Complete Summary

GUIDELINE TITLE

Screening for abdominal aortic aneurysms: recommendation statement.

BIBLIOGRAPHIC SOURCE(S)

Screening for abdominal aortic aneurysm: recommendation statement. Ann Intern Med 2005 Feb 1;142(3):198-202. PubMed

GUIDELINE STATUS

This is the current release of the guideline.

This version updates a previously published guideline: U.S. Preventive Services Task Force. Guide to clinical preventive services. 2nd ed. Baltimore (MD): Williams & Wilkins; 1996. Chapter 6, Screening for abdominal aortic aneurysm. p. 67-72.

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)

Abdominal aortic aneurysm

GUIDELINE CATEGORY

Prevention
Screening

CLINICAL SPECIALTY

Cardiology
Family Practice
Internal Medicine
Preventive Medicine
Vascular Surgery

INTENDED USERS

Advanced Practice Nurses
Allied Health Personnel
Nurses
Physician Assistants
Physicians

GUIDELINE OBJECTIVE(S)

- To summarize the U.S. Preventive Services Task Force recommendations on screening for abdominal aortic aneurysm and the supporting scientific evidence
- To update the 1996 recommendations contained in the *Guide to Clinical Preventive Services*, Second Edition

TARGET POPULATION

Asymptomatic adults, aged 65-75, seen in primary care settings

INTERVENTIONS AND PRACTICES CONSIDERED

Screening for abdominal aortic aneurysm by ultrasonography

MAJOR OUTCOMES CONSIDERED

- **Key Question 1a**: Does abdominal aortic aneurysm (AAA) screening, in an asymptomatic average-risk or high-risk population, reduce AAA-related adverse health outcomes?
- **Key Questions 1b**: For individuals who do not have AAAs on initial screening, does periodic repeat screening reduce AAA-related adverse health outcomes?
- **Key Question 2**: What are the harms associated with AAA screening?
- **Key Question 3**: For 3.0 to 5.4 cm AAAs detected through screening, does immediate repair or surveillance reduce AAA-related adverse health outcomes?
- **Key Question 4**: What are the harms associated with repair of AAAs $\geq$5.5 cm?
- **Key Question 5**: What are the harms associated with immediate repair or surveillance of 3.0 to 5.4 cm AAAs?

METHODOLOGY

METHODS USED TO COLLECT/SELECT EVIDENCE

Searches of Electronic Databases

DESCRIPTION OF METHODS USED TO COLLECT/SELECT THE EVIDENCE

Note from the National Guideline Clearinghouse (NGC): A systematic evidence review was prepared by the Oregon Evidence-based Practice Center (EPC) for the Agency for Healthcare Research and Quality (AHRQ) for use by the U.S. Preventive Services Task Force (USPSTF) (see the "Companion Documents" field).

Search Strategy

MEDLINE was searched from January 1994 to May 2004 to identify studies about the following: the effectiveness of abdominal aortic aneurysm (AAA) screening in population-based settings, screening harms, effective management strategies for AAAs 3.0 to 5.4 cm, and harms of treatment for AAAs 3.0 to 5.4 cm and AAAs $\geq$5.5 cm. Search strategies for each key question are detailed in Appendix 1 of the Systematic Evidence Synthesis (see "Companion Documents" field).

Only data published in full-article form was included. EPC staff also searched the online Cochrane Database of Systematic Reviews and Cochrane Controlled Trials Register. Additionally, articles from the reference lists of pertinent studies and reviews and from expert recommendations were obtained.

Inclusion/Exclusion Criteria

Two reviewers individually reviewed each abstract using the inclusion/exclusion criteria listed in Appendix 2 of the Systematic Evidence Synthesis (see "Companion Documents" field). Excluded studies are listed in Appendix 3. For key question 1, only randomized population-based trials of screening with unscreened controls were included. For key question 3, only randomized clinical trials of immediate repair or ultrasound surveillance for AAAs 3.0 to 5.4 cm were included. For key questions related to harms of screening and treatment, EPC staff included studies of harms from randomized controlled trials, or retrospective or prospective cohort studies with comparative data. Disagreements on inclusion/exclusion of individual studies were resolved by consensus by obtaining the source article and examining its relevance to the key question.

