with lower levels of education and income; and with mental health conditions.
References	<ul style="list-style-type: none"> • Moyer VA. Primary care interventions to prevent tobacco use in children and adolescents: US Preventive Services Task Force recommendation statement. <i>Pediatrics</i>. 2013; 132(3):560-5. doi: 10.1542/peds.2013-2079. PMID: 23979083. • Siu AL. Behavioral and pharmacotherapy interventions for tobacco smoking cessation in adults, including pregnant women: US Preventive Services Task Force recommendation statement. <i>Ann Intern Med</i>. 2015; 163(8):622-34. doi: 10.7326/m15-2023. PMID: 26389730.

Recommendations for Well-Woman Care – Clinical Summary Tables

Urinary Incontinence Screening	
<p>Rationale: Approximately 50% of women in the United States experience urinary incontinence that can adversely affect health, quality of life, and function.</p> <p>WPSI Recommendation: Screen women for urinary incontinence annually and provide or refer for further diagnostic evaluation if indicated.</p>	
Ages and frequency	Women of all ages and those postpartum
Clinical practice	<p>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 impacts activities and quality of life.</p> <p>Once women with incontinence are identified, they may undergo individualized clinical diagnostic evaluations to determine appropriate treatment and management options including behavioral, pharmacologic, nonpharmacologic, and surgical interventions specific to the type and severity of incontinence and patient preferences.</p>
Risk assessment	Although urinary incontinence is common among all groups of women, rates are higher for women with specific risk factors, particularly older age, obesity, and previous vaginal delivery. Additional risk factors include hysterectomy, cognitive impairment, functional impairment, and other chronic medical conditions.
References	<ul style="list-style-type: none"> • Women’s Preventive Services Initiative. <i>Recommendations for Preventive Services for Women: Final Report to the U.S. Department of Health and Human Services, Health Resources & Services Administration</i>. Washington, DC: 2017. [in press]

Recommendations for Well-Woman Care – Clinical Summary Tables

Gonorrhea and Chlamydia Screening	
<p>Rationale: Gonorrhea and chlamydia are the most commonly reported sexually transmitted infections (STIs) 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.</p> <p>USPSTF Recommendation: Screen for gonorrhea and chlamydia in sexually active women age 24 years or younger and in older women who are at increased risk for infection.</p> <p>Bright Futures Recommendation: Screen all sexually active females 24 years and younger for gonorrhea and chlamydia annually.</p>	
Age and Frequency	<p>13 to 24 years annually</p> <p>>24 annually if increased risk</p>
Clinical Practice	Gonococcal and chlamydial infections are diagnosed with nucleic acid amplification tests using urine, endocervical, or provider-collected or patient self-collected vaginal specimens.
Risk Assessment	Infection rates are highest in sexually active females age 15 to 24 years. Risk factors include new or multiple sex partners, a sex partner with concurrent partners, or a sex partner with a STI; inconsistent condom use; previous or concurrent STI; exchanging sex for money or drugs; history of sexual abuse; and patients at public STI clinics.
References	<ul style="list-style-type: none"> • LeFevre ML. Screening for gonorrhea and chlamydia: U.S. Preventive Services Task Force recommendation statement. <i>Ann Intern Med.</i> 2014; 161(12):902-10. doi: 10.7326/m14-1981. PMID: 25243785. • Sexually Transmitted Diseases Treatment Guidelines, 2015. <i>MMWR Recomm Rep</i> 2015;64(No. RR-3): 1-137. Available at: https://www.cdc.gov/std/tg2015/default.htm • American Academy of Pediatrics Committee on Adolescence and Society for Adolescent Health and Medicine. Screening for nonviral sexually transmitted infections in adolescents and young adults. <i>Pediatrics</i> 2014; 134 (1): e302-e311. Available at: http://pediatrics.aappublications.org/content/134/1/e302

