Update in Prevention Guidelines
Evidence-Based approach to the Adult Wellness Visit

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Outline of talk

• Review rationale for prevention measures
• Review some specific recommendations
• Discuss prevention considerations with respect to the aging patient
• Discuss *how to discuss* screening and prevention!
First, a question for you...

• True or false?
• Annual “wellness visits” by physicians improve patient outcomes
  A. True
  B. False
A conundrum!

- **Mehotra & Prochazka:**
  - NO evidence of any morbidity or mortality reduction
  - Comprehensive physical exam, routine labs find insignificant abnormalities
  - Cumulatively costs >$10 billion annually
  - Crowds out other visits on the physician’s schedule, access more difficult
  - Waste of patient time
  - Most prevention gets ordered at other visits
  - $ could instead promote chronic care management or health coaching

- **Goroll:**
  - Provides time to develop a trusted physician-patient relationship
  - Elicit & Review a person’s values & health care preferences
  - Patients value the visit
  - “Laying on of hands” – communicates caring, builds trust
  - Ideally much of the ordering and data review should be done by staff

So what about prevention?

Primum non nocere
Principles of a *good* preventive intervention

- REMEMBER SCREENING TESTS ARE IN ASYMPTOMATIC PEOPLE
- Low cost
- Simple, Safe, Socially Acceptable
- Tests should be sensitive and specific for the condition
- Condition must be relatively frequent & threaten life & wellness
  - Early treatment must be effective
Which Tumor is Best Suited for Screening?

Screen Detection Capability Based on Tumor Biology and Growth Rates


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Case in point: South Korea
Widespread screening found lots of cancer ...

But finding cancer early didn’t save lives ...

A cautionary tale

• Thyroid cancer is now the most common cancer in S Korea
• Post op Complications:
  – 11% of pts hypoparathyroidism
  – 2 % vocal cord paralysis
• In U.S., thyroid ca detection has more than doubled in the past 2 decades
• “All it takes to expose this reservoir is ultrasound screening”
Whose guideline is it?
USPSTF updates

• New items...
  – “B” recommendation for hep C screening in ALL adults ages 18-79 *(draft)*
  – “B” recommendation for illicit drug use WHEN services are available *(draft)*
  – “D” – AGAINST routine screening for pancreatic ca
  – “A” for screening for HIV in all people ages 15-65
  – “A” for prescribing PrEP (pre-exposure prophylaxis) for high risk
  – “B” for screening for unhealthy alcohol use in primary care settings in adults >18 AND providing brief behavioral counseling

• Oldies but goodies ...
  – Breast
  – Colon
  – Etc....
DO screen all adults for Hep C ... (USPSTF DRAFT statement)

• Prevalence is increasing in younger people
• Baby boomers are aging
• Cases of acute HCV infection have increased 3.5 fold in past decade, esp. among young whites in rural areas
• Prevalence among women 15-44 increasing
• 68% increase in infants born with HCV ... 1700 annually in US
• Oral Direct-Acting Antiviral regimens of shorter duration, higher rates of response, fewer harms

USPSTF Draft statement, 2019 – You can comment through Sept 23
Do Screen for illicit drug use (age >18), including nonmedical use of prescription drugs

• Variety of quick validated questionnaires
  – SUBS (substance use brief screener) – self-screener tests – 4 questions or longer (>3 days, >2 days, never in past 12 months)
• Can refer (or prescribe) naloxone, buprenorphine, methadone (if indicated) and/or refer to supportive counseling
• Lack of evidence about how frequently, though NIDA recommends re-screening in cases of accidents, injuries, mood disorders.
• “I” recommendation for <18

DRAFT COMMENTS – expired Sept. 9.
DON’T screen for Pancreatic Ca

• 3d most common cause of cancer death in the U.S.
  – Overall, still a rare cancer
  – Most cases detected at an advanced stage
    • 5-yr survival: Localized: 37.4%; Regional 12.5%; distant mets: 2.9%; overall 9.3%
• 56,770 diagnosed annually, 45,750 die annually in U.S.
  – 85-90% lack familial risk
• Lack of data on imaging-based methods in general population
  – Risk of precursor lesions progressing to invasive lesions unclear
  – Even among high-risk, most lesions detected on screening weren’t cancer
• No accurate, validated biomarkers for early detection
• Pancreatectomy has significant morbidity and mortality
  – 30-day mortality rate about 4%

