



Complete Summary

GUIDELINE TITLE

Screening for skin cancer: U.S. Preventive Services Task Force recommendation statement.

BIBLIOGRAPHIC SOURCE(S)

U.S. Preventive Services Task Force. Screening for skin cancer: U.S. Preventive Services Task Force recommendation statement. *Ann Intern Med* 2009 Feb 3;150(3):188-93. [12 references] [PubMed](#)

GUIDELINE STATUS

This is the current release of the guideline.

This release updates a previously published guideline: Berg AO. Screening for skin cancer: recommendations and rationale. *Am J Prev Med* 2001 Apr;20(3 Suppl):44-6.

COMPLETE SUMMARY CONTENT

SCOPE
METHODOLOGY - including Rating Scheme and Cost Analysis
RECOMMENDATIONS
EVIDENCE SUPPORTING THE RECOMMENDATIONS
BENEFITS/HARMS OF IMPLEMENTING THE GUIDELINE RECOMMENDATIONS
QUALIFYING STATEMENTS
IMPLEMENTATION OF THE GUIDELINE
INSTITUTE OF MEDICINE (IOM) NATIONAL HEALTHCARE QUALITY REPORT CATEGORIES
IDENTIFYING INFORMATION AND AVAILABILITY
DISCLAIMER

SCOPE

DISEASE/CONDITION(S)

Skin cancer:

- Malignant melanoma
- Basal cell carcinoma
- Squamous cell carcinoma

GUIDELINE CATEGORY

Prevention
Screening

CLINICAL SPECIALTY

Dermatology
Family Practice
Geriatrics
Internal Medicine
Nursing
Preventive Medicine

INTENDED USERS

Advanced Practice Nurses
Allied Health Personnel
Health Care Providers
Nurses
Patients
Physician Assistants
Physicians

GUIDELINE OBJECTIVE(S)

- To summarize the current U.S. Preventive Services Task Force (USPSTF) recommendations and supporting scientific evidence on screening for skin cancer
- To update the 2001 USPSTF recommendations on screening for skin cancer

TARGET POPULATION

The adult general population without a history of premalignant or malignant lesions

INTERVENTIONS AND PRACTICES CONSIDERED

1. Whole-body skin examination by a primary care clinician
2. Patient skin self-examination

MAJOR OUTCOMES CONSIDERED

Key Question: Does screening in asymptomatic persons with whole-body examination by a primary care clinician or by self-examination reduce morbidity and mortality from skin cancer?

Contextual Question 1: Can screening with whole-body examination by primary care clinicians or by self-examination accurately detect skin cancer?

Contextual Question 2: Does screening with whole-body examination or by self-examination detect melanomas at an earlier stage (thinner lesions)?

METHODOLOGY

METHODS USED TO COLLECT/SELECT EVIDENCE

Hand-searches of Published Literature (Secondary Sources)
Searches of Electronic Databases

DESCRIPTION OF METHODS USED TO COLLECT/SELECT THE EVIDENCE

Note from the National Guideline Clearinghouse (NGC): A targeted review of the literature was prepared by the Agency for Healthcare Research and Quality (AHRQ) for use by the U.S. Preventive Services Task Force (USPSTF) (see the "Availability of Companion Documents" field).

Data Sources and Searches

The English-language literature in MEDLINE was searched to identify randomized, controlled trials (RCTs) or case-control trials published from 1 June 1999 to 9 August 2005 to answer the following key question: Can screening reduce morbidity and mortality from skin cancer?

The terms *skin neoplasms*, *squamous cell neoplasms*, *basal cell neoplasms*, *melanoma*, and *mass screening* were used. In addition to the MEDLINE search, further literature was identified by reviewing reference lists of review articles and editorials and by consulting with experts. For the contextual questions, AHRQ staff performed targeted literature searches, reviewed searches performed for other questions, identified studies from reference lists, and consulted experts.

Study Selection

Two reviewers independently reviewed the title lists, abstracts, and full articles for the key question. Studies were excluded if they did not address skin cancer, did not report morbidity or mortality outcomes, were editorials or review articles, had no control group, or had a study population that included only persons with rare skin cancer syndromes. Studies were also excluded if the intervention was not screening with whole-body visual examination by a physician or by the patient, was not performed in a primary care setting, or was designed to improve diagnostic ability (and not screening). Studies selected by fewer than 2 reviewers were discussed and selection was based on consensus. A third reviewer was consulted if necessary. For contextual question 1, one author selected studies published since June 1999 that provided information on accuracy of screening examinations by primary care clinicians or by patient self-examination. For contextual question 2, one author selected studies published since June 1999 that provided information on thinness of lesions detected by screening examinations.