NUMBER OF SOURCE DOCUMENTS

Key Question 1 (a-b): 5 articles

Key Question 2: 4 articles

Key Question 3: 2 articles

Key Question 4: 2 articles

Key Question 5: 1 article

METHODS USED TO ASSESS THE QUALITY AND STRENGTH OF THE EVIDENCE

Weighting According to a Rating Scheme (Scheme Given)

RATING SCHEME FOR THE STRENGTH OF THE EVIDENCE

The U.S. Preventive Services Task Force (USPSTF) grades the **quality of the overall evidence** for a service on a 3-point scale (good, fair, poor):

Good

Evidence includes consistent results from well-designed, well-conducted studies in representative populations that directly assess effects on health outcomes.

Fair

Evidence is sufficient to determine effects on health outcomes, but the strength of the evidence is limited by the number, quality, or consistency of the individual studies, generalizability to routine practice, or indirect nature of the evidence on health outcomes.

Poor

Evidence is insufficient to assess the effects on health outcomes because of limited number or power of studies, important flaws in their design or conduct, gaps in the chain of evidence, or lack of information on important health outcomes.

METHODS USED TO ANALYZE THE EVIDENCE

Meta-Analysis of Randomized Controlled Trials
Systematic Review

DESCRIPTION OF THE METHODS USED TO ANALYZE THE EVIDENCE

Note from the National Guideline Clearinghouse (NGC): A systematic evidence review was prepared by the Oregon Evidence-based Practice Center (EPC) for the Agency for Healthcare Research and Quality (AHRQ) for use by the U.S. Preventive Services Task Force (USPSTF) (see the "Companion Documents" field).

Data Extraction and Synthesis

EPC staff assessed the quality of included studies based on published USPSTF criteria. For each study rated "Good" or "Fair" quality, they abstracted study design, setting, population demographics, and results for primary and secondary outcomes.

To assess the benefit of population-based abdominal aortic aneurysm (AAA) screening, and immediate repair versus surveillance for moderate-sized AAAs, EPC staff pooled eligible studies to estimate the likelihood that screening reduces AAA-related death and all-cause mortality. They calculated estimates of unadjusted odds ratios with 95% confidence intervals. They assessed heterogeneity by using graphs of the outcomes and the Mantel-Haenszel chi-square test. EPC staff performed meta-analyses using a random-effects model to account for the impact of differences in study design, follow-up, or outcomes ascertainment. Statistical analyses were performed with RevMan software.

EPC staff used these pooled estimates to model the impact of AAA screening in a hypothetical population. These analyses also incorporated the rates of other AAA-related events obtained by averaging rates across all trials. They modeled upper and lower bounds for outcomes using the 95% confidence intervals from the meta-analyses and the average rates of other events.

METHODS USED TO FORMULATE THE RECOMMENDATIONS

Balance Sheets
Expert Consensus

DESCRIPTION OF METHODS USED TO FORMULATE THE RECOMMENDATIONS

When the overall quality of the evidence is judged to be good or fair, the U.S. Preventive Services Task Force (USPSTF) proceeds to consider the magnitude of net benefit to be expected from implementation of the preventive service. Determining net benefit requires assessing both the magnitude of benefits and the magnitude of harms and weighing the two.

The USPSTF classifies benefits, harms, and net benefits on a 4-point scale: "substantial," "moderate," "small," and "zero/negative."

"Outcomes tables" (similar to "balance sheets") are the USPSTF's standard resource for estimating the magnitude of benefit. These tables, prepared by the topic teams for use at USPSTF meetings, compare the condition specific outcomes expected for a hypothetical primary care population with and without use of the preventive service. These comparisons may be extended to consider only people of specified age or risk groups or other aspects of implementation. Thus, outcomes tables allow the USPSTF to examine directly how the preventive service affects benefits for various groups.

When evidence on harms is available, the topic teams assess its quality in a manner like that for benefits and include adverse events in the outcomes tables. When few harms data are available, the USPSTF does not assume that harms are small or nonexistent. It recognizes a responsibility to consider which harms are likely and judge their potential frequency and the severity that might ensue from implementing the service. It uses whatever evidence exists to construct a general confidence interval on the 4-point scale (e.g., substantial, moderate, small, and zero/negative).

