Reproductive-Aged Women

Abdominal Examination
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Skin Cancer
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Visual Acuity/Glaucoma

Final WWTF Recommendation and Strength of Recommendation	Evidence Based	Evidence Informed	Uniform Expert Agreement
"Strong" = Based on evidence-based or evidence-informed guidelines "Qualified" = Based on expert opinion alone	Foundation for WWTF recommendations. Primarily USPSTF, IOM, and CDC guidelines.	Additional guidelines from medical societies used for developing consensus recommendations.	WWTF expert consensus: Describes resolution of conflicting guidelines or outlines expert opinion that does not have a strong evidence foundation.

TOPIC: ABDOMINAL EXAMINATION

Final WWTF Recommendation	Evidence Based	Evidence Informed	Uniform Expert Agreement
Adolescents (13–21 years)			
An abdominal examination is an appropriate component of the well-adolescent visit. (Qualified)		General: Standard physical examination taught in medical school and advanced practice programs includes abdominal examination as part of a routine periodic examination. The elements can include four-quadrant/nine-region abdominal inspection, auscultation, percussion, and palpation. Inspection can reveal distention, operative and traumatic scars, striae, pubic hair distribution, jaundice, and distended veins. Auscultation can reveal bowel sounds and fetal heart sounds. Percussion can reveal ascites. Palpation can assess superficial or deep tenderness, guarding, rebound tenderness, and rigidity. ACOG: Abdominal examination is recommended as part of well-woman physical examination regardless of age.[1,2,3] AAP Bright Futures: Annual well-child assessment and physical examination is recommended. At this visit, an age-appropriate physical examination is essential. The older child (11–21 years) will be undressed and suitably draped.[4]	
Adults (22 years and older)			
An abdominal examination is an appropriate component of the well-woman visit. (Qualified)		General: Standard physical examination taught in medical school and advanced practice programs includes abdominal examination as part of a routine periodic examination. An abdominal examination can assess a woman's risk of exposure to hepatitis C; drug and alcohol use or abuse; dietary, hereditary, or lifestyle risks for gastrointestinal disorders; and cancers of the skin and internal organs. ACOG: Abdominal examination is recommended as part of well-woman physical examination regardless of age.[1,2,3]	

TOPIC: ALCOHOL MISUSE

Final WWTF Recommendation	Evidence Based	Evidence Informed	Uniform Expert Agreement
Adolescents (13–18 years)			
Annual screening of adolescents for alcohol use by questionnaire, history, or both (not by laboratory testing) is recommended. Positive screening should prompt provision or referral of patient to counseling about alcohol use. (Strong)	USPSTF: There is inconclusive evidence that counseling is effective in adolescents.[5]	AAP Bright Futures: Recommends annual evaluation and counseling for alcohol use in adolescents.[6] AAP: Strongly advises against the use of alcohol, tobacco, and other illicit drugs by youth.[7] ACOG: Recommends annual screening for alcohol use in teens.[8] Recommends screening by questionnaire, history, or both (not by laboratory testing) at least yearly.[9] PCHHC: All women of childbearing age should be screened for alcohol use, and brief interventions should be provided in primary care settings, which should include advice regarding the potential for adverse health outcomes. Women who show signs of alcohol dependence should be educated about the risks of alcohol consumption; for women who are interested in modifying their alcohol use patterns, efforts should be made to identify programs that would assist them in achieving cessation and long-term abstinence (B I-a).[10] Assess at least annually for alcohol use patterns and risky drinking behaviors and provide appropriate counseling; all women should be advised of the risks to the embryo/ fetus of alcohol exposure in pregnancy and that no safe level of consumption has been established (A-III).[10] AAFP: The evidence is inconclusive that counseling is effective in adolescents. Recommends screening and behavioral counseling interventions in primary care settings to reduce alcohol misuse.[11] CDC: Binge drinking increases the risk of unintended pregnancy, delayed pregnancy recognition, STIs, and adverse pregnancy outcomes, including fetal alcohol spectrum disorder.[12] NIAAA: Recommends alcohol screening and brief intervention for youth.[13]	
Adults (19 years and older)			
Annual screening of adults for alcohol misuse by questionnaire, history, or both, but not by testing, is recommended. Provide or refer persons engaged in risky or hazardous drinking to brief behavioral counseling interventions to reduce alcohol misuse. (Strong)	USPSTF: Recommends that clinicians 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.[5]	AAFP: Recommends screening and behavioral counseling interventions in primary care settings to reduce alcohol misuse.[11] ACOG: Recommends screening by questionnaire, history, or both, but not by testing, at least yearly.[9] AAP Bright Futures: Recommends annual evaluation and counseling for alcohol use in adolescents through age 21 years.[6] PCHHC: All women of childbearing age should be screened for alcohol use, and brief interventions should be provided in primary care settings, which should include advice regarding the potential for adverse health outcomes. Women who show signs of alcohol dependence should be educated about the risks of alcohol consumption; for women who are interested in modifying their alcohol use patterns, efforts should be made to identify programs that would assist them in achieving cessation and long-term abstinence(B I-a).[10] Assess at least annually for alcohol use patterns and risky drinking behaviors and provide appropriate counseling; all women should be advised of the risks to the embryo/fetus of alcohol exposure in pregnancy and that no safe level of consumption has been established (A-III).[10]	

TOPIC: ANEMIA

Final WWTF Recommendation	Evidence Based	Evidence Informed	Uniform Expert Agreement
Adolescents & Adults (all ages)			
Routine screening for anemia is not recommended. (Qualified)	USPSTF: Evidence is insufficient to recommend for or against routine iron supplementation for nonanemic pregnant women (Grade I).[14]	There is no recommendation for routine screening for anemia in asymptomatic girls or women.	

TOPIC: BACTERIURIA

Final WWTF Recommendation	Evidence Based	Evidence Informed	Uniform Expert Agreement
Adolescents (13–18 years)			
Screening for bacteriuria in asymptomatic nonpregnant women is not recommended. (Strong)	USPSTF: Recommends against screening for asymptomatic bacteriuria in nonpregnant women.[15]	AAFP: Recommends against screening for asymptomatic bacteriuria in men and nonpregnant women.[16]	There is evidence of harm resulting from treatment of asymptomatic bacteriuria in nonpregnant women. There is no evidence of benefit to screening older, asymptomatic, nonpregnant women. Recommend following USPSTF guidelines.
Adults (19–64 years)			
Screening for bacteriuria in asymptomatic nonpregnant women is not recommended. (Strong)	USPSTF: Recommends against screening for asymptomatic bacteriuria in men and nonpregnant women.[15]	AAFP: Recommends against screening for asymptomatic bacteriuria in nonpregnant women.[16]	There is evidence of harm resulting from treatment of asymptomatic bacteriuria in nonpregnant women.

TOPIC: BLOOD PRESSURE SCREENING
(*See also* Cardiovascular Disease/Dyslipidemia)

Final WWTF Recommendation	Evidence Based	Evidence Informed	Uniform Expert Agreement
Adolescents and Adults (all ages)			
Routine blood pressure screening is recommended. (Strong)	USPSTF: Screen for high blood pressure in adults aged 18 years or older. Current evidence is insufficient to assess the balance of benefits and harms of screening for hypertension in asymptomatic children and adolescents to prevent subsequent cardiovascular disease in childhood or adulthood.[17,18]	AAFP: There is insufficient evidence to recommend for or against screening children and adolescents for high blood pressure to reduce risk of cardiovascular disease.[19] AAP Bright Futures: Recommends routine blood pressure measurement for adolescents.[6]	

TOPIC: BREAST AWARENESS

Final WWTF Recommendation	Evidence Based	Evidence Informed	Uniform Expert Agreement
Adults (all ages)			
Physicians should educate women about breast self-awareness, encouraging them to understand the normal appearance and feel of their breasts and to report any changes in their breasts to their health care providers. Breast self-awareness can include breast self-examination. (Qualified)	USPSTF: Recommends against teaching breast self-examination (Grade D).[20,21] Cochrane Collaborative: The review of data from two large population-based studies involving 388,535 women compared breast self-examination with no intervention did not find a beneficial effect of screening in terms of improvement in breast cancer mortality. The trials showed that women who were randomized to breast self-examination were almost twice as likely to undergo a biopsy of the breast. The authors suggest that the lack of supporting evidence from the two major studies should be discussed with these women to enable them to make an informed decision. Women should, however, be aware of any breast changes.[22]	ACOG: Because other screening methods can have false-negative results, and because breast cancer can occur in unscreened women, breast self-examination and breast self-awareness have a role in breast cancer screening. Physicians should consider teaching breast self-examination to high-risk patients. Recommend educating women about breast self-awareness.[23] NCCN: Breast awareness is encouraged.[24] ACS: Starting at age 20 years, women should be counseled on the benefits and limitations of breast self-examination.[25]	

TOPIC: BREAST CANCER, CHEMOPREVENTION

Final WWTF Recommendation	Evidence Based	Evidence Informed	Uniform Expert Agreement
Adults (all ages)			
For women who are at increased risk of breast cancer, it is recommended that clinicians engage in shared, informed decision-making with women about medications to reduce their risk. (Strong) **It is recommended that women who are at increased risk of breast cancer and at low risk of adverse medication effects be offered risk-reducing medications, such as tamoxifen or raloxifene. (Strong)**	USPSTF: Recommends that clinicians engage in shared, informed decision-making with women who are at increased risk of breast cancer about medications to reduce their risk. For women who are at increased risk of breast cancer and at low risk of adverse medication effects, clinicians should offer to prescribe risk-reducing medications, such as tamoxifen or raloxifene (Grade B).[26]	ACOG: Counsel women aged 35 years and older at high risk.[2] AAFP: 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. For women who are at increased risk for breast cancer and at low risk for adverse medication effects, clinicians should offer to prescribe risk-reducing medications, such as tamoxifen or raloxifene.[27]	Recommend following USPSTF guidelines.