NUMBER OF SOURCE DOCUMENTS

For the key question, one new fair-quality case-control study of skin self-examination that used data from a study identified in the 2001 report for the U.S. Preventive Services Task Force (USPSTF) was reviewed. No new studies on the benefits of screening by a physician that met inclusion and exclusion criteria and

were of appropriate quality were found. Additional studies were examined that addressed Contextual Question 1 (on whether screening accurately detects skin cancers) and Contextual Question 2 (on whether screening detects melanomas at an earlier stage).

METHODS USED TO ASSESS THE QUALITY AND STRENGTH OF THE EVIDENCE

Expert Consensus

RATING SCHEME FOR THE STRENGTH OF THE EVIDENCE

Not applicable

METHODS USED TO ANALYZE THE EVIDENCE

Systematic Review

DESCRIPTION OF THE METHODS USED TO ANALYZE THE EVIDENCE

Note from the National Guideline Clearinghouse (NGC): A targeted review of the literature was prepared by the Agency for Healthcare Research and Quality (AHRQ) for use by the U.S. Preventive Services Task Force (USPSTF) (see the "Availability of Companion Documents" field).

Data Extraction and Quality Assessment

For all citations that met the eligibility criteria for the key question, 2 reviewers independently reviewed, abstracted, and quality-rated the full articles. The 2 reviewers achieved consensus about article inclusion, content, and quality through discussion; a third reviewer resolved disagreements. Data was abstracted on the following items from the studies included for the key question: identification of case patients, case definition, selection of control participants, comorbid conditions, sun exposures, demographic characteristics of case patients and control participants, definition of screening examination, exposure to screening, rates of follow-up, and results. AHRQ staff performed quality evaluations of articles for the key question by using standard USPSTF methodology on internal and external validity. They evaluated the quality of randomized controlled trials (RCTs) and cohort studies on the following items: initial assembly of comparable groups, maintenance of comparable groups, important differential loss to follow-up or overall high loss to follow-up, measurements (equality, reliability, and validity of outcome measurements), clear definition of the interventions, and appropriateness of outcomes. They evaluated the quality of case-control studies on the following items: accurate ascertainment of cases, nonbiased selection of case patients and control participants with exclusion criteria applied equally to both, response rate, diagnostic testing procedures applied equally to each group, accurate measurement of exposure applied equally to each group, measurement of exposure accurate and applied equally to each group, and appropriate attention to potential confounding variables.

Data Synthesis and Analysis

Data from the included studies was synthesized qualitatively in a narrative format.

METHODS USED TO FORMULATE THE RECOMMENDATIONS

Balance Sheets
Expert Consensus

DESCRIPTION OF METHODS USED TO FORMULATE THE RECOMMENDATIONS

The U.S. Preventive Services Task Force (USPSTF) systematically reviews the evidence concerning both the benefits and harms of widespread implementation of a preventive service. It then assesses the certainty of the evidence and the magnitude of the benefits and harms. On the basis of this assessment, the USPSTF assigns a letter grade to each preventive service signifying its recommendation about provision of the service (see Table below). An important, but often challenging, step is determining the balance between benefits and harms to estimate "net benefit" (that is, benefits minus harms).

Table 1. U.S. Preventive Services Task Force Recommendation Grid*

Certainty of Net Benefit	Magnitude of Net Benefit			
	Substantial	Moderate	Small	Zero/Negative
High	A	B	C	D
Moderate	B	B	C	D
Low	Insufficient			

*A, B, C, D, and I (*Insufficient*) represent the letter grades of recommendation or statement of insufficient evidence assigned by the U.S. Preventive Services Task Force after assessing certainty and magnitude of net benefit of the service (see the "Rating Scheme for the Strength of the Recommendations" field).

The overarching question that the Task Force seeks to answer for every preventive service is whether evidence suggests that provision of the service would improve health outcomes if implemented in a general primary care population. For screening topics, this standard could be met by a large randomized, controlled trial (RCT) in a representative asymptomatic population with follow-up of all members of both the group "invited for screening" and the group "not invited for screening."

Direct RCT evidence about screening is often unavailable, so the Task Force considers indirect evidence. To guide its selection of indirect evidence, the Task Force constructs a "chain of evidence" within an analytic framework. For each key question, the body of pertinent literature is critically appraised, focusing on the following 6 questions:

1. Do the studies have the appropriate research design to answer the key question(s)?
2. To what extent are the existing studies of high quality? (i.e., what is the internal validity?)

3. To what extent are the results of the studies generalizable to the general U.S. primary care population and situation? (i.e., what is the external validity?)
4. How many studies have been conducted that address the key question(s)? How large are the studies? (i.e., what is the precision of the evidence?)
5. How consistent are the results of the studies?
6. Are there additional factors that assist us in drawing conclusions (e.g., presence or absence of dose–response effects, fit within a biologic model)?