Value judgments are involved in using the information in an outcomes table to rate either benefits or harms on the USPSTF's 4-point scale. Value judgments are also needed to weigh benefits against harms to arrive a rating of net benefit.

In making its determinations of net benefit, the USPSTF strives to consider what it believes are the general values of most people. It does this with greater confidence for certain outcomes (e.g., death) about which there is little disagreement about undesirability, but it recognizes that the degree of risk people are willing to accept to avert other outcomes (e.g., cataracts) can vary considerably. When the USPSTF perceives that preferences among individuals vary greatly, and that these variations are sufficient to make trade-off of benefits and harms a "close-call," then it will often assign a C recommendation (see the "Recommendation Rating Scheme" field). This recommendation indicates the decision is likely to be sensitive to individual patient preferences.

The USPSTF uses its assessment of the evidence and magnitude of net benefit to make recommendations. The general principles the USPSTF follows in making recommendations are outlined in Table 5 of the companion document cited below. The USPSTF liaisons on the topic team compose the first drafts of the recommendations and rationale statements, which the full panel then reviews and edits. Recommendations are based on formal voting procedures that include explicit rules for determining the views of the majority.

From: Harris RP, Helfand M, Woolf SH, Lohr KN, Mulrow, CD, Teutsch SM, Atkins D. Current methods of the U.S. Preventive Services Task Force: a review of the process. Methods Work Group, Third U.S. Preventive Services Task Force. Am J Prev Med 2001 Apr;20(3S):21-35.

RATING SCHEME FOR THE STRENGTH OF THE RECOMMENDATIONS

The USPSTF grades its recommendations according to one of 5 classifications (A, B, C, D, I) reflecting the strength of evidence and magnitude of net benefit (benefits minus harms):

A

The USPSTF strongly recommends that clinicians provide [the service] to eligible patients. The USPSTF found good evidence that [the service] improves important health outcomes and concludes that benefits substantially outweigh harms.

B

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

C

The USPSTF makes no recommendation for or against routine provision of [the service]. The USPSTF found at least fair evidence that [the service] can improve

health outcomes but concludes that the balance of benefits and harms is too close to justify a general recommendation.

D

The USPSTF recommends against routinely providing [the service] to asymptomatic patients. The USPSTF found at least fair evidence that [the service] is ineffective or that harms outweigh benefits.

I

The USPSTF concludes that the evidence is insufficient to recommend for or against routinely providing [the service]. Evidence that [the service] is effective is lacking, of poor quality, or conflicting and the balance of benefits and harms cannot be determined.

COST ANALYSIS

The U.S. Preventive Services Task Force review of 4 relevant cost-effectiveness studies of abdominal aortic aneurysm (AAA) yielded an estimated cost-effectiveness ratio of population-based AAA screening (compared with no screening) that is in the same range as that of other cost-effective preventive services.

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 (USPSTF) 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 systematic 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 and a final version of the systematic review before it votes on its recommendations about the service. Draft recommendations are then circulated for comment from reviewers representing professional societies, voluntary organizations, and Federal agencies. These comments are discussed before the whole USPSTF before final recommendations are confirmed.

Recommendation of Others. Recommendations for screening for abdominal aortic aneurysm from the following groups were discussed: the Society of Vascular Surgery and the Society for Vascular Medicine and Biology.

RECOMMENDATIONS

MAJOR RECOMMENDATIONS

The U.S. Preventive Services Task Force (USPSTF) grades its recommendations (A, B, C, D, or I) and the quality of the overall evidence for a service (good, fair, poor). The definitions of these grades can be found at the end of the "Major Recommendations" field.

The USPSTF recommends one-time screening for abdominal aortic aneurysm (AAA) by ultrasonography in men aged 65 to 75 who have ever smoked. **B recommendation**

The USPSTF found good evidence that screening for AAA and surgical repair of large AAAs (5.5 cm or more) in men aged 65 to 75 who have ever smoked (current and former smokers) leads to decreased AAA-specific mortality. There is good evidence that abdominal ultrasonography, performed in a setting with adequate quality assurance (i.e., in an accredited facility with credentialed technologists), is an accurate screening test for AAA. There is also good evidence of important harms of screening and early treatment, including an increased number of surgeries with associated clinically-significant morbidity and mortality, and short-term psychological harms. Based on the moderate magnitude of net benefit, the USPSTF concluded that the benefits of screening for AAA in men aged 65 to 75 who have ever smoked outweigh the harms.