Recommendations for Well-Woman Care – Clinical Summary Tables

Hepatitis B Screening	
<p>Rationale: Approximately 700,000 to 2.2 million persons 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 infection. Screening identifies chronically infected persons who may benefit from treatment or other interventions, such as surveillance for hepatocellular carcinoma.</p> <p>USPSTF Recommendations: Screen for HBV infection in adolescents and adults at high risk for infection and in pregnant women at their first prenatal visit.</p>	
Ages and Frequency	≥13 years: all pregnant women and high risk adolescents and adults who are not pregnant
Clinical Practice	<p>Chronic HBV infection is determined by immunoassays for detecting hepatitis B surface antigen (HBsAg).</p> <p>Periodic screening may be useful in patients with ongoing risk for HBV transmission who do not receive vaccination.</p> <p>Screening for HBV infection in pregnancy should occur at the first prenatal visit. Women should also be screened at delivery if they have unknown HBsAg status or new or continuing risk factors (such as injection drug use or STI).</p>
Risk Assessment	Risk factors include: born in a country with a prevalence of HBV infection ≥2%; lack of vaccination in infancy in U.S.-born persons with parents from a country or region with prevalence ≥8%; HIV-positive persons; injection drug users; household contacts or sexual partners of persons with HBV infection; travelers to endemic areas, who have not completed Hepatitis B vaccination series.
References	<ul style="list-style-type: none"> • LeFevre ML. Screening for hepatitis B virus infection in nonpregnant adolescents and adults: U.S. Preventive Services Task Force recommendation statement. <i>Ann Intern Med.</i> 2014; 161(1):58-66. doi: 10.7326/m14-1018. PMID: 24863637. • Calonge N, Petitti D, DeWitt T, et al. Screening for hepatitis B virus infection in pregnancy: U.S. Preventive Services Task Force reaffirmation recommendation statement. <i>Ann Intern Med.</i> 2009; 150(12):869-73, w154. PMID: 19528565.

Recommendations for Well-Woman Care – Clinical Summary Tables

Hepatitis C Screening	
<p>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.</p> <p>USPSTF Recommendation: Screen for HCV infection in persons at high risk for infection. Offer 1-time screening for HCV infection to adults born between 1945 and 1965.</p>	
Ages and Frequency	<p>≥13 years: high risk</p> <p>1-time screening for all adults born between 1945 and 1965.</p>
Clinical Practice	<p>Anti-HCV antibody testing followed by confirmatory polymerase chain reaction testing accurately detects chronic HCV infection.</p> <p>Persons 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 only be screened once. Persons with continued risk for HCV infection (injection drug users) should be screened periodically.</p>
Risk Assessment	<p>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 prior to 1992; long-term hemodialysis; being born to an HCV-infected mother; incarceration; intranasal drug use; having an unregulated tattoo; and having other percutaneous exposures (e.g. health care workers).</p>
References	<ul style="list-style-type: none"> Moyer VA. Screening for hepatitis C virus infection in adults: US Preventive Services Task Force recommendation statement. <i>Ann Intern Med.</i> 2013; 159(5):349-57. doi: 10.7326/0003-4819-159-5-201309030-00672. PMID: 23798026.

Recommendations for Well-Woman Care – Clinical Summary Tables

HIV Screening	
<p>Rationale: Screening for human immunodeficiency virus (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.</p> <p>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.</p> <p>Bright Futures Recommendation: Screen once between the ages of 15 and 18; retest annually if increased risk (sexually active, injection drug use, tested for other STIs).</p>	
Ages and Frequency	<p>≥13 years: risk assessment and prevention education annually; test if pregnant</p> <p>15-18 years: test once; retest annually if increased risk or pregnant</p> <p>>18 years: test at least once; retest if increased risk or pregnant</p>
Clinical Practice	<p>This recommendation refers to routine HIV screening, which is different from incident-based or exposure-based HIV testing.</p> <p>Annual or more frequent HIV testing is recommended for women who are high risk.</p> <p>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.</p> <p>Screening could 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.</p>
Risk Assessment	<p>Risk factors include injection drug use; unprotected vaginal or anal intercourse; 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.</p>
References	<ul style="list-style-type: none"> • Women’s Preventive Services Initiative. <i>Recommendations for Preventive Services for Women: Final Report to the US Department of Health and Human Services, Health Resources & Services Administration</i>. Washington, DC: 2016. • Moyer VA. Screening for HIV: U.S. Preventive Services Task Force recommendation statement. <i>Ann Intern Med</i>. 2013; 159(1):51-60. doi: 10.7326/0003-4819-159-1-201307020-00645. PMID: 23698354.