The next step in the Task Force process is to use the evidence from the key questions to assess whether there would be net benefit if the service were implemented. In 2001, the USPSTF published an article that documented its systematic processes of evidence evaluation and recommendation development. At that time, the Task Force's overall assessment of evidence was described as good, fair, or poor. The Task Force realized that this rating seemed to apply only to how well studies were conducted and did not fully capture all of the issues that go into an overall assessment of the evidence about net benefit. To avoid confusion, the USPSTF has changed its terminology. Whereas individual study quality will continue to be characterized as good, fair, or poor, the term *certainty* will now be used to describe the Task Force's assessment of the overall body of evidence about net benefit of a preventive service and the likelihood that the assessment is correct. Certainty will be determined by considering all 6 questions listed above; the judgment about certainty will be described as high, moderate, or low.

In making its assessment of certainty about net benefit, the evaluation of the evidence from each key question plays a primary role. It is important to note that the Task Force makes recommendations for real-world medical practice in the United States and must determine to what extent the evidence for each key question—even evidence from screening RCTs or treatment RCTs—can be applied to the general primary care population. Frequently, studies are conducted in highly selected populations under special conditions. The Task Force must consider differences between the general primary care population and the populations studied in RCTs and make judgments about the likelihood of observing the same effect in actual practice.

It is also important to note that 1 of the key questions in the analytic framework refers to the potential harms of the preventive service. The Task Force considers the evidence about the benefits and harms of preventive services separately and equally. Data about harms are often obtained from observational studies because harms observed in RCTs may not be representative of those found in usual practice and because some harms are not completely measured and reported in RCTs.

Putting the body of evidence for all key questions together as a chain, the Task Force assesses the certainty of net benefit of a preventive service by asking the 6 major questions listed above. The Task Force would rate a body of convincing evidence about the benefits of a service that, for example, derives from several RCTs of screening in which the estimate of benefits can be generalized to the general primary care population as "high" certainty (see the "Rating Scheme for the Strength of Recommendations" field). The Task Force would rate a body of evidence that was not clearly applicable to general practice or has other defects in quality, research design, or consistency of studies as "moderate" certainty.

Certainty is "low" when, for example, there are gaps in the evidence linking parts of the analytic framework, when evidence to determine the harms of treatment is unavailable, or when evidence about the benefits of treatment is insufficient. Table 4 in the methodology document listed below (see "Availability of Companion Documents" field) summarizes the current terminology used by the Task Force to describe the critical assessment of evidence at all 3 levels: individual studies, key questions, and overall certainty of net benefit of the preventive service.

Sawaya GF, et al. Update on the methods of the U.S. Preventive Services Task Force: estimating certainty and magnitude of net benefit. *Ann Intern Med.* 2007;147:871-875 [5 references].

For I statements, the USPSTF has a new plan to commission its Evidence-based Practice Centers to collect information in 4 domains pertinent to clinical decisions about prevention and to report this information routinely. This plan is described in a paper that was published with the Skin Cancer recommendation: Petitti DB et al. Update on the methods of the U.S. Preventive Services Task Force: insufficient evidence. *Ann Intern Med.* 2009;150:199-205 (see "Availability of Companion Documents" field).

The first domain is potential preventable burden of suffering from the condition. When evidence is insufficient, provision of an intervention designed to prevent a serious condition (such as dementia) might be viewed more favorably than provision of a service designed to prevent a condition that does not cause as much suffering (such as rash). The USPSTF recognized that "burden of suffering" is subjective and involves judgment. In clinical settings, it should be informed by patient values and concerns.

The second domain is potential harm of the intervention. When evidence is insufficient, an intervention with a large potential for harm (such as major surgery) might be viewed less favorably than an intervention with a small potential for harm (such as advice to watch less television). The USPSTF again acknowledges the subjective nature and the difficulty of assessing potential harms: For example, how bad is a "mild" stroke?

The third domain is cost-not just monetary cost, but opportunity cost, in particular the amount of time a provider spends to provide the service, the amount of time the patient spends to partake of it, and the benefits that might derive from alternative uses of the time or money for patients, clinicians, or systems. Consideration of clinician time is especially important for preventive services with only insufficient evidence because providing them could "crowd out" provision of preventive services with proven value, services for conditions that require immediate action, or services more desired by the patient. For example, a decision to routinely inspect the skin could take up the time available to discuss smoking cessation, or to address an acute problem or a minor injury that the patient considers important.

The fourth domain is current practice. This domain was chosen because it is important to clinicians for at least 2 reasons. Clinicians justifiably fear that not doing something that is done on a widespread basis in the community may lead to litigation. More important, addressing patient expectations is a crucial part of the clinician-patient relationship in terms of building trust and developing a

collaborative therapeutic relationship. The consequences of not providing a service that is neither widely available nor widely used are less serious than not providing a service accepted by the medical profession and thus expected by patients. Furthermore, ingrained care practices are difficult to change, and efforts should preferentially be directed to changing those practices for which the evidence to support change is compelling.