The USPSTF makes no recommendation for or against screening for AAA in men aged 65 to 75 who have never smoked. **C recommendation**

The USPSTF found good evidence that screening for AAA in men aged 65 to 75 who have never smoked leads to decreased AAA-specific mortality. There is, however, a lower prevalence of large AAAs in men who have never smoked compared with men who have ever smoked; thus, the potential benefit from screening men who have never smoked is small. There is good evidence that screening and early treatment leads to important harms, including an increased number of surgeries with associated clinically-significant morbidity and mortality, and short-term psychological harms. The USPSTF concluded that the balance between the benefits and harms of screening for AAA is too close to make a general recommendation in this population.

The USPSTF recommends against routine screening for AAA in women. **D recommendation.**

Because of the low prevalence of large AAAs in women, the number of AAA-related deaths that can be prevented by screening this population is small. There is good evidence that screening and early treatment result in important harms, including an increased number of surgeries with associated morbidity and mortality, and psychological harms. The USPSTF concluded that the harms of screening women for AAA outweigh the benefits.

Clinical Considerations

- The major risk factors for AAA include age (being 65 or older), male sex, and a history of ever smoking (at least 100 cigarettes in a person's lifetime). A first-degree family history of AAA requiring surgical repair also elevates a man's risk for AAA; this may also be true for women but the evidence is less certain. There is only a modest association between risk factors for atherosclerotic disease and AAA.
- Screening for AAA would most benefit those who have a reasonably high probability of having an AAA large enough, or that will become large enough, to benefit from surgery. In general, adults younger than age 65 and adults of any age who have never smoked are at low risk for AAA and are not likely to benefit from screening. Among men aged 65 to 74, an estimated 500 who have ever smoked - or 1,783 who have never smoked - would need to be screened to prevent 1 AAA-related death in the next 5 years. As always, clinicians must individualize recommendations depending on a patient's risk and likelihood of benefit. For example, some clinicians may choose to discuss screening with male nonsmokers nearing age 65 who have a strong first-degree family history of AAA that required surgery.
- The potential benefit of screening for AAA among women aged 65 to 75 is low because of the small number of AAA-related deaths in this population. The majority of deaths from AAA rupture occur in women aged 80 or older. Because there are many competing health risks at this age, any benefit of screening for AAA would be minimal. Individualization of care, however, is still required. For example, a clinician may choose to discuss screening in the unusual circumstance in which a healthy female smoker in her early 70s has a first-degree family history for AAA that required surgery.
- Operative mortality for open surgical repair of an AAA is 4% to 5%, and nearly one-third of patients undergoing this surgery have other important complications (e.g., cardiac and pulmonary). Additionally, men having this surgery are at increased risk for impotence.
- Endovascular repair of AAAs (EVAR) is currently being used as an alternative to open surgical repair. Although recent studies have shown a short-term mortality and morbidity benefit of EVAR compared with open surgical repair, the long-term effectiveness of EVAR to reduce AAA rupture and mortality is unknown. The long-term harms of EVAR include late conversion to open repair and aneurysmal rupture. EVAR performed with older-generation devices is reported to have an annual rate of rupture of 1% and conversion to open surgical repair of 2%. The conversion to open surgical repair is associated with a peri-operative mortality of about 24%. The long-term harms of newer-generation EVAR devices are yet to be reported.
- For most men, 75 years may be considered an upper age limit for screening. Patients cannot benefit from screening and subsequent surgery unless they have a reasonable life expectancy. The increased presence of comorbidities for people aged 75 and older decreases the likelihood that they will benefit from screening.
- Ultrasonography has a sensitivity of 95% and specificity of nearly 100% when performed in a setting with adequate quality assurance. The absence of quality assurance is likely to lower test accuracy. Abdominal palpation has poor accuracy and is not an adequate screening test.
- One-time screening to detect an AAA using ultrasonography is sufficient. There is negligible health benefit in re-screening those who have normal aortic diameter on initial screening.
- Open surgical repair for an AAA of at least 5.5 cm leads to an estimated 43% reduction in AAA-specific mortality in older men who undergo screening.