TOPIC: BREAST CANCER SCREENING

Final WWTF Recommendation	Evidence Based	Evidence Informed	Uniform Expert Agreement
Adults (all ages)			
For women aged 40 years and older, the decision to start or terminate regular screening mammography should be individualized and should take into account patient context, including an assessment of breast cancer risk, comorbidities, and the patient's values regarding specific benefits and harms of screening. (Strong) **Routine screening mammography should occur by age 50 years. (Strong)** **The frequency of routine screening should take into account patient context and should be either annual or biennial. (Qualified)**	**Age younger than 50 years** USPSTF: The decision to start regular, biennial screening mammography before the age of 50 years should be an individual one and take patient context into account, including the patient's values regarding specific benefits and harms (Grade C).[28] **Ages 50–74 years** USPSTF: Recommends biennial screening mammography for women between the ages of 50 years and 74 years (Grade B).[28] **Age older than 75 years** USPSTF: There is insufficient evidence to assess the additional benefits and harms of screening mammography in women aged 75 years or older.[28]	ACOG: Women aged 40 years and older should have annual mammograms.[23] ACP: Breast cancer risk is not evenly distributed in women between the ages of 40 years and 49 years. Thus, the benefits of screening mammography are not uniformly applicable in women in this age group. For women ages 40–49 years, individualized assessment of risk of breast cancer to guide decisions about mammography screening is recommended. Base screening on benefits and harms, women's preference, and risk.[29] AAFP: Mammography before age 50 years should be individualized and take into account patient context, including risks, values, and harms. There is insufficient evidence about the benefits and harms of mammography for women older than 75 years.[30] AWHONN: Supports access for women to screening mammography and other health care services based on an assessment for breast cancer risk. Risk assessment for breast cancer includes age; hormonal factors, such as early age of menarche, late age of menopause, late age of first pregnancy, nulliparity, and use of hormonal therapies; familial factors, including family history of breast cancer and genetic test results for *BRCA* mutations; and personal factors such as personal history of breast cancer, findings from earlier breast biopsies, and past exposure to chest irradiation. Other associated risk factors include postmenopausal obesity, lack of exercise, and alcohol use.[31] CTFPHC: Current evidence regarding the effectiveness of screening mammography does not suggest the inclusion of the manoeuvre or its exclusion from the periodic health examination of women aged 40–49 years at average risk of breast cancer (Grade C). Upon reaching the age of 40, Canadian women should be informed of the potential benefits and risks of screening mammography and assisted in deciding at what age they wish to initiate the manoeuvre (every 12–18 months).[32] ACS: Screening decisions in older women should be individualized by considering the potential benefits and risks of mammography in the context of current health status and estimated life expectancy. As long as a woman is in reasonably good health and would be a candidate for treatment, she should continue to be screened with mammography.[33]	The WWTF agrees with the USPSTF that "Mammography screening reduces breast cancer mortality for women aged 39–69 years: data are insufficient for older women. False-positive mammography and results and additional imaging are common."[20] Biennial screening achieves most, but not all, of the benefit of annual screening with less harm. "Decisions about the best strategy depend on program and individual objectives and the weight placed on benefits, harms and resource considerations."[34]

TOPIC: BREAST EXAMINATION

Final WWTF Recommendation	Evidence Based	Evidence Informed	Uniform Expert Agreement
Adults (all women)			
Clinical breast examination (CBE) may be offered to women in the context of a shared, informed decision-making approach that recognizes the uncertainty of additional benefits and harms of clinical breast examination beyond screening mammography. (Qualified) **Clinical breast examination may be offered to women ages 19–39 years every 1–3 years. (Qualified)** **Clinical breast examination may be offered annually to women aged 40 years and older. (Qualified)**	USPSTF: Current evidence is insufficient to assess the additional benefits and harms of clinical breast examination beyond screening mammography in women 40 years or older.[21]	ACOG: Clinical breast examination should be performed every 1–3 years for women ages 20–39 years and annually for women aged 40 years and older (Level C).[2] Clinical breast examination should be performed annually for women 40 or older. Although the value of screening clinical breast examination for women with low prevalence of breast cancer (ie, women aged 20–39 years) is not clear, clinical breast examination for these women is recommended every 1–3 years.[23] AAFP: Current evidence is insufficient to assess the benefits and harms of clinical breast examination for women aged 40 years and older.[27] ACS: Recommends clinical breast examination about every 3 years for women in their 20s and 30s and every year for women 40 years and older.[35] Susan G Komen: Clinical breast examination can be helpful in finding tumors in women younger than 40 years for whom mammography is not indicated. In women 40 years and older, clinical breast examination and mammography may find more cancers than mammography alone (ie, when used together fewer breast cancers are missed). Clinical breast examination is not a substitute for mammography in women older than 40 years.[36,37] CTFPHC: Recommends not routinely performing clinical breast examinations alone or in conjunction with mammography to screen for breast cancer (Weak recommendation; low-quality evidence).[38] WHO: The only breast cancer screening method that has proved to be effective is mammography screening. Research is underway to evaluate clinical breast examination as a low-cost approach to breast cancer screening that can work in less affluent countries.[39] Cochrane Collaborative: The only large population-based trial of clinical breast examination combined with breast self-examination that was identified was discontinued because of poor compliance with follow-up.[22] KPCMI: Recommends clinical breast examination be offered to asymptomatic women without breast cancer risk factors, in the context of a shared decision-making approach that takes into account a woman's personal preferences and the balance of benefit to harm.[40]	Clinical breast examination should be offered to asymptomatic women without breast cancer risk factors in the context of a shared decision-making approach that takes into account a woman's personal preferences and the balance of benefit to harm. Clinical breast examination should be performed annually for women aged 40 years and older. For women aged 20–39 years, clinical breast examinations are recommended every 1–3 years.

TOPIC: CARDIOVASCULAR DISEASE/DYSLIPIDEMIA

Final WWTF Recommendation	Evidence Based	Evidence Informed	Uniform Expert Agreement
Adults (18–44 years) *(See also Blood Pressure Screening; Genetic Screening (other than BRCA gene); Diet, Fitness, Nutrition; Obesity; Preconception/Interconception Care; Tobacco Use)*			
Dyslipidemia screening is recommended once between ages 18 years and 21 years. (Qualified)		AAP: Recommends dyslipidemia screening once between ages 18 years and 21 years.[4]	
Screening for asymptomatic carotid artery stenosis in the general adult population is not recommended. (Strong)	USPSTF: Recommends against screening for asymptomatic carotid artery stenosis in the general adult population (Grade D).[41]		
Screening with resting or exercise electrocardiography for the prediction of coronary heart disease events in asymptomatic adults at low risk of coronary heart disease events is not recommended. (Strong)	USPSTF: Recommends against screening with resting or exercise electrocardiography for the prediction of coronary heart disease events in asymptomatic adults at low risk for coronary heart disease events (Grade D).[42]		
Routine screening for abdominal aortic aneurysm in women is not recommended. (Strong)	USPSTF: Recommends against routine screening for abdominal aortic aneurysm in women (Grade D).[43]		
The use of beta-carotene supplements, either alone or in combination, for the prevention of cancer or cardiovascular disease is not recommended. (Strong)	USPSTF: Recommends against the use of beta-carotene supplements, either alone or in combination, for the prevention of cancer or cardiovascular disease (Grade D).[44]		
Adults (20–54 years) *(See also Blood Pressure Screening; Diet, Fitness, Nutrition; Obesity; Preconception/Interconception Care; Tobacco Use)*			
Screening for lipid disorders in women aged 20–45 years who are at increased risk of coronary heart disease is recommended. (Strong)	USPSTF: Recommends screening women aged 20–45 years for lipid disorders if they are at increased risk of coronary heart disease (Grade B).[45]		
The use of aspirin for stroke prevention in women younger than age 55 years is not recommended. (Strong)	USPSTF: Recommends against the use of aspirin for stroke prevention in women younger than 55 years (Grade D).[46]		
Adults (45 years and older) *(See also Blood Pressure Screening; Diet, Fitness, Nutrition; Obesity; Tobacco Use)*			
Screening for lipid disorders in women aged 45 years and older who are at increased risk of coronary heart disease is recommended. (Strong)	USPSTF: Recommends screening women aged 45 years and older for lipid disorders if they are at increased risk of coronary heart disease (Grade A).[45]		
The use of aspirin is recommended for women aged 55–79 years when the potential benefit of a reduction in risk of ischemic stroke outweighs the potential harm of an increase in risk of gastrointestinal hemorrhage. (Strong)	USPSTF: Recommends the use of aspirin for women aged 55–79 years when the potential benefit of a reduction in ischemic stroke outweighs the potential harm of an increase in gastrointestinal hemorrhage (Grade A).[46]		

TOPIC: CERVICAL CANCER SCREENING AND PREVENTION

Final WWTF Recommendation	Evidence Based	Evidence Informed	Uniform Expert Agreement
Adolescents (13–20 years) Screening			
Screening for cervical cancer is not recommended for women younger than 21 years. (Strong)	USPSTF: Screening is not recommended for cervical cancer in women younger than age 21 years. The recommendation does not apply to 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).[47] ACS/ASCCP/ACSP: Cervical cancer screening should begin at age 21 years. Women younger than 21 years should not be screened regardless of the age of sexual initiation or other risk factors.[48]	ACOG: Screening is not recommended for adolescents.[49] AAFP: Screening is not recommended for adolescents.[50]	Healthy women younger than 21 years should not be screened.
Adolescents (13–20 years) HPV Vaccination			
HPV vaccine is recommended for adolescents, preferably before the initiation of sexual activity and according to the ACIP schedule. (Strong)	ACIP: Girls aged 11 or 12 years should receive bivalent or quadrivalent HPV vaccine. The vaccine can be given as early as 9 years of age and should be given to women aged 13–26 years who have not been previously vaccinated.[51]	AAP, AAFP, ACP, ACOG, ACNM: ACIP adult and childhood vaccination schedules are endorsed.[52,53] AWHONN: HPV vaccine is recommended.[54]	Adolescents should receive HPV vaccine prior to the initiation of sexual activity.
There are conflicting vaccination guidelines for HIV-infected girls and women younger than 21 years. Adherence to ACIP/CDC vaccination guidelines is acceptable. (Qualified)	CDC: For those who are HIV positive, a Pap test should be obtained twice during the first year after diagnosis of HIV infection and, if the results are normal, annually thereafter.[55]	ACOG: Annual cytology screening starting at age 21 years is reasonable for this group.[49]	
Adults Screening (21–29 years, with a cervix and without history of in utero diethylstilbestrol exposure, immunocompromise, prior high-grade precancerous cervical lesion, or cervical cancer)			
Screening for cervical cancer is recommended with cytology testing alone every 3 years in women with a cervix who have not had a prior high-grade precancerous cervical lesion or cervical cancer, who have not been exposed to diethylstilbestrol in utero, or who are not immunocompromised. (Strong) **Screening with HPV testing is not recommended. (Strong)**	USPSTF: Recommends cytology testing every 3 years. Recommends against screening for cervical cancer with HPV testing, alone or in combination with cytology. The recommendations do not apply to 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).[47] ACS/ASCCP/ASCP: Recommend cytology testing alone every 3 years. Human papillomavirus testing should not be used for screening in this age group.[48]	ACOG, AAFP: For women aged 21–29 years, cytology testing alone every 3 years is recommended.[49,50]	ACOG, ACS, and USPSTF guidelines are all similar and appropriate for this age group.
Adults Vaccine (21–29 years, with a cervix and without history of in utero diethylstilbestrol exposure, immunocompromise, prior high-grade precancerous cervical lesion, or cervical cancer)			
Human papillomavirus vaccine is recommended for women 26 years and younger according to the ACIP schedule. (Strong)	ACIP: Girls aged 11 years or 12 years should receive bivalent or quadrivalent HPV vaccine. The vaccine can be given as early as 9 years of age and should be given to women aged 13–26 years who have not been previously vaccinated.[50] Bivalent or quadrivalent HPV vaccine should be given to women 21–26 years who have not been previously vaccinated.[56,57]	AAP, AAFP, ACP, ACOG, ACNM: ACIP adult and childhood vaccination schedules are endorsed.[53]	
Adults Screening/Testing (30–65 years, with a cervix and without history of in utero diethylstilbestrol exposure, immunocompromise, prior high-grade precancerous cervical lesion, or cervical cancer)			
Screening for cervical cancer with a combination of cytology and HPV testing (co-testing) is recommended every 5 years in women with a cervix who have not had prior high-grade precancerous cervical lesion or cancer, who have not been exposed to diethylstilbestrol in utero, or who are not immunocompromised. Screening with cytology testing alone every 3 years is acceptable. (Strong)	IOM: Recommends the addition of high-risk HPV DNA testing in addition to cytology testing in women with normal cytology results. Screening should begin at 30 years of age and should occur no more frequently than every 3 years.[58] USPSTF: Recommends cytology testing every 3 years. For women who want to lengthen the screening interval, combine cytology and HPV testing every 5 years. The recommendation does not apply to 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).[47] ACS/ASCCP/ASCP: Human papillomavirus and cytology testing (co-testing) every 5 years is the preferred approach. Cytology testing alone every 3 years is acceptable. Screening by HPV testing alone is not recommended for most clinical settings.[48]	ACOG: Cytology testing alone every 3 years is acceptable. Co-testing is preferable.[49] AAFP: Cytology testing alone every 3 years is recommended. For women who want to lengthen the screening interval, co-testing every 5 years is recommended.[50]	Despite conflicting opinions among the major sources of recommendations, co-testing is an acceptable strategy that allows lengthening of screening intervals.
Adults Screening/Testing (21 years and older, without a cervix)			
Screening for cervical cancer is not recommended for women who have had a hysterectomy with removal of the cervix provided they have no history of CIN2 or higher in the past 20 years. (Strong)	USPSTF: Screening for cervical cancer is not recommended in women who have had a hysterectomy with removal of the cervix and who do not have a history of a high-grade precancerous lesion (CIN 2 or 3) or cervical cancer. The recommendation does not apply to 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).[47] ACS/ASCCP/ASCP: After hysterectomy, screening is not recommended. The recommendation applies to women without a cervix and without a history of cervical cancer or CIN 2 or a more severe diagnosis in the past 20 years.[48]	ACOG: Do not screen women after total hysterectomy who have no history of CIN 2 or higher.[49] AAFP: Do not screen women who have had hysterectomy with removal of cervix and who do not have a history of high-grade precancerous lesion (CIN 2 or 3) or cervical cancer.[50]	