DO screen for HIV

- 1.1 million people in US live w HIV; >38,000 dx annually
  - 15% of people with HIV are unaware
  - “Unaware infected” account for 40 % of transmission
  - 8700 women w HIV give birth annually

- Current tests are highly accurate

- Early treatment leads to substantial benefit in risk of spread both to sex partners and to infants

- Also reduces the risk of AIDS-related infection and death

- ART does have some harms – overall magnitude small
  - Neuropsychiatric (10% - nausea or H/A in the first month)
  - Renal (usually reversible)
  - Hepatic
Do you prescribe pre-exposure prophylaxis for patients at high risk?

A. Yes, routinely
B. Yes, occasionally
C. No
Do prescribe PrEP for high-risk

- Tenofovir/emtricitabine; one tb QD, #30, 2 Refills
- High Risk includes:
  - MSM, sexually active, AND: HIV + partner; inconsistent condom use; STI (GC/chlamydia, syphilis) in past 6 mos
  - Heterosexually active women & men AND: HIV + partner; inconsistent condom use w high risk partner; STI w syphilis or GC
  - People who inject drugs AND: share or above
  - Transactional sex (for $, , ) with above risks
- Note condom use risk by 80 % but often is inconsistent
PrEP

- **1-888-448-4911**
- *Before* prescribing: HIV, kidney fxn, hep B & C, STI’s, ♂
- CAN’T give if:
  - HIV +;
  - Creatinine Clearance <60mL/min
  - Possible HIV exposure w/in past 72 hours
- MUST counsel patient; follow up at least Q 3 months
- Ideally call after a week
- PrEP line: 1-855-448-7737
- [http://nccc.ucsf.edu/clinician-consultation](http://nccc.ucsf.edu/clinician-consultation)
DO screen for unhealthy alcohol use

- 2006-2010: 88,000 alcohol-attributable deaths
- 7.8 % of men, 4.2 % of women meet criteria for alcohol use disorder
- “Risky” use:
  - >4 drinks/day or 14/wk for men
  - >3/day or 7/wk for women or >65
  - Standard drink: 12 oz of beer (5%) EtOH; 5 oz of wine (12%), 1.5 oz liquor (40%)
  - Any EtOH use is unhealthy in pregnant women and teens.
HOW should we screen?

• Screening tests:
  – CAGE: only detects dependence, not full spectrum of unhealthy use
  – AUDIT-C (alcohol use disorders identification test-consumption)
    • Frequency, Amount, Occasions (>6)
    • Used at the VA

  – Single Alcohol Screening Question (SASQ)
    • “How many times in the past year have you had 5 [for men] or 4 [for women & >65] or more drinks in a day?”

• Brief behavioral counseling associated with unhealthy use
Cervical Cancer Screening

(Aug 2018)

- **Ages 21-29**: cytology (pap) alone q 3 years
- **Ages 30-65**: 3 options:
  - Cytology alone q 3 years OR
  - HPV alone q 5 years *(new!)*
  - HPV plus cytology q 5 years
- <21: NO – D recommendation
- > 65: **NO** – IF adequate prior screening & NOT high risk
- S/P TAH for benign purposes: **NO**
- Does NOT apply to immunocompromised (HIV), hx high-grade lesions, hx cervical ca, DES
- “Adequate” prior screening: 3 neg cytology OR 2 neg HPV+cytology w/in 10 years before stopping screening w most recent w/in 5 years
- IF have a precancerous lesion need to continue routine screening for 20 yrs.
Breast Cancer Screening in AVERAGE risk:
(Annals of Internal Med, Jan 12, 2016)

- B recommendation for screening every other year ages 50-74
  - Note: benefits are small
- C recommendation for women ages 40-49
  - Doesn’t mean don’t screen; tailor to patient wishes
- I recommendation for >75
- I for digital breast tomosynthesis
  - Reduced Recall Rate, no apparent changes in stage of diagnosis
- I for supplemental screening in women with dense breasts
- Note: ACOG, Am College of Radiology recommend annual, >40
Do you offer risk-reducing medications to women at increased risk of breast cancer?