Recommendations for Well-Woman Care – Clinical Summary Tables

Latent Tuberculosis Screening	
<p>Rationale: Five to ten percent of individuals with latent tuberculosis infection progress to active tuberculosis disease. Identifying and treating latent tuberculosis is a key component of the strategy for reducing the burden of tuberculosis disease.</p> <p>USPSTF Recommendation: Screen for latent tuberculosis infection in populations at increased risk.</p>	
Ages and Frequency	≥13 year: increased risk
Clinical Practice	Screening tests include the Mantoux tuberculin skin test and interferon-gamma release assays.
Risk Assessment	Persons 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.
References	<ul style="list-style-type: none"> US Preventive Services Task Force. Screening for latent tuberculosis infection in adults. US Preventive Services Task Force recommendation statement. <i>JAMA</i>. 2016;316(9):962–969. doi:10.1001/jama.2016.11046

Recommendations for Well-Woman Care – Clinical Summary Tables

Sexually Transmitted Infections Counseling	
<p>Rationale: Sexually transmitted infections (STIs) are frequently asymptomatic and can be unknowingly spread to others. Serious sequelae of STIs include pelvic inflammatory disease, infertility, and cancer. Untreated STIs present during pregnancy or birth may cause perinatal infection, death, and serious physical and mental disabilities.</p> <p>WPSI Recommendation: Directed behavioral counseling by a health care provider or other appropriately trained individual for sexually active adolescent and adult women at an increased risk for 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.</p>	
Age and Frequency	<p>13 to 21 years</p> <p>>22 years for sexually active women with increased risk for STIs</p>
Clinical Practice	<p>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.</p> <p>Providers should select behavioral counseling interventions based on their effectiveness, appropriateness to the patient population, and feasibility of implementation.</p>
Risk Assessment	<p>All sexually active adolescents are at increased risk for STIs and should be counseled. Risk factors may include age <25, 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.</p> <p>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 with a history of sexual abuse, and patients at public STI clinics.</p>
References	<ul style="list-style-type: none"> • Women’s Preventive Services Initiative. <i>Recommendations for Preventive Services for Women: Final Report to the US Department of Health and Human Services, Health Resources & Services Administration</i>. Washington, DC: 2016. • LeFevre ML. Behavioral counseling interventions to prevent sexually transmitted infections: U.S. Preventive Services Task Force recommendation statement. <i>Ann Intern Med</i>. 2014;161:894-901.

Recommendations for Well-Woman Care – Clinical Summary Tables

Syphilis Screening	
<p>Rationale: Although less common than other sexually transmitted infections (STIs), 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 for acquiring or transmitting HIV infection.</p> <p>USPSTF Recommendations: Screen for syphilis in adolescents and adults at increased risk for infection and in all pregnant women.</p> <p>Bright Futures Recommendation: For high-risk teens, screen for syphilis at least once a year.</p>	
Ages and Frequency	≥13 years: all pregnant women and high risk adolescents and adults who are not pregnant
Clinical Practice	<p>Screening for syphilis infection is a two-step process involving an initial nontreponemal test (Venereal Disease Research Laboratory or rapid plasma reagin [RPR] test) followed by a confirmatory treponemal antibody detection test (fluorescent treponemal antibody absorption or <i>Treponema pallidum</i> particle agglutination test).</p> <p>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.</p>
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; exchanging sex for money or drugs.
References	<ul style="list-style-type: none"> • Bibbins-Domingo K, Grossman DC, Curry SJ, et al. Screening for syphilis infection in nonpregnant adults and adolescents: US Preventive Services Task Force recommendation statement. <i>JAMA</i>. 2016; 315(21):2321-7. doi: 10.1001/JAMA.2016.5824. PMID: 27272583. • Wolff T, Shelton E, Sessions C, et al. Screening for syphilis infection in pregnant women: evidence for the US Preventive Services Task Force reaffirmation recommendation statement. <i>Ann Intern Med</i>. 2009; 150(10):710-6. PMID: 19451578.

