Women Older Than 64 Years

Abdominal Examination
Alcohol Misuse
Anemia
Bacteriuria
Blood Pressure Screening
Breast Awareness
Breast Cancer, Chemoprevention
Breast Cancer Screening
Breast Examination
Cardiovascular Disease/Dyslipidemia
Cervical Cancer Screening and Prevention
Colorectal Screening
Depression
Diabetes
Diet, Fitness, Nutrition
Domestic and Intimate Partner Violence
Drug Use
Genetic Screening
Hearing
Hepatitis B Screening
Hepatitis C Screening
Hypothyroidism
Immunizations
Injury Prevention
Kidney Disease
Mental Health and Psychosocial Issues/ Suicide/Behavioral Assessment
Obesity
Oral Cavity Examination
Oral Hygiene
Osteoporosis
Ovarian Cancer
Pelvic Examination
Pelvic Floor Disorders (50+)
Sexual Health
Sexually Transmitted Infections
Skin Cancer
Sleep Disorders
Tobacco Use
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
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 of 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
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 individuals 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 individuals engaged in risky or hazardous drinking with brief behavioral counseling interventions to reduce alcohol misuse.[4]	AAFP: Recommends screening and behavioral counseling interventions in primary care settings to reduce alcohol misuse.[5] ACOG: Recommends screening by questionnaire, history, or both, but not by testing, at least yearly.[6]	

TOPIC: ANEMIA

Final WWTF Recommendation	Evidence Based	Evidence Informed	Uniform Expert Agreement
Adolescents and 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).[7]	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
Adults (65 years and older)			
Screening for bacteriuria in asymptomatic women is not recommended. (Strong)	USPSTF: Recommends against screening for asymptomatic bacteriuria in nonpregnant women.[8]		There is evidence of harm resulting from treatment of asymptomatic bacteriuria in nonpregnant women. Recommend following USPSTF guidelines.

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.[9]		

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).[10,11] 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.[12]	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.[13] NCCN: Breast awareness is encouraged.[14] ACS: Starting at age 20 years, women should be counseled on the benefits and limitations of breast self-examination.[15]	

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 for adverse medication effects, clinicians should offer to prescribe risk-reducing medications, such as tamoxifen or raloxifene (Grade B).[16]	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 of breast cancer about medications to reduce their risk. For women who are at increased risk for breast cancer and at low risk of adverse medication effects, clinicians should offer to prescribe risk-reducing medications, such as tamoxifen or raloxifene.[17]	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)**	**Ages 50–74 years** USPSTF: Recommends biennial screening mammography for women between the ages of 50 years and 74 years (Grade B).[18] **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.[18]	ACOG: Women aged 40 years and older should have annual mammograms.[13] 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.[19] 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.[20] 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 years, 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).[21] 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.[22]	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."[18] 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."[23]

TOPIC: BREAST EXAMINATION

Final WWTF Recommendation	Evidence Based	Evidence Informed	Uniform Expert Agreement
Adults (all women)			
Clinical breast examination 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 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.[18]	ACOG: Clinical breast examination should be performed every 1–3 years for women aged 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 years 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.[13] AAFP: Current evidence is insufficient to assess the benefits and harms of clinical breast examination for women aged 40 years and older.[19] 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.[24] 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.[25,26] CTFPHC: Recommends not routinely performing clinical breast examinations alone or in conjunction with mammography to screen for breast cancer (Weak recommendation; low-quality evidence).[27] 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.[28] 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 adherence to follow-up.[12] 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.[29]	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.

TOPIC: CARDIOVASCULAR DISEASE/DYSLIPIDEMIA

Final WWTF Recommendation	Evidence Based	Evidence Informed	Uniform Expert Agreement
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).[30]		
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).[31]		

TOPIC: CERVICAL CANCER SCREENING AND PREVENTION

Final WWTF Recommendation	Evidence Based	Evidence Informed	Uniform Expert Agreement
Adults Screening/Testing (older than 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 is not recommended for women older than 65 years who have had adequate prior screening with negative results. (Strong) **Routine screening for at least 20 years is recommended for women with a history of cervical intraepithelial neoplasia (CIN) 2 or 3 or a more severe diagnosis. (Strong)**	USPSTF: Recommends against screening for cervical cancer in women older than age 65 years who have had adequate prior screening and are not otherwise at high risk of 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).[32] ACS/ASCCP/ASCP: Screening is not recommended following adequate negative prior screening. Women with a history of CIN 2 or a more severe diagnosis should continue routine screening for at least 20 years.[33]	ACOG: Discontinue screening in women older than 65 years with evidence of adequate negative prior screening and no history of CIN 2 or a more severe CIN diagnosis.[34] AAFP: Do not screen women 65 and older who have had adequate prior screening and are not otherwise at high risk of cervical cancer[35]	