However, there is no current evidence that screening reduces all-cause mortality in this population.
- In men with intermediate-sized AAAs (4.0-5.4 cm), periodic surveillance offers comparable mortality benefit to routine elective surgery with the benefit of fewer operations. Although there is no evidence to support the effectiveness of any intervention in those with small AAAs (3.0-3.9 cm), there are expert opinion-based recommendations in favor of periodic repeat ultrasonography for these patients.

Definitions:

Strength of Recommendations

The USPSTF grades its recommendations according to one of 5 classifications (A, B, C, D, I) reflecting the strength of evidence and magnitude of net benefit (benefits minus harms):

A

The USPSTF strongly recommends that clinicians provide [the service] to eligible patients. The USPSTF found good evidence that [the service] improves important health outcomes and concludes that benefits substantially outweigh harms.

B

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

C

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

D

The USPSTF recommends against routinely providing [the service] to asymptomatic patients. The USPSTF found at least fair evidence that [the service] is ineffective or that harms outweigh benefits.

I

The USPSTF concludes that the evidence is insufficient to recommend for or against routinely providing [the service]. Evidence that [the service] is effective is lacking, of poor quality, or conflicting and the balance of benefits and harms cannot be determined.

Strength of Evidence

The U.S. Preventive Services Task Force (USPSTF) grades the **quality of the overall evidence** for a service on a 3-point scale (good, fair, poor):

Good

Evidence includes consistent results from well-designed, well-conducted studies in representative populations that directly assess effects on health outcomes.

Fair

Evidence is sufficient to determine effects on health outcomes, but the strength of the evidence is limited by the number, quality, or consistency of the individual studies, generalizability to routine practice, or indirect nature of the evidence on health outcomes.

Poor

Evidence is insufficient to assess the effects on health outcomes because of limited number or power of studies, important flaws in their design or conduct, gaps in the chain of evidence, or lack of information on important health outcomes.

CLINICAL ALGORITHM(S)

None provided

EVIDENCE SUPPORTING THE RECOMMENDATIONS

TYPE OF EVIDENCE SUPPORTING THE RECOMMENDATIONS

The type of evidence supporting the recommendations is identified in the "Major Recommendations" field.

BENEFITS/HARMS OF IMPLEMENTING THE GUIDELINE RECOMMENDATIONS

POTENTIAL BENEFITS

Appropriate screening for abdominal aortic aneurysm (AAA) by ultrasonography may result in decreased AAA-specific mortality.

Subgroups Most Likely to Benefit

Screening for AAA would most benefit those who have a reasonably high probability of having an AAA large enough, or that will become large enough, to benefit from surgery.

The major risk factors for AAA include male sex, a history of ever smoking (defined in surveys as 100 cigarettes in a person's lifetime), and age 65 or older. Other lesser risk factors include family history, coronary heart disease,

claudication, hypercholesterolemia, hypertension, cerebrovascular disease, and increased height. Factors associated with decreased risk include female sex, diabetes mellitus, and black race.

POTENTIAL HARMS

There is a short-term impact of abdominal aortic aneurysm (AAA) screening on quality-of-life measures. Those testing positive for AAA initially had more anxiety and lower physical and mental health scores (measured by the Short Form-36) than those testing negative. Those who underwent surgery, compared with those receiving continued surveillance, had slightly lower Short Form-36 scores but higher self-rated health scores 3 months after surgery. These negative psychological measures returned to normal levels within 12 months after screening or surgery.

QUALIFYING STATEMENTS

QUALIFYING STATEMENTS

Recommendations made by the U.S. Preventive Services Task Force are independent of the U.S. Government. They should not be construed as an official position of the Agency for Healthcare Research and Quality or the U.S. Department of Health and Human Services.

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
Pocket Guide/Reference Cards
Tool Kits

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)

Screening for abdominal aortic aneurysm: recommendation statement. Ann Intern Med 2005 Feb 1;142(3):198-202. PubMed

ADAPTATION

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

DATE RELEASED

1996 (revised 2005)

GUIDELINE DEVELOPER(S)

United States Preventive Services Task Force - Independent Expert Panel

SOURCE(S) OF FUNDING

United States Government

GUIDELINE COMMITTEE

U.S. Preventive Services Task Force (USPSTF)

COMPOSITION OF GROUP THAT AUTHORED THE GUIDELINE

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**Members of the USPSTF 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 and evidence-based practice center (EPC) staff disclose at each meeting if they have an important financial conflict for each topic being discussed. Task Force members and EPC staff with conflicts can participate in discussions about evidence, but members abstain from voting on recommendations about the topic in question.