Recommendations for Well-Woman Care – Clinical Summary Tables

Breast Cancer Screening	
<p>Rationale: Breast cancer is the second-leading cause of cancer death among women in the United States.</p> <p>WPSI Recommendation: Initiate mammography screening no earlier than age 40 and no later than age 50 for women at average risk for breast cancer. Screening should continue through at least age 74 and age alone should not be the basis to discontinue screening.</p>	
Ages and frequency	Begin at 40 to 50 years until at least 74 years at least biennially and as frequently as annually
Clinical practice	These recommendations are for women at average risk for breast cancer. The decision to screen women prior to age 50 and after age 74 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 for breast cancer (previous breast or ovarian cancer, BRCA mutation carriers, previous high-dose radiation to the chest) should also undergo periodic mammography screening and may require additional follow-up that is beyond the scope of this recommendation.
References	<ul style="list-style-type: none"> Women’s Preventive Services Initiative. <i>Recommendations for Preventive Services for Women: Final Report to the U.S. Department of Health and Human Services, Health Resources & Services Administration</i>. Washington, DC: 2016.

Recommendations for Well-Woman Care – Clinical Summary Tables

Cervical Cancer Screening	
<p>Rationale: Cervical cancer deaths in the United States have decreased since the implementation of widespread cervical cancer screening and most cases occur in women who have not been adequately screened.</p> <p>WPSI Recommendation: Cervical cancer screening for average-risk women age 21 to 65 years includes cervical cytology (Pap test) every 3 years for age 21 to 29 years; cytology and human papillomavirus testing every 5 years or cytology alone every 3 years for age 30 to 65 years.</p> <p>USPSTF recommendation: Screening for cervical cancer every 3 years with cervical cytology alone in women ages 21 to 29 years; and every 3 years with cervical cytology alone, every 5 years with high-risk human papillomavirus (hrHPV) testing alone, or every 5 years with hrHPV testing in combination with cytology (cotesting) in women ages 30 to 65 years.</p>	
Ages and frequency	<p>21 to 29 years: cervical cytology alone every 3 years</p> <p>30 to 65 years: cervical cytology alone every 3 years; or cytology and human papillomavirus testing every 5 years (WPSI); or high-risk human papillomavirus (hrHPV) testing alone every 5 years (USPSTF)</p>
Clinical practice	<p>This recommendation applies to women who have a cervix, regardless of sexual history or HPV vaccination status.</p> <p>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 for cervical cancer and should not be screened.</p>
Risk assessment	<p>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.</p>
References	<ul style="list-style-type: none"> • Women’s Preventive Services Initiative. <i>Recommendations for Preventive Services for Women: Final Report to the U.S. Department of Health and Human Services, Health Resources & Services Administration</i>. Washington, DC: 2016. • Moyer VA. Screening for cervical cancer: US Preventive Services Task Force recommendation statement. <i>Ann Intern Med</i>. 2012; 156(12):880-91, w312. doi: 10.7326/0003-4819-156-12-201206190-00424. PMID: 22711081 • https://www.uspreventiveservicestaskforce.org/Page/Document/UpdateSummaryFinal/cervical-cancer-screening2 • US Preventive Services Task Force. Screening for cervical cancer: US Preventive Services Task Force recommendation statement. 2018. • https://www.uspreventiveservicestaskforce.org/Page/Document/UpdateSummaryFinal/cervical-cancer-screening2

Recommendations for Well-Woman Care – Clinical Summary Tables

Colon Cancer Screening	
<p>Rationale: Colorectal cancer is most common among adults over age 50 years and early detection with screening can reduce mortality.</p> <p>USPSTF Recommendation: Screen for colorectal cancer starting at age 50 years and continuing until age 75 years.</p>	
Ages and frequency	50 to 75 years: frequency varies by method
Clinical practice	<p>Screening methods include gFOBT (guaiac-based fecal occult blood test), FIT (fecal immunochemical test), or FIT-DNA (multitargeted stool DNA test) every 1-2 years; flexible sigmoidoscopy or computed tomography (CT) colonography every 5 years; and colonoscopy every 10 years.</p> <p>The decision to screen for colorectal cancer in adults aged 76 to 85 years should be an individual one that considers the patient’s overall health and prior screening history.</p>
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 for colorectal cancer and may consider screening at earlier ages.
References	<ul style="list-style-type: none"> • Bibbins-Domingo K, Grossman DC, Curry SJ, et al. Screening for colorectal cancer: US Preventive Services Task Force recommendation statement. <i>JAMA</i>. 2016; 315(23):2564-75. doi: 10.1001/JAMA.2016.5989. PMID: 27304597.