TOPIC: COLORECTAL SCREENING

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.[36]	
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.[37]	ACP: All adults at average risk of colorectal cancer should be screened.[36] ACG: Screening should start at age 50 years. For African Americans, begin screening age 45 years.[38] 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 testing 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.[37]	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.[39] ACP: The following methods of screening are recommended:[36] 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:[38] Flexible sigmoidoscopy every 5–10 years Computed tomography colonography every 5 years Cancer detection test (fecal immunochemical test for blood)	
Adults (76 years and older)			
Individualized assessment of risk, including family history and individualized counseling, is recommended. (Strong)		ACP: Individualized assessment for risk of colorectal cancer is recommended.[36]	
Routine screening is not recommended for women aged 75–85 years, but individual considerations may support screening in some patients following shared, informed decision-making. (Strong) **Screening is not recommended for women older than 85 years. (Strong)**	USPSTF: Routine screening is not recommended for those aged 76 to 85 years. There may be considerations to support screening in individual patients. Screening is not recommended in adults older than 85 years.[37]	ACP: Do not screen women older than 75 years or with a life expectancy of less than 10 years.[36] AAFP: There may be considerations that support colorectal cancer screening in an individual patient. Do not screen patients over age 85 years.[39]	
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.[36]	
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 antiinflammatory drugs to prevent colorectal cancer in individuals at risk of colorectal cancer.[39]	
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.[39] 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.[38]	

TOPIC: DEPRESSION

Final WWTF Recommendation	Evidence Based	Evidence Informed	Uniform Expert Agreement
Adults (19 years and older) (See also Mental Health and Psychosocial Issues/Suicide/Behavioral Assessment; Sleep Disorders)			
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).[40] Recurrent 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).[40]	AAFP: Do not screen when staff-assisted depression care supports are not in place. Screen when staff-assisted depression care supports are in place to assure accurate diagnosis, effective treatment, and follow up.[41] ACOG: Evaluate and counsel women for suicide and depressive symptoms. Recommends screening in practices that have systems in place to ensure accurate diagnosis, effective treatment, and follow up.[2] 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.[42]	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
Adults (Women of Reproductive Age; Perimenopause/Menopause) *(See also Cardiovascular Disease/Dyslipidemia; 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 130/85 mm Hg.[43]	AAFP: Screen asymptomatic adults with sustained blood pressure (either treated or untreated) greater than 135/80 mm Hg.[44] ACOG: Begin screening every 3 years beginning at age 45 years, more frequently if risk factors are present.[2] American Diabetes Association: Begin screening every 3 years beginning at age 45 years, more frequently if risk factors are present.[45] AACE: Begin screening at age 30 years.[46]	Currently there is no expert consensus.

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)			
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.[47]	ACOG: 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.[2] 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.[48]	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
Adults (all ages)			
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.[49]	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). 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.[50,51] AAFP: There is insufficient evidence to assess the benefits and harms of screening elderly and vulnerable adults for abuse and neglect (Grade I).[52]	

TOPIC: DRUG USE

Final WWTF Recommendation	Evidence Based	Evidence Informed	Uniform Expert Agreement
Adults (all ages)			
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).[53]	ACOG: Evaluate and counsel on substance use other than alcohol and tobacco.[2] AAFP: Current evidence is insufficient to assess the balance of benefits and harms of screening adolescents, adults, and pregnant women for illicit drug use.[54] 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).[55]	

TOPIC: GENETIC SCREENING (as appropriate)