Although the reviewers did not explicitly recognize it when these domains were chosen, the domains all involve consideration of the potential consequences-for patients, clinicians, and systems-of providing or not providing a service. Others writing about medical decision making in the face of uncertainty have suggested that the consequences of action or inaction should play a prominent role in decisions.

RATING SCHEME FOR THE STRENGTH OF THE RECOMMENDATIONS

What the United States Preventive Services Task Force (USPSTF) Grades Mean and Suggestions for Practice

Grade	Grade Definitions	Suggestions for Practice
A	The USPSTF recommends the service. There is high certainty that the net benefit is substantial.	Offer or provide this service.
B	The USPSTF recommends the service. There is high certainty that the net benefit is moderate or there is moderate certainty that the net benefit is moderate to substantial.	Offer or provide this service.
C	The USPSTF recommends against routinely providing the service. There may be considerations that support providing the service in an individual patient. There is moderate or high certainty that the net benefit is small.	Offer or provide this service only if there are other considerations in support of the offering/providing the service in an individual patient.
D	The USPSTF recommends against the service. There is moderate or high certainty that the service has no net benefit or that the harms outweigh the benefits.	Discourage the use of this service.
I Statement	The USPSTF concludes that the current evidence is insufficient to assess the balance of benefits and harms of the service. Evidence is lacking, of poor quality or conflicting, and the balance of benefits and harms cannot be determined.	Read "Clinical Considerations" section of USPSTF Recommendation Statement (see "Major Recommendations" field). If offered, patients should understand the uncertainty about the balance of benefits and harms.

USPSTF Levels of Certainty Regarding Net Benefit

Definition: The U.S. Preventive Services Task Force defines certainty as "likelihood that the USPSTF assessment of the net benefit of a preventive service is correct." The net benefit is defined as benefit minus harm of the preventive service as implemented in a general, primary care population. The USPSTF assigns a certainty level based on the nature of the overall evidence available to assess the net benefit of a preventive service.

Level of Certainty	Description
High	The available evidence usually includes consistent results from well-designed, well-conducted studies in representative primary care populations. These studies assess the effects of the preventive service on health outcomes. This conclusion is therefore unlikely to be strongly affected by the results of future studies.
Moderate	<p>The available evidence is sufficient to determine the effects of the preventive service on health outcomes, but confidence in the estimate is constrained by factors such as:</p> <ul style="list-style-type: none"> • The number, size, or quality of individual studies • Inconsistency of findings across individual studies • Limited generalizability of findings to routine primary care practice • Lack of coherence in the chain of evidence <p>As more information becomes available, the magnitude or direction of the observed effect could change, and this change may be large enough to alter the conclusion.</p>
Low	<p>The available evidence is insufficient to assess effects on health outcomes. Evidence is insufficient because of:</p> <ul style="list-style-type: none"> • The limited number or size of studies • Important flaws in study design or methods • Inconsistency of findings across individual studies • Gaps in the chain of evidence • Findings not generalizable to routine primary care practice • A lack of information on important health outcomes <p>More information may allow an estimation of effects on health outcomes.</p>

COST ANALYSIS

A formal cost analysis was not performed and published cost analyses were not reviewed.

METHOD OF GUIDELINE VALIDATION

Comparison with Guidelines from Other Groups
 External Peer Review
 Internal Peer Review

DESCRIPTION OF METHOD OF GUIDELINE VALIDATION

Peer Review. Before the U.S. Preventive Services Task Force makes its final determinations about recommendations on a given preventive service, the Evidence-Based Practice Center and the Agency for Healthcare Research and Quality send a draft evidence review to 4 to 6 external experts and to federal agencies and professional and disease-based health organizations with interests in the topic. They ask the experts to examine the review critically for accuracy and completeness and to respond to a series of specific questions about the document. After assembling these external review comments and documenting the proposed response to key comments, the topic team presents this information to the Task Force in memo form. In this way, the Task Force can consider these external comments before it votes on its recommendations about the service. Draft recommendation statements are then circulated for comment from reviewers representing professional societies, voluntary organizations and Federal agencies. These comments are discussed before the final recommendations are confirmed.

Comparison with Guidelines from Other Groups. Recommendations for screening from the following groups were discussed: the Canadian Task Force on Preventive Health Care, the American Academy of Family Physicians, the Physician Data Query (PDQ) program of the National Cancer Institute, the American Cancer Society, the American College of Preventive Medicine, the American Academy of Dermatology, and the American College of Obstetricians and Gynecologists.

RECOMMENDATIONS

MAJOR RECOMMENDATIONS

The U.S. Preventive Services Task Force (USPSTF) grades its recommendations (A, B, C, D, or I) and identifies the Levels of Certainty regarding Net Benefit (High, Moderate, and Low). The definitions of these grades can be found at the end of the "Major Recommendations" field.