TOPIC: COLORECTAL SCREENING
(45+ or 40 depending on risk)

Final WWTF Recommendation	Evidence Based	Evidence Informed	Uniform Expert Agreement
Adults (45–75 years) Assessment			
Individualized assessment of risk, including family history and individualized counseling, is recommended. (Strong)	ACP: Individualized assessment for risk of colorectal cancer is recommended.[59]		
Adults (45–75 years) Screening			
Screening for colorectal cancer is recommended beginning at age 50 years. For African American women, screening should begin at age 45 years. (Strong)	USPSTF: Screening for colorectal cancer should begin at age 50 years and continue to age 75 years.[60]	ACP: All adults at average risk of colorectal cancer should be screened.[59] ACG: Screening should start at age 50 years. For African Americans, begin screening age 45 years.[61] ACOG: Screening should start at age 50 years. For African Americans, begin screening at age 45 years.[2]	Screening for all adults at average risk should begin at age 50 years, except for African Americans, for whom screening should begin at age 45 years.
Adults (45–75 years) Method of Screening			
Screening is recommended by one of the following methods: **• Colonoscopy every 10 years** **• Fecal occult blood testing or fecal immunochemical test annually** **• Flexible sigmoidoscopy every 5 years** **• Double contrast barium enema every 5 years** **• Computed tomography colonography every 5 years** **• Stool DNA, no interval determined** **Screening should not be performed using in-office fecal occult blood test-ing or fecal immunochemical test with sample collected during digital rectal examination. (Strong)**	USPSTF: The following methods of screening are recommended: Fecal occult blood testing Sigmoidoscopy Colonoscopy There is insufficient evidence to assess the benefits or harms of computed tomographic colonography and fecal DNA testing as screening modalities.[60]	AAFP: The following methods of screening are recommended: Fecal occult blood testing Sigmoidoscopy Colonoscopy There is insufficient evidence to assess the benefits or harms of computed tomographic colonography and fecal DNA testing as screening modalities.[62] ACP: The following methods of screening are recommended:[59] Stool-based test Flexible sigmoidoscopy Optical colonoscopy ACOG: Colonoscopy every 10 years is preferred method of screening. The following methods are acceptable: • Fecal occult blood testing or fecal immunochemical test annually • Flexible sigmoidoscopy every 5 years • Double contrast barium enema every 5 years • Computed tomography colonography every 5 years • Stool DNA (no interval determined) Do not use in-office fecal occult blood testing or fecal immunochemical test with samples collected during digital rectal examination.[2] ACG: Screening by colonoscopy is recommended. If colonoscopy is not available or affordable:[61] Flexible sigmoidoscopy every 5–10 years Computed tomography colonography every 5 years Cancer detection test (fecal immunochemical test for blood)	
Screening for Women at Increased Risk			
Screening for colorectal cancer with optical colonoscopy is recommended for women at increased risk, beginning at age 40 years or 10 years younger than the age at which the youngest affected relative was diagnosed with colorectal cancer. (Strong)		ACP: Screen via optical colonoscopy starting at age 40 years or 10 years younger than the age at which the youngest affected relative was diagnosed with colorectal cancer.[59]	
Treatment of Women at Increased Risk			
Prophylactic treatment is not recommended for women at increased risk of colorectal cancer. (Strong)		AAFP: Do not use aspirin or non-steroidal anti-inflammatory drugs to prevent colorectal cancer in individuals at risk for colorectal cancer.[62]	
Genetic Testing of Women at Increased Risk			
Women with newly diagnosed colorectal cancer should be offered genetic testing for Lynch syndrome to reduce morbidity and mortality to relatives. (Strong) **Women who are carriers of hereditary nonpolyposis colorectal cancer may be offered genetic counseling and should undergo colonoscopy every 2 years beginning at age 20–25 years until age 40 years, then annually thereafter. (Strong)** **For women with familial adenomatous polyposis, adenomatous polyposis coli mutation testing is recommended; if negative, MYH-associated polyposis mutation testing is recommended. For women with familial adenomatous polyposis or at risk of familial adenomatous polyposis based on family history, annual flexible sigmoidoscopy or colonoscopy is recommended until such time when colectomy is deemed appropriate by the patient and her physician. (Strong)**		AAFP: Genetic testing for Lynch syndrome is recommended for patients with newly diagnosed colorectal cancer to reduce morbidity and mortality to relatives. Those with Lynch syndrome should be offered earlier and more frequent screening, and their first-degree relatives should be offered genetic testing.[62] ACG: Patients who are hereditary nonpolyposis colorectal cancer (Lynch syndrome) carriers may be offered genetic counseling and should undergo colonoscopy every 2 years beginning at age 20–25 years until age 40 years, then annually thereafter. Patients with familial adenomatous polyposis should undergo adenomatous polyposis coli mutation testing and, if negative, MYH-associated polyposis mutation testing. Patients with familial adenomatous polyposis or at risk of familial adenomatous polyposis based on family history should undergo annual flexible sigmoidoscopy or colonoscopy until such time when colectomy is deemed the best treatment by the patient and provider.[61]	

TOPIC: CONTRACEPTION, STIs, & REPRODUCTIVE HEALTH
(*See also* Alcohol Misuse, Preconception/Interconception Care, Sexual Health)

Final WWTF Recommendation	Evidence Based	Evidence Informed	Uniform Expert Agreement
Adolescents (13–18 years) Methods			
Adolescents of reproductive capacity should be counseled regarding contraceptive methods (including postponing sexual activity); ensured access to basic contraceptive services, either within the office setting or by referral to appropriate services; and offered appropriate follow-up to ensure compliance and monitor for adverse effects and complications. (Strong)	IOM, CDC: Recommends that women with reproductive capacity have access to the full range of FDA-approved contraceptive methods, sterilization procedures, and patient education and counseling.[58,63]	ACOG: Recommends preventing unwanted and unintended pregnancy by postponing sexual involvement or using contraceptive options, including emergency contraception.[2,64] Recommends first reproductive care visit at ages 13–15 years, prior to sexual activity (usually does not include a pelvic examination).[65] AAP: Pediatricians should counsel about and ensure access to a broad range of contraceptive services for their adolescent patients.[66] AAP Bright Futures: Integrate sexuality education into the longitudinal relationship developed through care experiences with the preadolescent child, the adolescent, and the family.[67]	Adolescent visit provides an opportunity to establish a relationship. Content of visit can include screening, education, and guidance on sexual development, menses, HPV vaccine, preventing pregnancy, STIs, and other sexual health issues.[68]
Adolescents (13–18 years) Screening/Testing			
Annual chlamydia and gonorrhea testing is recommended for those who are sexually active. (Strong)	CDC: Routine screening *for Neisseria gonorrhoeae* in all sexually active women at risk for infection is recommended annually. Women aged 25 years or younger are at highest risk of gonorrhea infection. Routine screening for *Chlamydia trachomatis* of all sexually active females aged 25 years or younger is recommended annually.[69] USPSTF: Recommends that clinicians screen all sexually active women, including those who are pregnant, for gonorrhea infection if they are at increased risk for infection (that is, if they are young or have other individual or population risk factors). Women and men under the age of 25 years—including sexually active adolescents—are at highest risk of genital gonorrhea infection (Grade B).[70] Recommends screening for chlamydia infection for all sexually active, nonpregnant young women aged 24 years and younger and for older nonpregnant women who are at increased risk (Grade A).[71] Recommends high-intensity behavioral counseling to prevent STIs for all sexually active adolescents and for adults at increased risk of STIs (Grade B).[72]	AAP: Routine laboratory screening for nonviral STIs as recommended in published screening guidelines for sexually active adolescents.[73] These recommendations summarize published federal agency and medical professional organizations' clinical guidance for all sexually active adolescents. ACOG: Recommends chlamydia and gonorrhea testing, if sexually active. Urine-based STI screening is an efficient method without a speculum examination.[2]	
Adolescents (13–18 years) Prevention of Unwanted/Unintended Pregnancy			
	CDC: Prevent unwanted or unintended pregnancy by assessing the woman's need for contraceptive methods and those that are available for her.[63,74]		
Adults (all reproductive-aged women)			
Adult women of reproductive capacity should be evaluated at least annually regarding contraceptive method use and satisfaction. Women with reproductive capacity should have access to the full range of FDA-approved contraceptive methods, sterilization procedures, and patient education and counseling appropriate to their childbearing intentions. (Strong)	IOM, CDC: Recommends that women with reproductive capacity have access to the full range of FDA-approved contraceptive methods, sterilization procedures, and patient education and counseling.[63,58] CDC: Prevent unwanted or unintended pregnancy by assessing the woman's need for contraceptive methods and those that are available for her.[63,74,75] Safety, efficacy, availability, and acceptability should be considered by women, men, or couples when choosing the most appropriate contraceptive method. Voluntary informed choice of contraceptive methods is an essential guiding principle, and contraceptive counseling, where applicable, may be an important contributor to the successful use of contraceptive methods. Assessment as to the safety of a given contraceptive method for a person with a particular characteristic or medical condition should be included in counseling.[74]	ACOG: Prevent unwanted or unintended pregnancy by assessing the woman's need for contraceptive methods and those that are available for her.[2]	Time to counsel, educate, and solve problems regarding contraceptive needs and management should be part of any given visit. Alternatively, arrangements should be made for a separate visit for contraception follow-up.
Adults (all reproductive-aged women) Method			
Women who use contraceptive methods other than condoms should be counseled about the use of condoms and the risk for STIs. (Strong)	CDC: In choosing a method of contraception, the risk of STIs, including HIV, also must be considered. Although hormonal contraceptives and IUDs are highly effective at preventing pregnancy, they do not protect against STIs. Consistent and correct use of the male latex condom reduces the risk for STIs. When a male condom cannot be used properly for infection prevention, a female condom should be considered.[63,69,75]		
Adults (all reproductive-aged women) Postpartum			
Evidence-based guidance should be used in contraceptive counseling and prescribing during the immediate postpartum period. (Strong)	CDC: Unintended pregnancy and short interpregnancy birth spacing contribute to poor maternal and newborn outcomes. Initiation of contraception during the postpartum period is important to prevent unintended pregnancy and short birth intervals, which can lead to negative health outcomes for mother and infant. Venous thromboembolism risk should be assessed when recommending and prescribing contraception during the immediate postpartum period.[63,75]		
Adults (all ages) Sexual History			
A sexual history and risk assessment for STI exposure should be incorporated into each well-woman visit. Screening should be instituted according to the CDC STD Treatment Guidelines. (Strong)	USPSTF: Recommends high-intensity behavioral counseling to prevent STIs for all sexually active adolescents and for adults at increased risk for STIs.[72] CDC: Health care providers should routinely and regularly obtain sexual histories from their patients and address management of risk reduction for STIs.[69,71,72]		