Final WWTF Recommendation	Evidence Based	Evidence Informed	Uniform Expert Agreement
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 for 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 for potentially harmful mutations in *BRCA1* or *BRCA2* genes. Women with positive screening results should receive genetic counseling and, if indicated, *BRCA* testing (Grade B).[56]	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.[57] 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.[58] AAFP: Recommends referral for genetic counseling and evaluation for *BRCA* testing for women whose family history is associated with an increased risk for deleterious mutations in *BRCA1* or *BRCA2*.[19]	
Routine genetic counseling or *BRCA* testing is not recommended for women who do not have a personal or family history associated with an increased risk for potentially harmful 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).[56]	AAFP: 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 mutation in *BRCA1* or *BRCA2*.[19]	
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 for cardiovascular disease.[59] EGAPP: There is insufficient evidence to recommend testing for the 9p21 genetic variant or 57 other variants in 28 genes to assess risk for 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.[60]	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.[61]	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.[62]	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).[63]		

TOPIC: HEPATITIS C SCREENING

Final WWTF Recommendation	Evidence Based	Evidence Informed	Uniform Expert Agreement
Adolescents and Adults (all ages)			
Screening for HCV infection is recommended for women at high risk of 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).[63]	AAFP: 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.[64] 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 infection without prior ascertainment of HCV risk factors. Recommends routine testing of asymptomatic persons at high risk of HCV infection.[65,66]	

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 fair 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.[67]	AAFP: The evidence is insufficient to recommend for or against routine screening for thyroid disease in adults. Ultrasound screening for thyroid cancer in asymptomatic patients is not recommended.[68] ACOG: In 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 years.[2] AACE/ATA: Screening for hypothyroidism should be considered in patients older than 60 years. "Aggressive case finding" (rather than universal screening) should be considered in those at increased risk of hypothyroidism.[69]	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.
Screening for hypothyroidism is recommended in symptomatic and high-risk patients. (Strong)		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 deficiency), 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)*			
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.[71,72]		Recommend following ACIP guidelines for all immunizations.

TOPIC: INJURY PREVENTION

Final WWTF Recommendation	Evidence Based	Evidence Informed	Uniform Expert Agreement
Adults (65 years and older) (See also Domestic and Intimate Partner Violence)			
Clinicians should recommend exercise or physical therapy and vitamin D supplementation to prevent falls in community-dwelling adults aged 65 years or older who are at increased risk of falls. (Strong)	USPSTF: Recommends exercise or physical therapy and vitamin D supplementation to prevent falls in community-dwelling adults aged 65 years or older who are at increased risk of falls. There is insufficient evidence for or against vision correction, medication discontinuation, protein supplementation, education or counseling, and home hazard modification (Grade B).[70]		
Automatically performing an in-depth multifactorial risk assessment in conjunction with comprehensive management of identified risks to prevent falls in community-dwelling adults aged 65 years or older is not recommended because the likelihood of benefit is small. Individual factors such as history and circumstances of prior falls and comorbidities should be considered In determining whether this service is appropriate in individual cases. (Qualified)	USPSTF: Recommends against automatically performing an in-depth multifactorial risk assessment in conjunction with comprehensive management of identified risks to prevent falls in community-dwelling adults aged 65 years or older because the likelihood of benefit is small. In determining whether this service is appropriate in individual cases, patients and clinicians should consider the balance of benefits and harms on the basis of the circumstances of prior falls, comorbid medical conditions, and patient values (Grade C).[70]		Recommend following the USPSTF approach and individualizing assessment.

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.[73]	ACP: Recommends against screening for chronic kidney disease in asymptomatic adults without risk factors.[74] ASN: Strongly recommends screening even in the absence of risk factors.[75] NKF: Recommends screening for at-risk individuals aged 18 years or older (risks include diabetes, hypertension, family history of kidney disease).[76]	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
Adults (65 years and older) (See also Depression, Domestic and Intimate Partner Violence, Sleep Disorders)			
Routine screening of asymptomatic adults aged 65 years and older for dementia is not recommended. (Strong)	USPSTF, AHRQ: The evidence is insufficient to recommend for or against routine screening for dementia in older adults.[77,78]		
Screening adults aged 65 years and older for mild cognitive impairment is recommended. Refer those with signs of mild cognitive impairment for memory assessment services to aid in early identification of dementia. (Strong)	NICE: Primary health care staff should consider referring people who show signs of mild cognitive impairment for assessment by memory assessment services to aid early identification of dementia, because more than 50% of people with mild cognitive impairment later develop dementia. Mild cognitive impairment is a syndrome defined as cognitive decline greater than expected for an individual's age and education level, which does not interfere notably with activities of daily living. It is not a diagnosis of dementia of any type, although it may lead to dementia in some cases.[79]		
Evaluation of psychosocial aspects of health (interpersonal and family relationships, intimate partner violence, work satisfaction, lifestyle and stress, sleep disorders [all women]; 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, lifestyle and stress, sleep disorders, advance directive, neglect and abuse, depression, and family relationships.[2]	