Summary of Recommendations and Evidence

The USPSTF concludes that the current evidence is insufficient to assess the balance of benefits and harms of using a whole-body skin examination by a 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 general population. **This is an I statement.**

Clinical Considerations

Patient Population under Consideration

This recommendation applies to the adult general population without a history of premalignant or malignant lesions. The USPSTF did not examine the outcomes related to surveillance of patients at extremely high risk, such as those with familial syndromes (for example, the familial atypical mole and melanoma syndrome).

Suggestions for Practice Regarding the I Statement

Clinicians should remain alert for skin lesions with malignant features noted in the context of physical examinations performed for other purposes. Asymmetry, border irregularity, color variability, diameter greater than 6 mm (ABCD criteria), or rapidly changing lesions are features associated with an increased risk for cancer. Biopsy of suspicious lesions is warranted.

Assessment of Risk

Clinicians should be aware that fair-skinned men and women older than 65 years, patients with atypical moles, and those with more than 50 moles constitute known groups at substantially increased risk for melanoma. Other risk factors for skin cancer include family history and a considerable history of sun exposure and sunburns. Benefits from screening are uncertain, even in high-risk patients.

Useful Resources

The USPSTF has previously reviewed the evidence for counseling to prevent skin cancer. The recommendation statement and supporting documents are available on the AHRQ Web site (www.preventiveservices.ahrq.gov). The U.S. Task Force on Community Preventive Services has reviewed the evidence on interventions designed to reduce skin cancer; the recommendations are available at The Community Guide (www.thecommunityguide.org).

Definitions:

What the United States Preventive Services Task Force (USPSTF) Grades Mean and Suggestions for Practice

Grade	Grade Definitions	Suggestions for Practice
A	The USPSTF recommends the service. There is high certainty that the net benefit is substantial.	Offer or provide this service.
B	The USPSTF recommends the service. There is high certainty that the net benefit is moderate or there is moderate certainty that the net benefit is moderate to substantial.	Offer or provide this service.
C	The USPSTF recommends against routinely providing the service. There may be considerations that support providing the service in an individual patient. There is moderate or high certainty that the net benefit is small.	Offer or provide this service only if there are other considerations in support of the offering/providing the service in an individual patient.
D	The USPSTF recommends against the service. There is moderate or high certainty that the service has no net benefit or that the harms outweigh the benefits.	Discourage the use of this service.
I Statement	The USPSTF concludes that the current evidence is insufficient to	Read "Clinical Considerations" section of USPSTF Recommendation

Grade	Grade Definitions	Suggestions for Practice
	assess the balance of benefits and harms of the service. Evidence is lacking, of poor quality or conflicting, and the balance of benefits and harms cannot be determined.	Statement (see "Major Recommendations" field). If offered, patients should understand the uncertainty about the balance of benefits and harms.

USPSTF Levels of Certainty Regarding Net Benefit

Definition: The U.S. Preventive Services Task Force defines certainty as "likelihood that the USPSTF assessment of the net benefit of a preventive service is correct." The net benefit is defined as benefit minus harm of the preventive service as implemented in a general, primary care population. The USPSTF assigns a certainty level based on the nature of the overall evidence available to assess the net benefit of a preventive service.

Level of Certainty	Description
High	The available evidence usually includes consistent results from well-designed, well-conducted studies in representative primary care populations. These studies assess the effects of the preventive service on health outcomes. This conclusion is therefore unlikely to be strongly affected by the results of future studies.
Moderate	<p>The available evidence is sufficient to determine the effects of the preventive service on health outcomes, but confidence in the estimate is constrained by factors such as:</p> <ul style="list-style-type: none"> • The number, size, or quality of individual studies • Inconsistency of findings across individual studies • Limited generalizability of findings to routine primary care practice • Lack of coherence in the chain of evidence <p>As more information becomes available, the magnitude or direction of the observed effect could change, and this change may be large enough to alter the conclusion.</p>
Low	<p>The available evidence is insufficient to assess effects on health outcomes. Evidence is insufficient because of:</p> <ul style="list-style-type: none"> • The limited number or size of studies • Important flaws in study design or methods • Inconsistency of findings across individual studies • Gaps in the chain of evidence • Findings not generalizable to routine primary care practice • A lack of information on important health outcomes <p>More information may allow an estimation of effects on health outcomes.</p>

CLINICAL ALGORITHM(S)

None available

EVIDENCE SUPPORTING THE RECOMMENDATIONS

TYPE OF EVIDENCE SUPPORTING THE RECOMMENDATIONS

The type of supporting evidence is not specifically stated for each recommendation.

BENEFITS/HARMS OF IMPLEMENTING THE GUIDELINE RECOMMENDATIONS

POTENTIAL BENEFITS

Benefits of Detection and Early Treatment

The evidence is insufficient (lack of studies) to determine whether early detection of skin cancer reduces mortality or morbidity from skin cancer. This is a critical gap in the evidence.