Recommendations for Well-Woman Care – Clinical Summary Tables

Lung Cancer Screening	
<p>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 lung cancer cases.</p> <p>USPSTF Recommendation: Screen for lung cancer with low-dose computed tomography in adults aged 55 to 80 years who have a 30 pack-year smoking history and currently smoke or have quit within the past 15 years.</p>	
Ages and frequency	55 to 80 years 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 persons aged 55 years or older. Increasing age and cumulative exposure to tobacco smoke are the two most common risk factors for lung cancer. Approximately 37% of adults in the United States are current or former smokers.
References	<ul style="list-style-type: none">• Moyer VA. Screening for lung cancer: US Preventive Services Task Force recommendation statement. <i>Ann Intern Med.</i> 2014; 160(5):330-8. doi: 10.7326/m13-2771. PMID: 24378917

Recommendations for Well-Woman Care – Clinical Summary Tables

Medications to Reduce Breast Cancer Risk	
<p>Rationale: While 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 for estrogen receptor (ER)–positive breast cancer.</p> <p>USPSTF Recommendation: Clinicians should offer to prescribe risk-reducing medications for women who are at increased risk for breast cancer and at low risk for adverse medication effects.</p>	
Ages and frequency	≥40 years: assess risk annually
Clinical practice	USPSTF recommends that clinicians engage in shared, informed decision making with women who are at increased risk for breast cancer about medications to reduce their risk, and recommends against their use in women who are not at increased risk for 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.
References	<ul style="list-style-type: none"> Moyer VA. Medications to decrease the risk for breast cancer in women: recommendations from the US Preventive Services Task Force recommendation statement. <i>Ann Intern Med.</i> 2013; 159(10):698-708. doi: 10.7326/0003-4819-159-10-201311190-00717. PMID: 24061412.

Recommendations for Well-Woman Care – Clinical Summary Tables

Risk Assessment for BRCA Testing	
<p>Rationale: Inherited mutations of the BRCA gene increase risks for breast, ovarian, and fallopian tube cancer. These mutations occur in an estimated 1 in 300 to 500 women (0.2% to 0.3%) in the general population, but are more common within families with previously diagnosed cancer.</p> <p>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 for potentially harmful mutations in breast cancer susceptibility genes (<i>BRCA1</i> or <i>BRCA2</i>). Women with positive screening results should receive genetic counseling and, if indicated after counseling, BRCA testing.</p>	
Ages and frequency	≥18 years: assess risk periodically
Clinical practice	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 for potentially harmful mutations in breast cancer susceptibility genes (<i>BRCA1</i> or <i>BRCA2</i>). 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.
References	<ul style="list-style-type: none"> Moyer VA. Risk assessment, genetic counseling, and genetic testing for BRCA-related cancer in women: US Preventive Services Task Force recommendation statement. <i>Ann Intern Med.</i> 2014; 160(4):271-81. doi: 10.7326/m13-2747. PMID: 24366376.

Recommendations for Well-Woman Care – Clinical Summary Tables

Skin Cancer Counseling	
<p>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 skin cancer cases, it is responsible for 80% of skin cancer deaths. Exposure to ultraviolet radiation increases risk.</p> <p>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 to 24 years).</p>	
Ages and frequency	13 to 24 years annually
Clinical practice	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 sunscreen with a sun-protection factor of 15 or greater; 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, 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.
References	<ul style="list-style-type: none"> Bibbins-Domingo K, Grossman DC, Curry SJ, et al. Screening for Skin Cancer: US Preventive Services Task Force Recommendation Statement. <i>JAMA</i>. 2016; 316(4):429-35. doi: 10.1001/JAMA.2016.8465. PMID: 27458948.

Recommendations for Well-Woman Care – Clinical Summary Tables

Low-dose Aspirin for Prevention of Preeclampsia	
<p>Rationale: Preeclampsia is a hypertensive disorder occurring during pregnancy with potentially serious, even fatal health outcomes. Maternal complications include stroke, eclampsia, and organ failure; and adverse perinatal outcomes include intrauterine growth restriction, low birth weight, and stillbirth. Low-dose aspirin can reduce risk for preeclampsia.</p> <p>USPSTF Recommendation: Use low dose aspirin (81mg/d) as preventive medication after 12 weeks' gestation in women who are at high risk for preeclampsia.</p>	
Ages and Frequency	All pregnant women at high risk for preeclampsia
Clinical Practice	After 12 weeks' gestation, initiate daily low-dose aspirin in women at high risk for preeclampsia.
Risk Assessment	Risk factors include history of preeclampsia (including early-onset preeclampsia), intrauterine growth restriction (IUGR), or preterm birth; placental abruption or fetal death; maternal comorbid conditions (including type 1 or 2 pregestational diabetes, chronic hypertension, renal disease, and autoimmune diseases); and multifetal gestation.
References	<ul style="list-style-type: none"> LeFevre ML. Low-dose aspirin use for the prevention of morbidity and mortality from preeclampsia: US Preventive Services Task Force recommendation statement. <i>Ann Intern Med.</i> 2014;161:819–826. doi: 10.7326/M14-1884