TOPIC: OBESITY

Final WWTF Recommendation	Evidence Based	Evidence Informed	Uniform Expert Agreement
		Adults (all ages) *(See also Cardiovascular Disease/Dyslipidemia; Diet, Fitness, Nutrition)*	
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).[80]	AAFP: Refer patients with BMI of 30 or higher to intensive, multicomponent behavioral interventions (Grade B).[81] ACOG: Determine BMI and evaluate and counsel on physical activity, dietary and nutrition assessment, and obesity as cardiovascular risk factors.[2]	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.[82]	ACS: Physicians should examine the mouth and throat during routine cancer-related check-ups.[83] ADA: Clinicians should remain alert for signs of malignancy when performing routine visual and tactile examination of dental patients.[84]	There is insufficient evidence to recommend a distinct oral cavity examination.

TOPIC: ORAL HYGIENE

Final WWTF Recommendation	Evidence Based	Evidence Informed	Uniform Expert Agreement
		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: OSTEOPOROSIS

Final WWTF Recommendation	Evidence Based	Evidence Informed	Uniform Expert Agreement
		Adults (65 years and older)	
Screening for osteoporosis in women aged 65 years or older is recommended. (Strong)	USPSTF: Recommends screening for osteoporosis in women aged 65 years or older and in younger women whose fracture risk is equal to or greater than that of a 65-year-old white woman who has no additional risk factors (B Recommendation).[85]	AAFP: Recommends screening for osteoporosis in women aged 65 years or older and in younger women whose fracture risk is equal to or greater than that of a 65-year-old white woman who has no additional risk factors.[86] ACOG: Bone density screening for women should begin at age 65 years. Dual-energy X-ray absorptiometry screening can be used selectively for women younger than age 65 years if they are postmenopausal and have other significant risk factors for osteoporosis or fracture.[87] ACP: Follow USPSTF guidelines.[85]	

TOPIC: OVARIAN CANCER

Final WWTF Recommendation	Evidence Based	Evidence Informed	Uniform Expert Agreement
		Adults (Women of Reproductive Age; Perimenopause/Menopause) *(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.[88]	AAFP: The USPSTF recommends against routine screening for ovarian cancer.[89] 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.[90]	
		Women at High Risk	
Women with *BRCA1* or *BRCA2* mutations or hereditary nonpolyposis colorectal cancer should be offered risk-reducing surgery. (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)**	USPSTF: Interventions that may reduce risk of 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 the types of interventions.[88]	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 years and 40 years if childbearing is no longer desired.[58] NCCN: For those patients who elect not to have risk-reducing salpingo-oophorectomy, consider concurrent transvaginal ultrasound (preferably between day 1 and day 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.[91]	

TOPIC: PELVIC EXAMINATION

Final WWTF Recommendation	Evidence Based	Evidence Informed	Uniform Expert Agreement
		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: PELVIC FLOOR DISORDERS (50+)

Final WWTF Recommendation	Evidence Based	Evidence Informed	Uniform Expert Agreement
		Adults (50 years and older)	
For women 50 years and older, screening for urinary and fecal incontinence is recommended. (Qualified)	CDC: Health care providers should routinely ask patients aged 65 years and older about urinary incontinence.[92]	WHO: All women aged 50 years and older should be screened for urinary incontinence.[93] ACOG: Functional assessment of the elderly woman includes evaluation of bowel and bladder function.[2] For all adults aged 18 years and older, screening history of urinary and fecal incontinence is recommended.[2] AMA/CCP/NCQA: Recommend assessment of presence or absence of urinary incontinence in women aged 65 years or older.[94]	Health care providers should routinely ask patients aged 65 years and older about urinary incontinence.[92] Urinary and fecal incontinence has profound effects on quality of life and is associated with depression and anxiety, work impairment, social isolation, and sexual dysfunction.