POTENTIAL HARMS

Harms of Detection and Early Treatment

The evidence is insufficient (lack of studies) to determine the magnitude of harms from screening for skin cancer. Potential harms of screening for skin cancer include misdiagnosis, overdiagnosis, and the resultant harms from biopsies and overtreatment. This is a critical gap in the evidence.

QUALIFYING STATEMENTS

QUALIFYING STATEMENTS

- The U.S. Preventive Services Task Force (USPSTF) makes recommendations about preventive care services for patients without recognized signs or symptoms of the target condition.
- Recommendations are based on a systematic review of the evidence of the benefits and harms and an assessment of the net benefit of the service.
- The USPSTF recognizes that clinical or policy decisions involve more considerations than this body of evidence alone. Clinicians and policy-makers should understand the evidence but individualize decision making to the specific patient or situation.

IMPLEMENTATION OF THE GUIDELINE

DESCRIPTION OF IMPLEMENTATION STRATEGY

The experiences of the first and second U.S. Preventive Services Task Force (USPSTF), as well as that of other evidence-based guideline efforts, have highlighted the importance of identifying effective ways to implement clinical

recommendations. Practice guidelines are relatively weak tools for changing clinical practice when used in isolation. To effect change, guidelines must be coupled with strategies to improve their acceptance and feasibility. Such strategies include enlisting the support of local opinion leaders, using reminder systems for clinicians and patients, adopting standing orders, and audit and feedback of information to clinicians about their compliance with recommended practice.

In the case of preventive services guidelines, implementation needs to go beyond traditional dissemination and promotion efforts to recognize the added patient and clinician barriers that affect preventive care. These include clinicians' ambivalence about whether preventive medicine is part of their job, the psychological and practical challenges that patients face in changing behaviors, lack of access to health care or of insurance coverage for preventive services for some patients, competing pressures within the context of shorter office visits, and the lack of organized systems in most practices to ensure the delivery of recommended preventive care.

Dissemination strategies have changed dramatically in this age of electronic information. While recognizing the continuing value of journals and other print formats for dissemination, the Agency for Healthcare Research and Quality will make all U.S. Preventive Services Task Force (USPSTF) products available through its [Web site](#). The combination of electronic access and extensive material in the public domain should make it easier for a broad audience of users to access U.S. Preventive Services Task Force materials and adapt them for their local needs. Online access to U.S. Preventive Services Task Force products also opens up new possibilities for the appearance of the annual, pocket-size *Guide to Clinical Preventive Services*.

To be successful, approaches for implementing prevention have to be tailored to the local level and deal with the specific barriers at a given site, typically requiring the redesign of systems of care. Such a systems approach to prevention has had notable success in established staff-model health maintenance organizations, by addressing organization of care, emphasizing a philosophy of prevention, and altering the training and incentives for clinicians. Staff-model plans also benefit from integrated information systems that can track the use of needed services and generate automatic reminders aimed at patients and clinicians, some of the most consistently successful interventions. Information systems remain a major challenge for individual clinicians' offices, however, as well as for looser affiliations of practices in network-model managed care and independent practice associations, where data on patient visits, referrals, and test results are not always centralized.

IMPLEMENTATION TOOLS

- Foreign Language Translations
- Patient Resources
- Personal Digital Assistant (PDA) Downloads
- Pocket Guide/Reference Cards
- Staff Training/Competency Material

For information about [availability](#), see the "Availability of Companion Documents" and "Patient Resources" fields below.

INSTITUTE OF MEDICINE (IOM) NATIONAL HEALTHCARE QUALITY REPORT CATEGORIES

IOM CARE NEED

Staying Healthy

IOM DOMAIN

Effectiveness
Patient-centeredness

IDENTIFYING INFORMATION AND AVAILABILITY

BIBLIOGRAPHIC SOURCE(S)

U.S. Preventive Services Task Force. Screening for skin cancer: U.S. Preventive Services Task Force recommendation statement. *Ann Intern Med* 2009 Feb 3;150(3):188-93. [12 references] [PubMed](#)

ADAPTATION

Not applicable: The guideline was not adapted from another source.

DATE RELEASED

1996 (revised 2009)

GUIDELINE DEVELOPER(S)

United States Preventive Services Task Force - Independent Expert Panel

GUIDELINE DEVELOPER COMMENT

The U.S. Preventive Services Task Force (USPSTF) is a federally-appointed panel of independent experts. Conclusions of the U.S. Preventive Services Task Force do not necessarily reflect policy of the U.S. Department of Health and Human Services (DHHS) or its agencies.