Recommendations for Well-Woman Care – Clinical Summary Tables

Asymptomatic Bacteriuria Screening	
<p>Rationale: In pregnant women, asymptomatic bacteriuria has been associated with an increased incidence of pyelonephritis and low birthweight.</p> <p>USPSTF Recommendation: Screen for asymptomatic bacteriuria with urine culture for pregnant women at 12 to 16 weeks' gestation or at their first prenatal visit if later.</p>	
Ages and Frequency	<p>All pregnant women</p> <p>Screen at 12 to 16 weeks' gestation or at the first prenatal visit if later. The optimal frequency of subsequent urine testing during pregnancy is uncertain.</p>
Clinical Practice	<p>Asymptomatic bacteriuria can be reliably detected through urine culture. The presence of at least 10^5 colony-forming units per mL of urine of a single uropathogen from a midstream clean-catch specimen is considered a positive test result.</p>
Risk Assessment	<p>N/A</p>
References	<ul style="list-style-type: none">• U.S. Preventive Services Task Force. Screening for asymptomatic bacteriuria in adults: US Preventive Services Task Force reaffirmation recommendation statement. <i>Ann Intern Med</i> 2008;149:43-47.

Recommendations for Well-Woman Care – Clinical Summary Tables

Breastfeeding Services & Supplies	
<p>Rationale: While breastfeeding is associated with multiple health benefits for infants and mothers, nearly half of all mothers in the United States who initially breastfeed stop doing so by 6 months.</p> <p>WPSI Recommendation: Comprehensive lactation support services (including counseling, education, and breastfeeding equipment and supplies) during the antenatal, perinatal, and postpartum periods to ensure the successful initiation and maintenance of breastfeeding.</p> <p>USPSTF Recommendation: Provide interventions during pregnancy and after birth to support breastfeeding. Interventions may include more than one component and be delivered over prenatal, perinatal, and postpartum periods.</p>	
Ages and Frequency	All pregnant and postpartum women
Clinical Practice	Lactation support services include counseling, education, and breastfeeding equipment and supplies. A lactation care provider should deliver lactation support and provide services across the antenatal, perinatal, and postpartum periods to ensure successful preparation, initiation and continuation of breastfeeding.
Risk Assessment	Not applicable
References	<ul style="list-style-type: none"> • Women’s Preventive Services Initiative. <i>Recommendations for Preventive Services for Women: Final Report to the U.S. Department of Health and Human Services, Health Resources & Services Administration</i>. Washington, DC: 2016. • US Preventive Services Task Force. Primary care interventions to support breastfeeding. US Preventive Services Task Force recommendation statement. <i>JAMA</i>. 2016;316(16):1688–1693. doi:10.1001/jama.2016.14697