TOPIC: DEPRESSION

Final WWTF Recommendation	Evidence Based	Evidence Informed	Uniform Expert Agreement
Adolescents (13–18 years) *(See also Mental Health and Psychosocial Issues/Suicide/Behavioral Assessment; Preconception/Interconception Care)*			
Annual screening of adolescents for depressive disorders, using a validated tool, is recommended. (Qualified) **Screening postpartum adolescents for depression, using a validated tool, is recommended. (Qualified)**	USPSTF: Recommends screening adolescents (12–18 years of age) for major depressive disorder when systems are in place to ensure accurate diagnosis, psychotherapy (cognitive-behavioral or interpersonal), and follow-up (Grade B).[16]	AMA: Screen adolescents who may be at risk as a result of family problems, drug or alcohol use, or other indicators of risk.[17,18] AAP Bright Futures: Recommends universal screening for depression in adolescents ages 11–21 years. Ask questions about depression in routine history-taking throughout adolescence. Patients with depression risk factors should be identified and systematically monitored over time.[4] AAFP: Screen for major depressive disorder when systems are in place to ensure accurate diagnosis, psychotherapy (cognitive-behavioral or interpersonal), and follow-up.[19] AWHONN: Health care facilities that serve pregnant women, new mothers, and newborns should have routine screening protocols and educational mechanisms for staff training and education related to postpartum mood and anxiety disorders.[20] ACOG: Recommends asking annually about emotions and behaviors that indicate recurrent or severe depression and thoughts of killing or harming themselves.[5] Recommends screening in practices that have systems in place to ensure accurate diagnosis, treatment, and follow-up.[1] ACNM: Recommends universal screening, treatment, or referral for depression as part of routine primary health care. Recommends increasing the number of postpartum visits for all women.[21]	Patients should not be denied recommended screening because of any limitation of local resources. Rather, providers should have plans for referral, even if it means the patient will have to travel outside her community. Providers are encouraged to develop initial management skills that are within the scope of their specialty and practice to meet local patient needs. Patients should be counseled about limitations in local resources at the time of testing.
Adults (19 years and older) *(See also Mental Health and Psychosocial Issues/Suicide/Behavioral Assessment; Preconception/Interconception Care)*			
Annual screening for depression, using a validated tool, is recommended. (Qualified) **Screening postpartum women for depression, using a validated tool, is recommended. (Qualified)**	USPSTF: Recommends against routinely screening adults for depression when staff-assisted depression care supports are not in place. There may be considerations that support screening for depression in an individual patient (Grade C).[22] Recommends screening may be most productive in patients with a history of depression, unexplained somatic symptoms, comorbid psychological conditions (eg, panic disorder or generalized anxiety), substance abuse, or chronic pain. Recommends screening adults for depression when staff-assisted depression care supports are in place to assure accurate diagnosis, effective treatment, and follow up (Grade B).[16]	AWHONN: Health care facilities that serve pregnant women, new mothers, and newborns should have routine screening protocols and educational mechanisms for staff training and client education related to postpartum mood and anxiety disorders.[20] AAFP: Do not screen when staff-assisted depression care supports are not in place.[19] Screen when staff-assisted depression care supports are in place to assure accurate diagnosis, effective treatment, and follow-up.[19] ACOG: Evaluate and counsel women for suicide and depressive symptoms.[1] Recommends screening in practices that have systems in place to ensure accurate diagnosis, treatment, and follow-up.[1] ACNM: Recommends universal screening, treatment and/or referral for depression as part of routine primary health care. Recommends increasing the number of postpartum visits for all women.[21] PCHHC: Providers should screen and be vigilant for depression and anxiety disorders among women of reproductive age because treating or controlling these conditions before pregnancy may help prevent negative pregnancy and family outcomes. Women of reproductive age with depressive and anxiety disorders who are planning a pregnancy or who could become pregnant should be informed about the potential risks of an untreated illness during pregnancy and about the risks and benefits of various treatments during pregnancy (B-III).[10]	Patients should not be denied recommended screening because of any limitation of local resources. Rather, providers should have plans for referral, even if it means the patient will have to travel outside her community. Providers are encouraged to develop initial management skills that are within the scope of their specialty and practice to meet local patient needs. Patients should be counseled about limitations in local resources at the time of testing.

TOPIC: DIABETES

Final WWTF Recommendation	Evidence Based	Evidence Informed	Uniform Expert Agreement
Adolescents (13–18 years) *(See also Cardiovascular Disease/Dyslipidemia; Diabetes Postpartum; Diet, Fitness, Nutrition; Obesity)*			
Routine screening for diabetes in adolescents is not recommended except for those who are obese, defined as a body mass index (BMI) of 30 or higher. (Qualified)			There is no recommendation for routine screening in asymptomatic adolescents.
Adults *(See also Cardiovascular Disease/Dyslipidemia; Diabetes Postpartum; Diet, Fitness, Nutrition; Obesity)*			
Screening for diabetes is recommended every 3 years beginning at age 45 years or earlier for those with risk factors for diabetes. (Strong)	USPSTF: Screen for diabetes in adults with blood pressure over 135/85 mm Hg.[6]	AAFP: Screen asymptomatic adults with sustained blood pressure (either treated or untreated) greater than 135/80 mm Hg.[19] ACOG: Begin screening every 3 years beginning at age 45 years, more frequently if risk factors are present.[1] American Diabetes Association: Begin screening every 3 years beginning at age 45 years, more frequently if risk factors are present.[23] AACE: Begin screening at age 30 years.[24]	Currently there is no expert consensus.

TOPIC: DIABETES POSTPARTUM

Final WWTF Recommendation	Evidence Based	Evidence Informed	Uniform Expert Agreement
All Women of Reproductive Capacity *(See also Diabetes)*			
For patients with a history of gestational diabetes, laboratory screening for diabetes is recommended at 6–12 weeks postpartum and follow-up screening at least every 3 years is recommended. (Strong)		ACOG: Recommends screening 6–12 weeks postpartum, then every 3 years.[25] American Diabetes Association: Recommends screening 6–12 weeks postpartum, then every 3 years.[6]	

TOPIC: DIET, FITNESS, NUTRITION

Final WWTF Recommendation	Evidence Based	Evidence Informed	Uniform Expert Agreement
Adolescents and Adults (all ages) *(See also Cardiovascular Disease/Dyslipidemia, Obesity, Preconception/Interconception Care)*			
Routine weight assessment using BMI calculation is recommended. For women with risk factors for diet-related chronic disease, BMI less than 19 or greater than 25, assessment of diet, nutritional status, and physical activity, followed by intensive counseling and behavioral interventions, is recommended. (Qualified)	USPSTF: Recommends intensive behavioral dietary counseling for adult patients with hyperlipidemia and other known risk factors for cardiovascular and diet-related chronic disease. All adult patients should be screened for obesity and offered intensive counseling and behavioral interventions.[26]	AAP: Recommends intensive behavioral dietary counseling for adult patients with hyperlipidemia and other known risk factors for cardiovascular and diet-related chronic disease. All adult patients should be screened for obesity and offered intensive counseling and behavioral interventions. Also recommends evaluation and counseling on physical activity.[7] American Dietetic Association: Recommends intensive behavioral dietary counseling for adult patients with hyperlipidemia and other known risk factors for cardiovascular and diet-related chronic disease. All adult patients should be screened for obesity and offered intensive counseling and behavioral interventions. Also recommends evaluation and counseling on physical activity.[27] AAP Bright Futures: Recommends assessing BMI annually.[4]	All agree that diet, nutrition, and exercise are keys to good health and improved health and can prevent illness. However, the science on how this is best accomplished is debatable.

TOPIC: DOMESTIC AND INTIMATE PARTNER VIOLENCE

Final WWTF Recommendation	Evidence Based	Evidence Informed	Uniform Expert Agreement
Adolescents (13–18 years) *(See also Preconception/Interconception Care)*			
Screening is recommended at least annually for intimate partner violence, such as domestic violence or reproductive or sexual coercion. Provide or refer women who screen positive to intervention services. (Strong)	USPSTF: Current evidence is insufficient to assess the balance of benefits and harms of primary care interventions to prevent child maltreatment (aged 0–18 years) (Grade I).[28] Recommends that clinicians screen women of childbearing age for intimate partner violence, such as domestic violence, and provide or refer women who screen positive to intervention services (Grade B).[29] IOM: Screening and counseling involve elicitation of information from women and adolescents about current and past violence and abuse in a culturally sensitive and supportive manner to address current health concerns about safety and other current or future health problems.[30]	AAP: Consider screening adolescents if they say they have a new intimate partner, when signs or symptoms raise concerns, or during any prenatal visits.[4] Screen for intimate partner violence and sexual coercion at least annually and with each new partner. (If a patient has multiple visits, for pregnancy or STI testing, consider these as clinical indictors to assess more frequently.) ACOG: Screen periodically in all women (eg, annual visit, new patient, postpartum visit) and in women at risk (signs of depression, substance abuse, mental health problems, requests for repeat pregnancy tests when the woman does not wish to be pregnant, new or recurrent STIs, requests for STI testing, expresses fear when negotiating condom use).[31] Signs or symptoms of abuse or neglect should prompt risk assessment. Evidence of neglect or abuse must be reported to law enforcement agencies as required by state or federal laws and regulations.[32]	
Adults (all ages) *(See also Preconception/Interconception Care)*			
Screening is recommended at least annually for intimate partner violence, such as domestic violence or reproductive or sexual coercion. Provide or refer women who screen positive to intervention services. (Strong)	IOM: Screening and counseling involve elicitation of information from women and adolescents about current and past violence and abuse in a culturally sensitive and supportive manner to address current health concerns about safety and other current or future health problems.[30] USPSTF: Recommends that clinicians screen women of childbearing age for intimate partner violence, such as domestic violence, and provide or refer women who screen positive to intervention services (Grade B).[29] Current evidence is insufficient to assess the balance of benefits and harms of screening all elderly or vulnerable adults (physically or mentally dysfunctional) for abuse and neglect (Grade I).[33]	AAP: Screen for intimate partner violence and sexual coercion at least annually and with each new partner. (If a patient has multiple visits, for pregnancy or STI testing, consider these as clinical indictors to assess more frequently.) ACOG: Screen periodically in all women (eg, annual visit, new patient, and postpartum visit) and in women at risk (signs of depression, substance abuse, mental health problems, requests for repeat pregnancy tests when the woman does not wish to be pregnant, new or recurrent STIs, requests STI testing, expressing fear when negotiating condom use).[31] Signs or symptoms of abuse or neglect should prompt risk assessment. Evidence of neglect or abuse must be reported to law enforcement agencies as required by state or federal laws and regulations.[32] AAFP: Screen women of childbearing age for intimate partner violence and provide or refer women who screen positive to intervention services; this applies to women who do not have signs or symptoms of abuse. (Grade B).[34] There is insufficient evidence to assess the benefits and harms of screening elderly and vulnerable adults for abuse and neglect (Grade I).[35]	