TOPIC: SEXUAL HEALTH

Final WWTF Recommendation	Evidence Based	Evidence Informed	Uniform Expert Agreement
		Adults (all ages)	
Address sexual health and sexuality as part of every annual comprehensive health assessment. **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.[95] ACOG: Obtain a sexual history if women present with a potential sexual problem.[96]	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.[97] Patients, regardless of age, want to discuss sexual health issues with their providers.[98]

TOPIC: SEXUALLY TRANSMITTED INFECTIONS
(*See also* Alcohol Misuse, Sexual Health)

Final WWTF Recommendation	Evidence Based	Evidence Informed	Uniform Expert Agreement
		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 of STIs.[99] CDC: Health care providers should routinely and regularly obtain sexual histories from their patients and address management of risk reduction for STIs.[100,101]		
		Adults (all ages) Method	
Women who use contraceptive methods other than condoms should be counseled about the use of condoms and the risk of STIs. (Strong)	CDC: Consistent and correct use of the male latex condom reduces the risk of STIs. When a male condom cannot be used properly for infection prevention, a female condom should be considered.[102]		

TOPIC: SKIN CANCER

Final WWTF Recommendation	Evidence Based	Evidence Informed	Uniform Expert Agreement
	Adults (19 years and older)		
Routine whole-body skin examination or patient skin self-examination for detection of skin cancers is not recommended. (Strong) **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 screening for skin cancer by primary care clinicians or by patient skin self-examination.[105] USPSTF: Current evidence is insufficient to assess the balance of benefits and harms of counseling adults older than 24 years about minimizing exposure to prevent skin cancer (Grade I).[106]	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).[107] AAFP: There is insufficient evidence to assess benefits and harms of counseling adults older than 24 years (Grade I).[107]	

TOPIC: SLEEP DISORDERS

Final WWTF Recommendation	Evidence Based	Evidence Informed	Uniform Expert Agreement
	Adults (65 years and older) (See also Depression)		
Assessment for sleep disorders is recommended as part of depression screening or evaluation of other psychosocial issues. (Qualified)		ACOG: Recommends assessing for sleep disorders as part of an assessment for depression in those 65 years and older and "psychosocial issues" for those of other ages.[1]	The 2006 IOM report "Sleep Disorders and Sleep Deprivation: An Unmet Public Health Problem" focuses on research needs.[108]

TOPIC: TOBACCO USE

Final WWTF Recommendation	Evidence Based	Evidence Informed	Uniform Expert Agreement
	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).[42] 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).[109]	AAFP: Strongly recommends counseling to smoking parents with children in their care regarding the harmful effects of smoking on children's health. Screen for tobacco use and provide tobacco cessation interventions for those who use tobacco products (Grade A).[110] ACOG: Recommends annual screening for tobacco use, evaluation and counseling but the intensity and intensity of such interventions should take place are not specified.[1]	

TOPIC: VISUAL ACUITY/GLAUCOMA

Final WWTF Recommendation	Evidence Based	Evidence Informed	Uniform Expert Agreement
	Adults (65 years and older)		
Routine screening by primary care providers for visual acuity in adults aged 65 years and older is not recommended. (Qualified)	USPSTF: Current evidence is insufficient to assess the balance of benefits and harms of screening for vision acuity for the improvement of outcomes in older adults (aged 65 years of older).[111]	ACOG: Recommends evaluation and counseling.[1] AAFP: There is insufficient evidence to assess the benefits and harms of screening for visual acuity for the improvement of outcomes in older adults.[48]	

Abbreviations: AAFP, American Academy of Family Physicians; AAP, American Academy of Pediatrics; AAPD, American Academy of Pediatric Dentistry; ACIP, Advisory Committee on Immunization Practices; ACNMGG, American College of Medical Genetics and Genomics; ACNM, American College of Nurse-Midwives; ACOG, The American College of Obstetricians and Gynecologists; ACP, American College of Physicians; ACS, American Cancer Society; ACSCP, 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; CTFPH, Canadian Task Force on Preventive Health Care; HCV, hepatitis C virus; HIV, human immunodeficiency virus; HPHB, National Healthy Mothers, Healthy Babies Coalition; HPV, human papillomavirus infection; IOM, Institute of Medicine; IUD, intrauterine device; NCCN, National Comprehensive Cancer Network; NDSS, National Down Syndrome Society; NIH, National Institutes of Health; PCMHC, Preconception Health and Health Care; PHLI, U.S. Public Health Service; STD, sexually transmitted disease; STI, sexually transmitted infection; USPSTF, United States Preventive Services Task Force; WHO, World Health Organization; WWTF, Well Woman Task Force.

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