SOURCE(S) OF FUNDING

United States Government

GUIDELINE COMMITTEE

U.S. Preventive Services Task Force (USPSTF)

COMPOSITION OF GROUP THAT AUTHORED THE GUIDELINE

*Task Force Members**: Ned Calonge, MD, MPH, *Chair*, USPSTF (Colorado Department of Public Health and Environment, Denver, Colorado); Diana B. Petitti, MD, MPH, *Vice-chair*, USPSTF (Arizona State University, Phoenix, Arizona); Thomas G. DeWitt, MD (Children's Hospital Medical Center, Cincinnati, Ohio); Leon Gordis, MD, MPH, DrPH (Johns Hopkins Bloomberg School of Public Health, Baltimore, Maryland); Kimberly D. Gregory, MD, MPH (Department of Obstetrics and Gynecology, Cedars-Sinai Medical Center, Los Angeles, California); Russell Harris, MD, MPH (University of North Carolina School of Medicine, Chapel Hill, North Carolina); Kenneth W. Kizer, MD, MPH (National Quality Forum, Washington, DC); Michael L. LeFevre, MD, MSPH (University of Missouri School of Medicine, Columbia, Missouri); Carol Loveland-Cherry, PhD, RN (University of Michigan School of Nursing, Ann Arbor, Michigan); Lucy N. Marion, PhD, RN (School of Nursing, Medical College of Georgia, Augusta, Georgia); Virginia A. Moyer, MD, MPH (Baylor College of Medicine, Houston, Texas); Judith K. Ockene, PhD (University of Massachusetts Medical School, Worcester, Massachusetts); George F. Sawaya, MD (University of California, San Francisco, California); Albert L. Siu, MD, MSPH (Mount Sinai Medical Center, New York, New York); Steven M. Teutsch, MD, MPH (Merck & Company, Inc., West Point, Pennsylvania); and Barbara P. Yawn, MD, MSPH, MSc (Olmsted Medical Center, Rochester, Minnesota)

**Members of the Task Force at the time this recommendation was finalized. For a list of current Task Force members, go to www.ahrq.gov/clinic/uspstfab.htm.*

FINANCIAL DISCLOSURES/CONFLICTS OF INTEREST

The U.S. Preventive Services Task Force has an explicit policy concerning conflict of interest. All members disclose at each meeting if they have a significant financial, professional/business, or intellectual conflict for each topic being discussed. Task Force members with conflicts may be recused from discussing or voting on recommendations about the topic in question.

GUIDELINE STATUS

This is the current release of the guideline.

This release updates a previously published guideline: Berg AO. Screening for skin cancer: recommendations and rationale. *Am J Prev Med* 2001 Apr;20(3 Suppl):44-6.

GUIDELINE AVAILABILITY

Electronic copies: Available from the [U.S. Preventive Services Task Force \(USPSTF\) Web site](http://www.ahrq.gov/clinic/uspstfab.htm) and the [Annals of Internal Medicine Web site](http://www.ahrq.gov/clinic/uspstfab.htm).

Print copies: Available from the Agency for Healthcare Research and Quality (AHRQ) Publications Clearinghouse. For more information, go to <http://www.ahrq.gov/news/pubsix.htm> or call 1-800-358-9295 (U.S. only).

AVAILABILITY OF COMPANION DOCUMENTS

The following are available:

Evidence Reviews:

- Wolff T, Tai E, Miller T. Screening for skin cancer: an update of the evidence for the U.S. Preventive Services Task Force. Evidence Synthesis No. 67. AHRQ Publication No. 08-05128-EF-1. Rockville, Maryland: Agency for Healthcare Research and Quality. 2009 Feb. Electronic copies: Available from the [U.S. Preventive Services Task Force \(USPSTF\) Web site](#).
- Wolff T, Tai E, Miller T. Screening for skin cancer: an update of the evidence for the U.S. Preventive Services Task Force. Ann Intern Med. 2009;150:194-198. Electronic copies: Available from the [U.S. Preventive Services Task Force \(USPSTF\) Web site](#) and the [Annals of Internal Medicine Web site](#).

The following are also available:

- Screening for skin cancer: clinical summary of U.S. Preventive Services Task Force recommendation. Rockville (MD): Agency for Healthcare Research and Quality, 2009. Electronic copies: Available from the [U.S. Preventive Services Task Force \(USPSTF\) Web site](#).
- A continuing medical education (CME) activity is available from the [Annals of Internal Medicine Web site](#).

Background Articles:

- Barton M et al. How to read the new recommendation statement: methods update from the U.S. Preventive Services Task Force. Ann Intern Med. 2007;147:123-127.
- Guirguis-Blake J et al. Current processes of the U.S. Preventive Services Task Force: refining evidence-based recommendation development. Ann Intern Med. 2007;147:117-122. [2 references]
- Sawaya GF et al., Update on the methods of the U.S. Preventive Services Task Force: estimating certainty and magnitude of net benefit. Ann Intern Med. 2007;147:871-875. [5 references].
- Petitti DB, Teutsch SM, Barton MB, Sawaya GF, Ockene JK, DeWitt T. Update on the methods of the U.S. Preventive Services Task Force: insufficient evidence. Ann Intern Med. 2009;150:199-205.