TOPIC: DRUG USE

Final WWTF Recommendation	Evidence Based	Evidence Informed	Uniform Expert Agreement
Adolescents (13–18 years) *(See also Preconception/Interconception Care)*			
At least annual screening for substance abuse by history (not laboratory testing) is recommended. Provide or refer patients to counseling as needed. (Strong)	USPSTF: Current evidence is insufficient to assess the balance of benefits and harms of screening adolescents, adults, and pregnant women for illicit drug use (Grade I).[36]	ACOG: Recommends annual screening by questionnaire or history (not laboratory testing) for illicit drugs, prescription and nonprescription medications, and performance-enhancing drugs.[8] Evaluate and counsel on substance use other than alcohol and tobacco.[8] AAP: Evaluation and counseling and screening are part of an age-appropriate comprehensive history. Recommends annual screening for alcohol, tobacco, and substance abuse. Strongly advise against the use of alcohol, tobacco, and other illicit drugs by youth.[4] PCHHC: A careful history should be obtained to identify use of illegal substances as part of the preconception risk assessment. Men and women should be counseled about the risks of using illicit drugs before and during pregnancy and offered information on programs that support abstinence and rehabilitation. Contraception services should be offered, and pregnancy should be delayed until individuals are drug-free.[10] AAFP: Current evidence is insufficient to assess the balance of benefits and harms of screening adolescents, adults, and pregnant women for illicit drug use (Grade I).[37] NAHIC: Recommends annual screening and counseling for substance abuse.[38] AHRQ: Screen by history for substance use at every health maintenance examination or initial pregnancy visit (repeat as indicated), using a validated screening tool (improves accuracy of detecting substance abuse or dependence) (Grade D).[39] NCQA: Healthcare Effectiveness Data and Information Set discusses engagement in treatment and referral for smoking cessation and alcohol and marijuana dependence.[40]	
Adults (all ages) *(See also Preconception/Interconception Care)*			
At least annual screening for substance abuse by history (not laboratory testing) is recommended. Provide or refer patients to counseling as needed. (Strong)	USPSTF: Current evidence is insufficient to assess the balance of benefits and harms of screening adolescents, adults, and pregnant women for illicit drug use (Grade I).[36]	ACOG: Evaluate and counsel on substance use other than alcohol and tobacco.[1] PCHHC: A careful history should be obtained to identify use of illegal substances as part of the preconception risk assessment. Men and women should be counseled about the risks of using illicit drugs before and during pregnancy and offered information on programs that support abstinence and rehabilitation. Contraception services should be offered, and pregnancy should be delayed until individuals are drug-free.[10] AAFP: Current evidence is insufficient to assess the balance of benefits and harms of screening adolescents, adults, and pregnant women for illicit drug use.[41] NAHIC: Recommends annual screening and counseling for substance abuse.[42] AHRQ: Screen by history for substance use at every health maintenance examination or initial pregnancy visit (repeat as indicated), using a validated screening tool (improves accuracy of detecting substance abuse or dependence) (Grade D).[43] NCQA: Healthcare Effectiveness Data and Information Set discusses engagement in treatment and referral for smoking cessation and alcohol and marijuana dependence.[44]	

TOPIC: GENETIC SCREENING (as appropriate)

Final WWTF Recommendation	Evidence Based	Evidence Informed	Uniform Expert Agreement
Adults (all ages)			
For adolescents, if medical or psychosocial benefits of a genetic test will not accrue until adulthood (eg, for carrier status or adult-onset diseases), testing generally should be deferred until adulthood or until the adolescent has developed mature decision-making capacities. (Qualified)		ACOG: If medical or psychosocial benefits of a genetic test will not accrue until adulthood, as in the case of carrier status or adult-onset diseases, genetic testing generally should be deferred.[44] AAP/ACMGG: Genetic testing for adult-onset conditions generally should be deferred until adulthood or until the adolescent has developed mature decision-making capacities. It is inappropriate to test for late-onset disorders when genetic information has not been shown to reduce morbidity and mortality through interventions initiated in childhood. Routine carrier testing in minors is not supported when such testing does not provide health benefits in childhood.[100]	
Adults (all ages) (See also Cardiovascular Disease/Dyslipidemia; Ovarian Cancer)			
All women should receive a family history evaluation as a screening tool for inherited risk of cancer. If their personal or family history is associated with an increased risk of potentially harmful mutations, they should be referred for genetic counseling, if genetic counseling services are available, and be offered genetic testing. (Strong)	USPSTF: Recommends that women who have family members with breast, ovarian, tubal, or peritoneal cancers be screened with one of several screening tools designed to identify increased risk of potentially harmful mutations in *BRCA1* or *BRCA2* genes. Women with positive screening results should receive genetic counseling and, if indicated, *BRCA* testing (Grade B).[101]	ACOG: Recommends that all women receive a family history evaluation as a screening tool for inherited risk. Family history information should be reviewed and updated regularly, especially when there are important changes to family history. Where appropriate, further evaluation should be considered for positive responses, with referral to genetic testing and counseling as needed.[102] Genetic risk assessment is recommended for women with greater than an approximate 20%–25% chance of having an inherited predisposition to breast cancer and ovarian cancer. Genetic risk assessment may be helpful for women with greater than an approximate 5%–10% chance of having an inherited predisposition to breast and ovarian cancer.[6] AAFP: Recommends referral for genetic counseling and evaluation for *BRCA* testing for women whose family history is associated with an increased risk of deleterious mutations in *BRCA1* or *BRCA2*.[37]	
Routine genetic counseling or *BRCA* testing is not recommended for women whose family history is not associated with an increased risk of deleterious mutations in *BRCA1* or *BRCA2* genes. (Strong)	USPSTF: Recommends against routine referral for genetic counseling or routine *BRCA* testing for women whose family history is not associated with an increased risk for deleterious mutations in *BRCA1* or *BRCA2* (Grade D).[101]	AAFP: Recommends against routine referral for genetic counseling or for *BRCA* testing for women whose family history is not associated with increased risk of deleterious mutation in *BRCA1* or *BRCA2* genes.[37]	
Genetic Screening for Cardiovascular Disease			
Testing for genetic variants to assess for risk of cardiovascular disease in the general population is not recommended. (Strong)		AAFP: Recommends against genomics profile to assess risk of cardiovascular disease.[103] EGAPP: There is insufficient evidence to recommend testing for the 9p21 genetic variant or 57 other variants in 28 genes to assess risk of cardiovascular disease in the general population, specifically heart disease and stroke. The magnitude of net health benefit from use of any of these tests alone or in combination is negligible. Clinical use is discouraged unless further evidence supports improved clinical outcomes. Based on the available evidence, the overall certainty of net health benefit is deemed low.[104]	Recommend against genomics profile to assess risk for cardiovascular disease, as current evidence finds the net health benefit to be negligible.

TOPIC: HEARING

Final WWTF Recommendation	Evidence Based	Evidence Informed	Uniform Expert Agreement
Adults (all ages)			
Hearing screening in adults who show no signs or symptoms of hearing loss is not recommended. (Strong)	USPSTF: There is insufficient evidence to assess the benefits or harms of screening for hearing loss in asymptomatic adults aged 50 years and older who show no signs or symptoms of hearing loss.[105]	AAFP: There is insufficient evidence to assess the benefits or harms of screening for hearing loss in asymptomatic adults aged 50 years and older who show no signs or symptoms of hearing loss.[106]	Hearing screening in adults who show no signs or symptoms of hearing loss is not recommended.

TOPIC: HEPATITIS B SCREENING

Final WWTF Recommendation	Evidence Based	Evidence Informed	Uniform Expert Agreement
Adolescents and Adults (all ages) (See also Immunizations)			
Routine screening of the general population for chronic hepatitis B infection is not recommended. (Strong)	USPSTF: Recommends against routinely screening the general asymptomatic population for chronic hepatitis B virus infection (Grade D).[107]		
Screening pregnant women for hepatitis B infection is recommended at the first prenatal visit. (Strong)	USPSTF: Recommends screening pregnant women for hepatitis B infection at their first prenatal visit (Grade A).[108]	ACOG: Recommends routine prenatal screening of all pregnant women by hepatitis B surface antigen (HBsAg) testing (Level A).[109]	

TOPIC: HEPATITIS C SCREENING

Final WWTF Recommendation	Evidence Based	Evidence Informed	Uniform Expert Agreement
Adolescents and Adults (all ages)			
Screening for hepatitis C virus (HCV) infection is recommended for women at high risk for infection. (Strong) **One-time screening for HCV infection should be offered to women born between 1945 and 1965. (Strong)**	USPSTF: Recommends screening for HCV infection in persons at high risk of infection. Recommends offering one-time screening for HCV infection to adults born between 1945 and 1965 (Grade B).[110]	AAFP: Recommends screening for HCV infection in persons at high risk for infection. Recommends offering one-time screening for HCV infection to adults born between 1945 and 1965.[111] ACOG: Recommends one-time testing for persons born from 1945 through 1965 who are unaware of their infection status.[2] CDC: Adults born during 1945 through 1965 should be tested once for HCV without prior ascertainment of HCV risk factors. Recommends routine testing of asymptomatic persons at high risk for HCV infection.[112,113] PCHHC: Recommends screening for high-risk women. Women who are positive for hepatitis C and desire pregnancy should be counseled regarding the uncertain infectivity, the link between viral load and neonatal transmission, the importance of avoiding hepatotoxic drugs, and the risk of chronic liver disease.[114]	

TOPIC: HYPOTHYROIDISM

Final WWTF Recommendation	Evidence Based	Evidence Informed	Uniform Expert Agreement
Adults (19 years and older)			
Routine screening is not recommended for asymptomatic women at low risk. (Strong)	USPSTF: There is sufficient evidence that the thyroid-stimulating hormone test can detect subclinical thyroid disease in people without symptoms of thyroid dysfunction, but poor evidence that treatment improves clinically important outcomes in adults with screen-detected thyroid disease. The evidence is insufficient to recommend for or against routine screening for thyroid disease in adults.[115]	AAFP: The evidence is insufficient to recommend for or against routine screening for thyroid disease in adults.[116] ACOG: Women aged 19 years and older, examine thyroid. Thyroid-stimulating hormone screening is recommended for women aged 19–49 years at high risk (eg, strong family history of thyroid disease, autoimmune disease). Thyroid-stimulating hormone screening is recommended every 5 years beginning at age 50.[2] AACE/ATA: Screening for hypothyroidism should be considered in patients over the age of 60 years. "Aggressive case finding" (rather than universal screening) should be considered in those at increased risk of hypothyroidism.[117]	There is insufficient evidence for routine screening for hypothyroidism in asymptomatic, low-risk women, as available evidence does not show that diagnosis and treatment improves outcome.
Universal screening is not recommended for patients who are pregnant or are planning pregnancy, including those undergoing assisted reproduction. (Qualified)		AACE/ATA: Universal screening is not recommended for patients who are pregnant or are planning pregnancy, including those undergoing assisted reproduction. "Aggressive case finding" (rather than universal screening) should be considered for patients who are planning pregnancy.[117]	While there is evidence to suggest that subclinical hypothyroidism in early pregnancy may be associated with impaired intellectual and psychomotor development, a randomized controlled trial did not demonstrate improvement with levothyroxine supplementation.[118]
Screening for hypothyroidism is recommended in symptomatic and high-risk patients. (Strong)		AACE/ATA: "Aggressive case finding" (rather than universal screening) should be considered in those at increased risk for hypothyroidism.[117] Screening is suggested for those with the following: Autoimmune disease, such as type 1 diabetes Pernicious anemia A first-degree relative with autoimmune thyroid disease A history of neck radiation to the thyroid gland, including radioactive iodine therapy for hyperthyroidism and external beam radiotherapy for head and neck malignancies A prior history of thyroid surgery or dysfunction An abnormal thyroid examination Psychiatric disorders Taking amiodarone or lithium -Additional diagnoses: adrenal insufficiency, alopecia, anemia (unspecified), cardiac dysrhythmia (unspecified), changes in skin texture, congestive heart failure, constipation, dementia, type 1 diabetes mellitus, dysmenorrhea, hypercholesterolemia, hypertension, mixed hyperlipidemia, malaise and fatigue, myopathy (unspecified), prolonged QT interval, vitiligo, weight gain	

TOPIC: IMMUNIZATIONS

Final WWTF Recommendation	Evidence Based	Evidence Informed	Uniform Expert Agreement
Adolescents and Adults (all ages) (See also Cervical Cancer Screening and Prevention, Hepatitis B Screening, Preconception/Interconception Care)			
Immunization is recommended according to the schedule and protocols outlined by ACIP. (Strong)	ACIP: Recommends routine vaccines for children, adolescents, and adults according to its published immunization schedule.[119,120]		Recommend following ACIP guidelines for all immunizations.