Recommendations for Well-Woman Care – Clinical Summary Tables

Gestational Diabetes Screening	
<p>Rationale: Gestational diabetes mellitus (GDM) is glucose intolerance discovered during pregnancy. Pregnant women with gestational diabetes are at increased risk for maternal and fetal complications, including preeclampsia, fetal macrosomia (which can cause shoulder dystocia and birth injury), and neonatal hypoglycemia. Women with GDM are also at increased risk for developing type 2 diabetes mellitus.</p> <p>WPSI Recommendation: Screen pregnant women for gestational diabetes mellitus after 24 weeks’ gestation (preferably between 24 and 28 weeks) to prevent adverse birth outcomes. Screen women with risk factors for preexisting diabetes before 24 weeks’ gestation, ideally at the first prenatal visit.</p>	
Ages and Frequency	<p>All pregnant women after 24 weeks’ gestation</p> <p>Pregnant women with risk factors at the first prenatal visit</p>
Clinical Practice	<p>Screening after 24 weeks: 50-g oral glucose challenge test (followed by a 3-hour oral glucose tolerance test if results on the initial oral glucose challenge test are normal) is preferred because of its high sensitivity and specificity.</p> <p>Screening prior to 24 weeks: 50-g oral glucose challenge test; 2-hour 75-g oral glucose tolerance test; hemoglobin A1c test; random plasma glucose test; or a fasting plasma glucose test.</p>
Risk Assessment	<p>Risk factors include obesity, increased maternal age, history of GDM, family history of diabetes, and belonging to an ethnic group with increased risk for type 2 diabetes mellitus (Hispanic, Native American, South or East Asian, African American, or Pacific Islands descent).</p>
References	<ul style="list-style-type: none"> • Women’s Preventive Services Initiative. <i>Recommendations for Preventive Services for Women: Final Report to the U.S. Department of Health and Human Services, Health Resources & Services Administration</i>. Washington, DC: 2016.

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Preeclampsia Screening	
<p>Rationale: Preeclampsia is defined as new-onset hypertension (or, in patients with existing hypertension, worsening hypertension) occurring after 20 weeks of gestation, combined with either new-onset proteinuria (excess protein in the urine) or other signs or symptoms involving multiple organ systems. Preeclampsia has multiple subtypes and can have potentially serious, even fatal health outcomes, for both mother and infant. Maternal complications include stroke, eclampsia, and organ failure; and adverse perinatal outcomes include intrauterine growth restriction, low birth weight, and stillbirth. Many of the complications associated with preeclampsia lead to early induction of labor or cesarean delivery and subsequent preterm birth.</p> <p>USPSTF Recommendation: Screen for preeclampsia with blood pressure measurements throughout pregnancy.</p>	
Ages and Frequency	All pregnant women at each prenatal visit
Clinical Practice	Blood pressure measurements should be obtained during each prenatal care visit throughout pregnancy. If a patient has an elevated blood pressure reading, the reading should be confirmed with repeated measurements.
Risk Assessment	Risk factors include history of preeclampsia (including early-onset preeclampsia), a previous adverse pregnancy outcome, maternal comorbid conditions (including type 1 or 2 diabetes prior to pregnancy, gestational diabetes, chronic hypertension, renal disease, and autoimmune diseases), and multifetal gestation. Other risk factors include nulliparity, obesity, African American race, low socioeconomic status, and advanced maternal age.
References	<ul style="list-style-type: none"> US Preventive Services Task Force. Screening for preeclampsia. US Preventive Services Task Force recommendation statement. <i>JAMA</i>. 2017;317(16):1661–1667. doi:10.1001/jama.2017.3439

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Rh(D) Blood Typing	
<p>Rationale: Rh(D) blood typing, anti-Rh(D) antibody testing, and intervention with Rh(D) immunoglobulin, as appropriate, prevents maternal sensitization and improves outcomes for newborns.</p> <p>USPSTF Recommendation: Rh(D) blood typing and antibody testing for all pregnant women during their first visit for pregnancy-related care, and repeated Rh(D) antibody testing for all unsensitized Rh(D)-negative women at 24 to 28 weeks' gestation, unless the biological father is known to be Rh(D)-negative.</p>	
Ages and Frequency	All pregnant women
Clinical Practice	<p>Administration of a full (300 µg) dose of Rh(D) immunoglobulin is recommended for all unsensitized Rh(D)-negative women after repeated antibody testing at 24 to 28 weeks' gestation.</p> <p>Unless the biological father is known to be Rh(D)-negative, a full dose of Rh(D) immunoglobulin is recommended for all unsensitized Rh(D)-negative women after amniocentesis and after induced or spontaneous abortion; however, if the pregnancy is less than 13 weeks, a 50-µg dose is sufficient.</p> <p>If a Rh(D)-positive or weakly Rh(D)-positive infant is delivered, a dose of Rh(D) immunoglobulin should be repeated postpartum, preferably within 72 hours after delivery.</p>
Risk Assessment	N/A
References	<ul style="list-style-type: none"> • <i>Screening for Rh (D) Incompatibility: A Brief Evidence Update for the U.S. Preventive Services Task Force.</i> Rockville, MD, Agency for Healthcare Research and Quality, 2004. Available at http://www.uspreventiveservicestaskforce.org.