Electronic copies: Available from [U.S. Preventive Services Task Force \(USPSTF\) Web site](#).

The following is also available:

- The guide to clinical preventive services, 2008. Recommendations of the U.S. Preventive Services Task Force. Rockville (MD): Agency for Healthcare Research and Quality (AHRQ), 2008. 249 p. Electronic copies available from the [AHRQ Web site](#). See the related QualityTool summary on the [Health Care Innovations Exchange Web site](#).

Print copies: Available from the Agency for Healthcare Research and Quality Publications Clearinghouse. For more information, go to <http://www.ahrq.gov/news/pubsix.htm> or call 1-800-358-9295 (U.S. only).

The [Electronic Preventive Services Selector \(ePSS\)](#), available as a PDA application and a web-based tool, is a quick hands-on tool designed to help primary care clinicians identify the screening, counseling, and preventive medication services that are appropriate for their patients. It is based on current recommendations of the USPSTF and can be searched by specific patient characteristics such as age, sex, and selected behavioral risk factors.

PATIENT RESOURCES

The following are available:

- Men: stay healthy at any age. Your checklist for health. Rockville (MD): Agency for Healthcare Research and Quality. AHRQ Pub. No. 07-IP006-A. February 2007. Electronic copies: Available from the [USPSTF Web site](#). See the related QualityTool summary on the [Health Care Innovations Exchange Web site](#).
- Women: stay healthy at any age. Your checklist for health. Rockville (MD): Agency for Healthcare Research and Quality. AHRQ Pub. No. 07-IP005-A. February 2007. Electronic copies: Available from the [USPSTF Web site](#). See the related QualityTool summary on the [Health Care Innovations Exchange Web site](#).

Print copies: Available in English and Spanish from the Agency for Healthcare Research and Quality (AHRQ) Publications Clearinghouse. For more information, go to <http://www.ahrq.gov/news/pubsix.htm> or call 1-800-358-9295 (U.S. only).

Myhealthfinder is a new tool that provides personalized recommendations for clinical preventive services specific to the user's age, gender, and pregnancy status. It features evidence-based recommendations from the USPSTF and is available at www.healthfinder.gov.

The following is also available:

- Screening for skin cancer: U.S. Preventive Services Task Force Recommendation. Summaries for patients. Ann Intern Med. 2009 Feb 3;150(3):I-40. Available from the [Annals of Internal Medicine Web site](#).

Please note: This patient information is intended to provide health professionals with information to share with their patients to help them better understand their health and their diagnosed disorders. By providing access to this patient information, it is not the intention of NGC to provide specific medical advice for particular patients. Rather we urge patients and their representatives to review this material and then to consult with a licensed health professional for evaluation of treatment options suitable for them as well as for diagnosis and answers to their personal medical questions. This patient information has been derived and prepared from a guideline for health care professionals included on NGC by the authors or publishers of that original guideline. The patient information is not reviewed by NGC to establish whether or not it accurately reflects the original guideline's content.

NGC STATUS

This summary was completed by ECRI on April 6, 2001. The information was verified by the guideline developer as of April 10, 2001. This NGC summary was updated by ECRI Institute on February 9, 2009. The updated information was verified by the guideline developer on March 19, 2009.

COPYRIGHT STATEMENT

Requests regarding copyright should be sent to: Randie A. Siegel, Electronic Dissemination Advisor, Division of Print and Electronic Publishing, Agency for Healthcare Research and Quality (formerly the Agency for Health Care Policy and Research), 540 Gaither Road, Rockville, MD 20850. Facsimile: 301-427-1873. E-mail: Randie.siegel@ahrq.hhs.gov.

DISCLAIMER

NGC DISCLAIMER

The National Guideline Clearinghouse™ (NGC) does not develop, produce, approve, or endorse the guidelines represented on this site.

All guidelines summarized by NGC and hosted on our site are produced under the auspices of medical specialty societies, relevant professional associations, public or private organizations, other government agencies, health care organizations or plans, and similar entities.

Guidelines represented on the NGC Web site are submitted by guideline developers, and are screened solely to determine that they meet the NGC Inclusion Criteria which may be found at <http://www.guideline.gov/about/inclusion.aspx>.

NGC, AHRQ, and its contractor ECRI Institute make no warranties concerning the content or clinical efficacy or effectiveness of the clinical practice guidelines and related materials represented on this site. Moreover, the views and opinions of developers or authors of guidelines represented on this site do not necessarily state or reflect those of NGC, AHRQ, or its contractor ECRI Institute, and inclusion or hosting of guidelines in NGC may not be used for advertising or commercial endorsement purposes.

Readers with questions regarding guideline content are directed to contact the guideline developer.

© 1998-2009 National Guideline Clearinghouse

Date Modified: 3/30/2009