TOPIC: INJURY PREVENTION

Final WWTF Recommendation	Evidence Based	Evidence Informed	Uniform Expert Agreement
Adolescents (13–18 years) (See also Alcohol Misuse, Domestic and Intimate Partner Violence, Drug Use, Tobacco Use)			
Discussion of injury prevention is recommended as part of every well-child visit. Adolescent counseling should be part of a broader discussion of healthy lifestyle choices, especially the avoidance of alcohol, tobacco, or other drug use. (Strong)	USPSTF: There is insufficient evidence to assess the balance of benefits and harms of counseling in the primary care setting in improving rates of proper use of motor vehicle occupant restraints (child safety seats, booster seats, and lap-and-shoulder belts).[121]	AAP: Integrate counseling about preventing unintentional injury into every well-child visit. Adolescent counseling should be part of a broader discussion of healthy lifestyle choices, especially the avoidance of alcohol, tobacco, or other drug use.[5]	Recommend incorporating AAP guideline.

TOPIC: KIDNEY DISEASE

Final WWTF Recommendation	Evidence Based	Evidence Informed	Uniform Expert Agreement
Adults (all ages)			
Routine screening for chronic kidney disease in asymptomatic adults is not recommended. (Qualified)	USPSTF: There is insufficient evidence to assess the balance of benefits and harms of routine screening for chronic kidney disease in asymptomatic adults.[122]	ACP: Recommends against screening for chronic kidney disease in asymptomatic adults without risk factors.[123] ASN: Strongly recommends screening even in the absence of risk factors.[124] NKF: Recommends screening for at-risk individuals aged 18 years or older (risks include diabetes, hypertension, family history of kidney disease).[125]	Recommend against screening for chronic kidney disease in asymptomatic adults without risk factors, based on lack of evidence to assess the balance of benefits and harms. The major risk factors include diabetes, hypertension, and cardiovascular disease. The current evidence is insufficient to evaluate the benefits and harms of screening in asymptomatic adults with risk factors.

TOPIC: MENTAL HEALTH AND PSYCHOSOCIAL ISSUES/ SUICIDE/BEHAVIORAL ASSESSMENT

Final WWTF Recommendation	Evidence Based	Evidence Informed	Uniform Expert Agreement
Adolescents (13–18 years) (See also Depression, Domestic and Intimate Partner Violence, Preconception/Interconception Care)			
Annual screening of all adolescents for mental health disorders is recommended. (Strong) **Annual assessment for emotions and behaviors that indicate recurrent or severe depression and thoughts of killing or harming themselves is recommended. (Strong)**		AAP: Recommends annual screening for depression, suicide, and mental health. Surveillance at yearly health supervision visits; continuous monitoring of a child's developmental and behavioral status. May include history taking and use of structured parent questionnaires.[5] ACOG: Assess and provide health guidance on psychosocial development annually.[6] Recommends psychosocial evaluation for suicide; depressive symptoms; interpersonal and family relationships; sexual orientation and gender identity; personal goal development; behavioral and learning disorders; emotional, physical, and sexual abuse by family or partner; school experience; peer relationships; acquaintance rape prevention; and bullying.[2] ACOG: Ask annually about emotions and behaviors that indicate recurrent or severe depression and thoughts of killing or harming themselves.[6]	During annual preventive care visits, all adolescents should be screened for any mental health disorder by asking questions (such as those found in Bright Futures, Third Edition) that address depressive symptoms; interpersonal and family relationships; sexual orientation and gender identity; personal goal development; behavioral and learning disorders; emotional, physical, and sexual abuse by family or partner; school experience; peer relationships; acquaintance rape prevention; and bullying.
Adults (19–64 years) (See also Depression, Domestic and Intimate Partner Violence, Preconception/Interconception Care)			
Evaluation of psychosocial aspects of health (interpersonal and family relationships, intimate partner violence, work satisfaction, lifestyle and stress, sleep disorders [all women]; acquaintance rape prevention [women aged 19–39 years]; advance directives [women 40 years and older]; neglect and abuse; depression [all women]) is recommended as part of routine health assessment. (Strong)		ACOG: Evaluate psychosocial aspects of health: interpersonal and family relationships, intimate partner violence, work satisfaction, lifestyle and stress, sleep disorders (all women); acquaintance rape prevention (women aged 19–39 years); advance directives (women 40 years and older); neglect and abuse; depression.[2]	
Routine screening for suicide risk in asymptomatic general populations is not recommended. (Strong)	USPSTF: The evidence is insufficient to recommend for or against routine screening by primary care clinicians to detect suicide risk in the general population.[127]	AAFP: There is insufficient evidence to recommend for or against routine screening by primary care clinicians to detect suicide risk in the general population (Grade I).[128] ACOG: Evaluate and counsel women for suicide and depressive symptoms.[2]	

TOPIC: METABOLIC SYNDROME

Final WWTF Recommendation	Evidence Based	Evidence Informed	Uniform Expert Agreement
Adolescents (13–18 years) (See also Cardiovascular Disease/Dyslipidemia, Diabetes, Obesity)			
Screening for dyslipidemia is recommended once in late adolescence for all patients regardless of risk factors. (Strong) **Screening for dyslipidemia and hyperglycemia is recommended for patients with elevated BMI. Provide or refer patients to counseling about appropriate lifestyle modifications, medical treatment, or both. (Strong)**	USPSTF: Screen children aged 6 years and older for obesity and offer or refer to comprehensive, intensive behavioral interventions to promote improvement in weight status (Grade B).[129]	AAP: Assess BMI and screen for dyslipidemia. Screening for dyslipidemia is recommended once in late adolescence for all patients regardless of risk factors.[5]	Screen patients with elevated BMI for dyslipidemia and hyperglycemia.
Adults (19–65 years) (See also Cardiovascular Disease/Dyslipidemia, Diabetes, Obesity)			
Screening is recommended for patients with elevated BMI for dyslipidemia and hyperglycemia. Provide or refer patients to counseling about appropriate lifestyle modifications, medical treatment, or both. (Strong)	CDC: Diagnosis of metabolic syndrome requires at least three of the following traits:[130] 1) Abdominal obesity: waistline 40 inches or greater for men, greater than 35 inches for women 2) Triglycerides of 150 mg/dL or higher or on medications to treat 3) HDL cholesterol lower than 40 mg/dL in men, lower than 50 mg/dL in women or on medications to treat 4) Blood pressure of 130/85 mm Hg or higher on medications to treat 5) Fasting glucose of 100 mg/dL or higher on medications to treat	AHA, USPSTF, NIH, ADA: Identify appropriate lifestyle modifications and medications.	Screen patients via physical examination and blood work, then help patient identify appropriate lifestyle modifications, medical treatment, or both.

TOPIC: NEURAL TUBE DEFECTS

Final WWTF Recommendation	Evidence Based	Evidence Informed	Uniform Expert Agreement
All Women of Reproductive Capacity			
Counsel all women planning or capable of pregnancy to take a daily supplement containing 0.4–0.8 mg (400–800 micrograms) of folic acid. The recommended dose should be increased to 4 mg per day in those taking anticonvulsant medications or who have a personal history of neural tube defects or have delivered a baby affected by neural tube defects in an earlier pregnancy. (Strong)	USPSTF, CDC: Recommend that all women planning or capable of pregnancy take a daily supplement containing 0.4–0.8 mg (400–800 micrograms) of folic acid.[131,132]	AAP, AAFP, HMHB, March of Dimes: All women planning or capable of pregnancy should take a daily supplement containing 0.4–0.8 mg (400–800 micrograms) of folic acid. Increase dosage to 4 mg in patients who have delivered a baby with neural tube defects, a history of neural tube defects herself, or taking anticonvulsant medications.[133,134,135,136]	Adopt the evidence-informed guideline and recommend increased levels for patients at high risk.

TOPIC: OBESITY

Final WWTF Recommendation	Evidence Based	Evidence Informed	Uniform Expert Agreement
Adolescents (13–18 years) (See also Cardiovascular Disease/Dyslipidemia, Diet, Fitness, Nutrition; Preconception/Interconception Care)			
Routine weight assessment using BMI calculation is recommended. Results should be explained to the patient. For those with BMI greater than 30, provide or refer patients to intensive multicomponent behavioral interventions. (Strong)	USPSTF: Recommends screening all adults for obesity. Clinicians should offer or refer patients with a BMI of 30 or higher to intensive, multicomponent behavioral interventions (Grade B).[137]	ACOG: Screen annually for obesity and overweight with BMI for age percentile, talk about body image, eating patterns, activity levels, and sedentary behavior.[6] AAP: For overweight and obese adolescents, choose interventions according to the patient's age, BMI, weight goals, and health risk. AAP interventions are categorized as progressive, encompassing Stage 1, Prevention Plus; Stage 2, Structured Weight Management; Stage 3, Comprehensive Multidisciplinary Intervention; and Stage 4, Tertiary Care Intervention.[138,139]	The USPSTF approach is reasonable. At the very least, BMI should be calculated and some counseling should take place recommending solutions that are available locally.
Adults (all ages) (See also Cardiovascular Disease/Dyslipidemia, Diet, Fitness, Nutrition; Preconception/Interconception Care)			
Routine weight assessment using BMI calculation is recommended. Results should be explained to the patient. For those with BMI greater than 30, provide or refer patients to intensive multicomponent behavioral interventions. (Strong)	USPSTF: Recommends screening all adults for obesity. Clinicians should offer or refer patients with a BMI of 30 or higher to intensive, multicomponent behavioral interventions (Grade B).[140]	AAFP: Refer adults with BMI of 30 or higher to intensive, multicomponent behavioral interventions (Grade B).[141] ACOG: Determine BMI and evaluate and counsel on physical activity, dietary and nutrition assessment, and obesity as cardiovascular risk factor.[2] PCHHC: Calculate BMI at least annually. All women with BMI of 26 or more should be counseled about the risks to their own health, the risks of exceeding the overweight category, and the risks to future pregnancies, including infertility. These women should be offered specific behavioral strategies to decrease caloric intake and increase physical activity and be encouraged to consider enrolling in structured weight loss programs (Strength and quality of evidence: AIII).[14]	The USPSTF approach is reasonable. At the very least, BMI should be calculated and some counseling should take place recommending solutions that are available locally.