From: Harris RP, Helfand M, Woolf SH, Lohr KN, Mulrow, CD, Teutsch SM, Atkins D. Current methods of the U.S. Preventive Services Task Force: a review of the process. Methods Work Group, Third U.S. Preventive Services Task Force. Am J Prev Med 2001 Apr;20(3S):21-35.

GUIDELINE STATUS

This is the current release of the guideline.

This version updates a previously published guideline: U.S. Preventive Services Task Force. Guide to clinical preventive services. 2nd ed. Baltimore (MD): Williams & Wilkins; 1996. Chapter 6, Screening for abdominal aortic aneurysm. p. 67-72.

GUIDELINE AVAILABILITY

Electronic copies: Available from the U.S. Preventive Services Task Force (USPSTF) Web site. Also available from Annals of Internal Medicine Online.

Electronic copies: Available from the U.S. Preventive Services Task Force (USPSTF) Web site.

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:

- Meenan RT, Fleming C, Whitlock EP, Beil TL, Smith P. Cost-effectiveness analyses of population-based screening for abdominal aortic aneurysm: evidence summaries. Portland (OR); Agency for Healthcare Research and Quality (AHRQ); 2005. 23 p.

  Electronic copies: Available from the U.S. Preventive Services Task Force (USPSTF) Web site.

- Fleming C, Whitlock E, Beil T, Lederle F. Screening for abdominal aortic aneurysm: a best-evidence systematic review for the U.S. Preventive Services Task Force. Rockville (MD); Agency for Healthcare Research and Quality (AHRQ); Ann Intern Med 2005 Feb 1; 142(3):203-11.

  Electronic copies: Available from the U.S. Preventive Services Task Force (USPSTF) Web site. Also available from Annals of Internal Medicine Online.

- Fleming C, Whitlock EP, Beil T, Lederle FA. Primary care screening for abdominal aortic aneurysm: systematic evidence synthesis. Rockville (MC); Agency for Healthcare Research and Quality (AHRQ); 2005 Feb. 59 p.

  Electronic copies: Available from the U.S. Preventive Services Task Force (USPSTF) Web site.

Background Articles:

- Woolf SH, Atkins D. The evolving role of prevention in health care: contributions of the U.S. Preventive Services Task Force. Am J Prev Med 2001 Apr;20(3S):13-20.
- Harris RP, Helfand M, Woolf SH, Lohr KN, Mulrow, CD, Teutsch SM, Atkins D. Current methods of the U.S. Preventive Services Task Force: a review of the process. Methods Work Group, Third U.S. Preventive Services Task Force. Am J Prev Med 2001 Apr;20(3S):21-35.
- Saha S, Hoerger TJ, Pignone MP, Teutsch SM, Helfand M, Mandelblatt JS. The art and science of incorporating cost effectiveness into evidence-based recommendations for clinical preventive services. Cost Work Group of the Third U.S. Preventive Services Task Force. Am J Prev Med 2001 Apr;20(3S):36-43.

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

The following are also available:

- The guide to clinical preventive services, 2006. Recommendations of the U.S. Preventive Services Task Force. Rockville (MD): Agency for Healthcare Research and Quality (AHRQ), 2006. 228 p. Electronic copies available from the AHRQ Web site.
- A step-by-step guide to delivering clinical preventive services: a systems approach. Rockville (MD): Agency for Healthcare Research and Quality (AHRQ), 2002 May. 189 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 is available:

- The pocket guide to good health for adults. Rockville (MD): Agency for Healthcare Research and Quality (AHRQ); 2003.

  Electronic copies: Available from the U.S. Preventive Services Task Force (USPSTF) Web site. Copies also available in Spanish from the USPSTF Web site.

  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).

- Screening for abdominal aortic aneurysm: recommendations from the U.S. Preventive Services Task Force. Ann Intern Med 2005 Feb 1;142(3);I-52.

  Electronic copies: Available from the Annals of Internal Medicine Online 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.

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