TOPIC: ORAL CAVITY EXAMINATION

Final WWTF Recommendation	Evidence Based	Evidence Informed	Uniform Expert Agreement
Adults (all ages) (See also Oral Hygiene, Tobacco Use)			
Examination of the mouth and throat may be performed as part of an assessment of overall health and oral hygiene. (Qualified)	USPSTF: There is insufficient evidence to make a recommendation on oral cancer screening.[142]	ACS: Performs oral examination during cancer-related check-ups.[143] ADA: Clinicians should remain alert for signs of malignancy when performing routine visual and tactile examination of dental patients.[144]	There is insufficient evidence to recommend a distinct oral cavity examination.

TOPIC: ORAL HYGIENE

Final WWTF Recommendation	Evidence Based	Evidence Informed	Uniform Expert Agreement
Adolescents (13–18 years) (See also Oral Cavity Examination, Tobacco Use)			
Fluoride supplementation should be recommended for adolescents up to age 16 years who live in areas with inadequate fluoride in the water supply. (Strong)	USPSTF: Recommends that primary care clinicians prescribe oral fluoride supplementation at currently recommended doses to preschool children older than 6 months of age whose primary water source is deficient in fluoride (Grade B).[145] The evidence is insufficient to recommend for or against routine risk assessment of preschool children by primary care clinicians for the prevention of dental disease (Grade I).[145]	AAP: For children aged 6 months to 16 years, fluoride supplementation is recommended to prevent dental caries in areas with inadequate fluoride in the water supply.[146] ACOG: Counsel on fluoride supplementation and dental hygiene.[6] AAP: Recommends oral health risk assessment. Dietary counseling for optimal oral health should be an intrinsic component of general health counseling. Administration of all fluoride modalities should be based on individuals' caries risk. Supervised use of fluoride toothpaste is recommended for all children with teeth. The application of fluoride varnish by the medical practitioner is appropriate for patients with significant risk of dental caries who are unable to establish a dental home.[147]	Caries risk assessment is not supported by the literature, and no reliable risk assessment tool exists. Oral health risk assessment should concurrently include asking about smoking (oral cancer risk).
Adults (all ages) (See also Oral Cavity Examination, Tobacco Use)			
Oral health risk assessment and dietary counseling for optimal oral health may be performed as part of an assessment of overall health and oral hygiene. (Qualified)		ACOG: Counsel on hygiene, including dental hygiene.[2]	Caries risk assessment is not supported by the literature, and no reliable risk assessment tool exists. Oral health risk assessment and dietary counseling for optimal oral health may be recommended as part of general health counseling. Oral health risk assessment could conceivably include asking about smoking (oral cancer risk).

TOPIC: OVARIAN CANCER

Final WWTF Recommendation	Evidence Based	Evidence Informed	Uniform Expert Agreement
Adults (See also Genetic Screening)			
Women at Low Risk			
Screening for ovarian cancer is not recommended for women who are not at high risk. (Strong)	USPSTF: Screening for ovarian cancer is not recommended in women without known genetic mutations that increase the risk of ovarian cancer. There is at least moderate certainty that the harms of screening for ovarian cancer outweigh the benefits.[148]	AAFP: The USPSTF recommends against routine screening for ovarian cancer.[149] ACOG: Because of the low prevalence of epithelial ovarian cancer, reported to be approximately one case per 2,500 women per year, it has been estimated that a test with even 100% sensitivity and 99% specificity would have a positive predictive value of only 4.8%, which means 20 of 21 women undergoing surgery would not have primary ovarian cancer. There is currently no effective strategy for ovarian cancer screening.[150]	
Women at High Risk			
Women with *BRCA1* or *BRCA2* mutations or hereditary nonpolyposis colorectal cancer should be offered risk-reducing salpingo-oophorectomy. (Strong) **Women with hereditary ovarian cancer syndromes who choose not to have risk-reducing surgery may be offered surveillance with a combination of transvaginal ultrasonography and CA-125 testing. (Qualified)**	Interventions that may reduce risk for cancer or cancer-related death in women who are *BRCA* mutation carriers include earlier, more frequent, or intensive cancer screening; risk-reducing medications (eg, tamoxifen or raloxifene); and risk-reducing surgery (eg, mastectomy or salpingo-oophorectomy). However, the strength of evidence varies across types of interventions.[101]	ACOG: Women with *BRCA1* or *BRCA2* mutations should be offered risk-reducing salpingo-oophorectomy by age 40 years or after the conclusion of childbearing. It is reasonable to offer women with hereditary nonpolyposis colorectal cancer risk-reducing hysterectomy and bilateral salpingo-oophorectomy between ages 35 and 40 years if childbearing is no longer desired.[99] NCCN: For those patients who elect not to have risk-reducing salpingo-oophorectomy, consider concurrent transvaginal ultrasound (preferably between days 1–10 of the menstrual cycle in premenopausal women) plus CA-125 testing (preferably after day 5 of the menstrual cycle in premenopausal women). Note: There are data that show that annual transvaginal ultrasound and CA-125 testing are not effective strategies for screening for ovarian cancer in high-risk women. There are limited data regarding the effectiveness of a 6-month screening interval. Thus, until such data are available it is reasonable to consider this approach in high-risk women, especially in the context of a clinical research setting.[151]	

TOPIC: PELVIC EXAMINATION

Final WWTF Recommendation	Evidence Based	Evidence Informed	Uniform Expert Agreement
Adolescents (13–20 years)			
Internal and speculum examinations should be reserved for symptomatic patients or those with specific indications (eg, intrauterine device placement) and need not be part of the well-woman visit in this age group. (Strong)		ACOG: Recommends pelvic examinations be performed only when indicated by the medical history for patients younger than age 21 years. An "external-only" genital examination can provide the health care provider with the opportunity to evaluate the patient for normal external genital anatomy; issues of personal hygiene; and abnormalities of the vulva, introitus, and perineum that might require further investigation.[2]	
An external examination is an appropriate component of the well-woman visit in this age group at some point in the adolescent's development. (Strong)		AAP: Examination of the external genitalia should be included as part of the annual comprehensive physical examination of children and adolescents of all ages. Routinely explaining and including this examination normalizes the experience rather than setting it apart as something that is only performed as an exception. Most adolescents do not need an internal examination involving a speculum or bimanual examination. More extensive examination, which may include internal or speculum examination, is appropriate in the primary care setting for patients with persistent vaginal discharge, dysuria or urinary tract symptoms in a sexually active female, dysmenorrhea unresponsive to nonsteroidal anti-inflammatory drugs, amenorrhea, abnormal vaginal bleeding, lower abdominal pain, suspected or reported rape or sexual abuse, or pregnancy. It is also appropriate as part of contraceptive counseling about use of an intrauterine device or diaphragm and in conjunction with a Pap test.[152]	
Adults (21 years and older)			
Speculum and/or bimanual examination is recommended for symptomatic patients and asymptomatic patients with specific indications (eg, intrauterine device placement, cervical cancer screening). External examinations may be performed annually in healthy patients. Inclusion of speculum, bimanual examination, or both, in otherwise well women should be a shared, informed decision between patient and provider. (Qualified)		ACOG: Recommends pelvic examination be performed on an annual basis in all patients aged 21 years and older. The decision whether to perform a complete pelvic examination at the time of the periodic health examination for the asymptomatic patient should be a shared decision after a discussion between the patient and her health care provider. The decision to receive an internal examination can be left to the patient if she is asymptomatic and has undergone a total hysterectomy and bilateral salpingo-oophorectomy for benign indications and has no history of vulvar intraepithelial neoplasia, cervical intraepithelial neoplasia 2 or 3, or cancer; is not HIV infected; is not immunocompromised; and was not exposed to diethylstilbestrol in utero. Annual examination of the external genitalia should continue. Also, when a woman's age or health would lead her to refuse medical intervention for conditions detected during routine examination, pelvic examinations may be discontinued, particularly if she is discontinuing other routine health care maintenance assessments.[2]	

TOPIC: PIERCING AND TATTOOING

Final WWTF Recommendation	Evidence Based	Evidence Informed	Uniform Expert Agreement
Adolescents (13–18 years)			
Annual evaluation and counseling adolescents about concerns associated with piercing and tattooing is recommended. (Strong)		ACOG: Recommends annual evaluation and counseling. Educate adolescents about concerns (eg, infections, scars, allergies, permanence of body art) associated with piercing and tattooing.[6] AAPD: Provide anticipatory guidance and counseling on intraoral and oral piercing beginning at age 12 years or older annually.[153]	

TOPIC: PRECONCEPTION/INTERCONCEPTION CARE

Final WWTF Recommendation	Evidence Based	Evidence Informed	Uniform Expert Agreement
All Women of Reproductive Capacity (See also Alcohol Misuse; Contraception, STIs, and Reproductive Health; Depression; Diabetes; Diabetes Postpartum; Mental Health and Psychosocial Issues/Suicide/Behavioral Assessment; Sexual Health; Tobacco Use)			
Risk assessment, education, and health promotion counseling, based on the individual woman's desire for pregnancy, are recommended for all women to prevent unintended pregnancy, reduce risks, and improve pregnancy outcomes. (Strong)	IOM: Provide evidence-based tests, procedures, and screening for nonpregnant women to optimize reproductive outcomes and prevent or optimize treatments for chronic conditions as well as topics for counseling and guidance for preconception health.[56] IOM, CDC: Ensure access to the full range of FDA-approved contraceptive methods, sterilization procedures, and patient education and counseling for women with reproductive capacity.[56,61]	ACOG, AAP, PCHHC: Counsel patients about preventing unwanted and unintended pregnancy by postponing sexual involvement or using contraceptive options, including emergency contraception.[18,154]	
Postpartum screening and development of a plan for continuing care are recommended for women with risks identified in pregnancy that have implications for subsequent pregnancies, as well as for chronic disease development (eg, pregnancy-induced hypertension, gestational diabetes mellitus) or management (eg, clotting disorders, hepatitis). (Strong)	IOM: Obtain a history of pregnancy complications, including preeclampsia, gestational hypertension, and gestational diabetes mellitus in all women who have had at least one pregnancy.[56] CDC: Safety, efficacy, availability, and acceptability should be considered by women, men, or couples when choosing the most appropriate contraceptive method. Voluntary informed choice of contraceptive methods is an essential guiding principle, and contraceptive counseling may contribute to the successful use of contraceptives. Assessment of the safety of a given contraceptive method for a person with a particular medical condition or characteristic should be included in counseling.[61]	AHA: Health care professionals who meet women for the first time later in their lives (ie, after their reproductive years) should take a careful and detailed history of pregnancy complications with focused questions about a history of gestational diabetes mellitus, preeclampsia, preterm birth, or birth of an infant who was small for gestational age.[155] AHA/ASA: Because of the increased risk of future hypertension and stroke 1–30 years after delivery in women with a history of preeclampsia (Level of Evidence B), it is reasonable to (1) consider evaluating all women starting 6 months to 1 year postpartum, as well as those who are past childbearing age, for a history of preeclampsia/eclampsia and document their history of preeclampsia/eclampsia as a risk factor, and (2) evaluate and treat for cardiovascular risk factors including hypertension, obesity, smoking, and dyslipidemia (Class IIa; Level of Evidence C).[156]	
Postpartum screening, follow-up, and development of a plan for continuing care are recommended for women with lifestyle behaviors (eg, use of tobacco, alcohol, or illicit drugs) or mental health issues (eg, antepartum or postpartum depression) identified during pregnancy that increase health risks. (Strong)	IOM, USPSTF: Clinicians should ask all adults about tobacco use and provide tobacco cessation interventions for those who use tobacco products (Grade A).[56,157] Screening and behavioral counseling interventions are recommended to reduce alcohol misuse by adults, including pregnant women, in primary care settings (Grade B).[158] PCHHC Initiative, USDHHS: Assess at least annually for alcohol use patterns and risky drinking behaviors and provide appropriate counseling; all women should be advised of the risks alcohol exposure poses to the embryo and fetus and that no safe level of alcohol consumption during pregnancy has been established (PCHHC AIII).[18,158] Assess for tobacco use at each encounter with the health care system. Women who smoke should be counseled, using the 5 A's, to limit exposure. (PCHHC A II-2) (USDHHS/PHS: Level A for screening, B and C for interventions)[14,159] IOM: Screen for suicide ideation and postpartum depression in women who are pregnant or who have recently given birth.[56]		

TOPIC: SEXUAL HEALTH

Final WWTF Recommendation	Evidence Based	Evidence Informed	Uniform Expert Agreement
Adolescents (13–18 years) (See also Contraception, STIs, and Reproductive Health)			
Providers should offer the opportunity for respectful and open dialogue about sexual health and sexuality that includes sexual orientation, gender identity, and sexual dysfunction at every comprehensive health visit. (Qualified)			Open and respectful dialogue by health care providers is recommended. Although adolescents often want this dialogue, providers are reluctant to discuss sexual health with adolescents beyond advising patients to avoid unplanned pregnancy and STIs.[160] A holistic approach with adolescents to sexual health that includes discussion of desire and relationships may increase healthy sexual behavior.[161] Sexuality is a normal and healthy part of adolescent development.[162] Interventions to improve the quality and availability of reproductive health services should be targeted toward obstetrician–gynecologists and family practitioners.[48]
Adults (all ages)			
Address sexual health and sexuality as part of every annual comprehensive health assessment. (Strong) **Sexually active women can be screened for sexual health issues with one or two questions, such as "Are you satisfied with your sex life?" or "Do you have any questions or concerns about sex?" (Qualified)**		WHO: Sexual health is a state of physical, mental, and social well-being in relation to sexuality. Sexual health requires a positive and respectful approach to sexuality and sexual relationships. It is also essential for the possibility of having pleasurable and safe sexual experiences, free of coercion, discrimination, and violence.[163] ACOG: Obtain a sexual history if women present with a potential sexual problem.[164]	Patient interactions addressing sexual health should occur regularly and evolve over the life course. The type of interaction depends on the patient's age and personal circumstances, such as relationship status, sexual orientation, gender identity, and pregnancy intent.[165] Patients, regardless of age, want to discuss sexual health issues with their providers.[166]

TOPIC: SKIN CANCER

Final WWTF Recommendation	Evidence Based	Evidence Informed	Uniform Expert Agreement
Adolescents (13–18 years) (See also Contraception, STIs, and Reproductive Health)			
Counseling adolescents about minimizing their exposure to ultraviolet radiation is recommended to reduce risk for skin cancer. (Strong)	USPSTF: Recommends counseling children, adolescents, and young adults aged 10–24 years who have fair skin about minimizing their exposure to ultraviolet radiation to reduce risk for skin cancer (Grade B).[167]	AAFP: Counsel children, adolescents and young adults (10–24 years) who have fair skin about minimizing their exposure to ultraviolet radiation to reduce risk for skin cancer (Grade B).[168] AAP: Incorporate advice about ultraviolet radiation exposure into health-supervision practices for all children, especially for children at high risk of developing skin cancer (children with light skin; those with nevi, freckling, or both; and those with a family history of melanoma). Aim to incorporate ultraviolet radiation exposure advice into at least one health-maintenance visit per year, beginning in infancy. Because melanoma occurs in teenagers and is a common cancer among young adults, clinicians caring for these groups should include a skin examination as part of a complete physical examination.[169] ACOG: Counsel about skin exposure to ultraviolet rays.[6]	
Adolescents should be encouraged to use sunscreen regularly and avoid artificial tanning. (Strong)		ACOG: Encourage regular use of sunscreen and avoidance of artificial tanning.[6]	
Adults (19 years and older)			
Counseling young adults aged 19–24 years about minimizing their exposure to ultraviolet radiation is recommended to reduce risk for skin cancer. (Strong)	USPSTF: Recommends counseling children, adolescents, and young adults aged 10–24 years who have fair skin about minimizing their exposure to ultraviolet radiation to reduce risk for skin cancer (Grade B).[167]	AAFP: Counsel children, adolescents, and young adults (10–24 years) who have fair skin about minimizing their exposure to ultraviolet radiation to reduce risk for skin cancer.[168]	
Routine whole-body skin examination or patient skin self-examination for detection of skin cancers is not recommended. (Strong)	USPSTF: Current evidence is insufficient to assess the balance of benefits and harms of screening for skin cancer by patient skin self-examination.[170]	AAFP: There is insufficient evidence to assess benefits and harms of using whole-body skin examination by primary care clinician or patient skin self-examination for the early detection of cutaneous melanoma, basal cell cancer, or squamous cell skin cancer in the adult population (Grade I).[168]	
Adults should be encouraged to use sunscreen regularly and avoid artificial tanning. (Strong)	USPSTF: Current evidence is insufficient to assess the balance of benefits and harms of counseling adults older than 24 years about minimizing risks to prevent skin cancer (Grade I).[171]	AAFP: There is insufficient evidence to assess benefits and harms of counseling adults older than 24 years (Grade I).[168] ACOG: Encourage regular use of sunscreen and avoidance of artificial tanning.[6]	

TOPIC: TOBACCO USE

Final WWTF Recommendation	Evidence Based	Evidence Informed	Uniform Expert Agreement
Adolescents (13–18 years) (See also Oral Hygiene)			
Providing annual education or brief counseling to prevent initiation of tobacco use is recommended. (Strong) **Screening annually for tobacco use and tobacco smoke exposure is recommended. For those who use tobacco products, encourage tobacco use cessation and provide cessation strategies. (Strong)** **Provide effective interventions for treating tobacco use and dependence among adolescents. (Strong)**	USPSTF: Recommends that primary care clinicians provide interventions, including education or brief counseling, to prevent initiation of tobacco use in school-aged children and adolescents (Grade B).[172]	AAFP: Strongly recommends counseling to smoking parents with children at home regarding the harmful effects of smoking on children's health.[172] Effectiveness of physician's advice and counseling in this area is uncertain; avoidance of tobacco products by children and adolescents is desirable.[173] AAP: Screen annually for tobacco and smoke exposure, encourage tobacco use cessation, and provide tobacco cessation strategies and resources at most visits.[5] ACOG: Ask about use of tobacco products.[6] AAP: Counseling should be developmentally appropriate and relevant across various age groups.[174] ACOG: Recommends annual screening for tobacco use and evaluation and counseling, but the intervals at which such interventions should take place are not specified.[2] PCHHC: Assess for tobacco use at each encounter with the health care system; women who smoke should be counseled, using the 5 As, to limit exposure (A II-2). All women of childbearing age should be screened for tobacco use. Brief interventions should be provided to all tobacco users and should include brief counseling that describes the benefits of not smoking before, during, and after pregnancy; discussion of medication; and referral for more intensive services (individual, group, or telephone counseling) if the woman is willing to use these services. For pregnant women, augmented counseling interventions should be used (A I-a).[10]	
Adults (19 years and older) (See also Oral Cavity Examination, Oral Hygiene)			
Screening all women annually for tobacco use is recommended. For those who use tobacco products, provide tobacco cessation education and treatment. (Strong) **Routine screening for lung cancer in asymptomatic women is not recommended. (Strong)**	USPSTF: Screen annually for tobacco use and provide tobacco cessation education and treatment (Grade A).[157] Evidence is insufficient to recommend for or against screening asymptomatic persons for lung cancer with either low-dose computerized tomography, chest x-ray, sputum cytology, or a combination of these tests (Grade I).[175]	AAFP: Strongly recommends counseling to smoking parents with children at home regarding the harmful effects of smoking on children's health.[172] Screen for tobacco use and provide tobacco cessation interventions for those who use tobacco products (Grade A).[173] ACOG: Recommends annual screening for tobacco use, evaluation and counseling, but the intervals at which such interventions should take place are not specified.[2] PCHHC: Assess for tobacco use at each encounter with the health care system; women who smoke should be counseled, using the 5 As, to limit exposure (A II-2). All women of childbearing age should be screened for tobacco use. Brief interventions should be provided to all tobacco users and should include brief counseling that describes the benefits of not smoking before, during, and after pregnancy; discussion of medication; and referral for more intensive services (individual, group, or telephone counseling) if the woman is willing to use these services. For pregnant women, augmented counseling interventions should be used (A I-a).[10]	

TOPIC: VISUAL ACUITY/GLAUCOMA

Final WWTF Recommendation	Evidence Based	Evidence Informed	Uniform Expert Agreement
Adolescents (13–18 years)			
Screening for visual acuity is recommended twice: once in early adolescence (younger than 15 years) and once in late adolescence (15–18 years). Refer patients with any abnormality or suspicion of abnormality to an optometrist or ophthalmologist. (Qualified)		AAP: Screen for visual acuity once per year for ages 3–6, 8, 10, 12, 15, and 18 years. Screening should take place during other health supervision visits based on risk assessment or any concern on the part of the families or the child.[6]	Visual acuity screening should be performed once a year at ages 15 years and 18 years, if screening was performed at age 12 years. If no screening was performed at age 12 years, then screening should take place when the adolescent is seen at age 13 years or 14 years, then again at ages 15 years and 18 years. Any abnormality or suspicion of abnormality should be referred to an optometrist or ophthalmologist.
Adults (all ages)			
Routine screening by primary care providers for glaucoma is not recommended. (Qualified)	USPSTF: There is insufficient evidence to recommend for or against screening adults for glaucoma.[176]	AAFP: There is insufficient evidence to recommend for or against screening adults for glaucoma.[177]	

Abbreviations: AAFP, American Academy of Family Physicians; AAP, American Academy of Pediatrics; AAPD, American Academy of Pediatric Dentistry; ACIP, Advisory Committee on Immunization Practices; ACMGG, American College of Medical Genetics and Genomics; ACNM, American College of Nurse-Midwives; ACOG, American College of Obstetricians and Gynecologists; ACP, American College of Physicians; ACS, American Cancer Society; ADA, Americans with Disabilities Act; AHA, American Heart Association; AHRQ, Agency for Healthcare Research and Quality; ASA, American Stroke Association; ASCCP, American Society for Colposcopy and Cervical Pathology; ASCP, American Society for Clinical Pathology; AWHONN, Association of Women's Health, Obstetric and Neonatal Nurses; BMI, body mass index; CDC, Centers for Disease Control and Prevention; FDA, Food and Drug Administration; HIV, human immunodeficiency virus; HMHB, National Healthy Mothers, Healthy Babies Coalition; HPV, human papillomavirus infection; IOM, Institute of Medicine; NAHIC, National Adolescent and Young Adult Health Information Center; NCCN, National Comprehensive Cancer Network; NCQA, National Committee for Quality Assurance; NIAAA, National Institute on Alcohol Abuse and Alcoholism; NIH, National Institutes of Health; PCHHC, Preconception Health and Health Care; PHS, U.S. Public Health Service; STIs, sexually transmitted infections; USPSTF, United States Preventive Services Task Force; WHO, World Health Organization; WWTF, Well Woman Task Force.

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