1. Yes
2. No
Medication to Reduce Breast Cancer Risk (Draft, 2019)

• **B** rec to offer it to women at ↑ risk for cancer, ↓ risk for adverse events
• **D** (against) offering it to women *not* at ↑ risk
• ↑ risk of breast cancer: no specific model endorsed
• Note *only* reduces risk of ER, PR + cancer
• **Med Risks:**
  – *Raloxifene*: hot flashes, DVT (benefit: increased vertebral BMD)
  – *Aromatase inhibitors*: potential small increase risk of CVA, CAD, fractures; not FDA approved for this indication
>1.66% 5-year predicted risk
The “Katie” Effect …
Colorectal Cancer Screening for average risk:

• **A** recommendation for ages 50-75
• **C** recommendation >75
  • Should be healthy enough to undergo treatment
  • No comorbid conditions limiting life expectancy
• American Cancer Society:
  • Start regular screening at age 45, through 75

• Am Coll Gastroenterology:
  • **IF Family hx** colon ca OR adenomatous polyps <60: age 40 or 10 yrs prior to dx
  • COLONOSCOPY

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<table>
<thead>
<tr>
<th>Family History</th>
<th>Risk of LRR (vs. general population)</th>
<th>Recommendations</th>
</tr>
</thead>
<tbody>
<tr>
<td>One first-degree relative with CRC or advanced adenoma diagnosed before 60 years of age, or two first-degree relatives diagnosed at any age</td>
<td>Three- to fourfold</td>
<td>Start screening colonoscopy at 40 years of age or 10 years younger than the earliest diagnosis in the patient’s family, whichever comes first; colonoscopy should be repeated every five years</td>
</tr>
<tr>
<td>One first-degree relative with CRC or advanced adenoma diagnosed at 60 years or older, or two second-degree relatives with CRC</td>
<td>Two- to threefold</td>
<td>Start screening colonoscopy at 40 years of age; colonoscopy should be repeated every 10 years</td>
</tr>
<tr>
<td>One second- or third-degree relative with CRC</td>
<td>1.5-fold</td>
<td>Average-risk screening (e.g., start at 50 years of age)</td>
</tr>
</tbody>
</table>

CRC = colorectal cancer

*First-degree relatives include parents, siblings, and children. Second-degree relatives include grandparents, aunts, and uncles. Third-degree relatives include great-grandparents and cousins.*
HOW TO SCREEN?

• FOR AVERAGE RISK

• Several screening strategies are acceptable
  • gFOBT, FIT annually
  • FIT-DNA 1 or 3 years
  • Colonoscopy q 10 years
  • CT Colonography q 5 y
  • Flex Sig q 5 yrs
  • Flex sig every 10 plus annual FIT
Prostate Cancer Screening (May, 2018)

• **USPSTF:**
  - **C recommendation** for men ages 55-69 “individual decision”
    - “*Potential benefit*” of reduction of prostate ca death
      - May prevent 3 cases of metastatic prostate ca per 1000 men screened
    - BUT significant potential harms of screening
  - **Ages >70**: Recommend **AGAINST** (D recommendation)
    - Increased risk of overdiagnosis
    - Post-radical prostatectomy:
      - 20% develop long-term urinary incontinence requiring pads
      - 2/3 develop long-term erectile dysfunction
    - **XRT:**
      - >50% develop long-term erectile dysfunction
      - 1/6: long-term bowel symptoms: fecal urgency, incontinence
  - LACK of DATA regarding screening in men w family hx

• **AUA**: men 55-69 should be informed of benefits & harms
  - Engage in *shared decision-making*
Immunizations ... CDC:

- **Flu** – all adults, annually
- **Recombinant Zoster**: 2 doses if older than 50
- **HPV**: for women, up to 26; for men, up to 21; MSM to age 26 (note – FDA-approved until 45)
- **PCV 13** for >65 or immunocomp, *then* **PPSV 23** if indicated
- **MMR**: health care personnel born >1957 w no evidence of immunity: 2 dose series at least 4 wks apart
- **Hep A**: Homeless need it routinely – 2 doses
- **Hep B** – Diabetics Ages 19-60 as soon as diagnosis is made
What about older people?

- Depends on co-morbid condition and general functioning.
- Most major screening trials *excluded* this group.
- Some cancers are more common with age, some less common.
- Benefits of screening are delayed.
  - Cervical cancer >5-10 y
  - Prostate Ca >7-10 y
  - Colon Ca > 5-10 Y
  - Breast Ca >4-5 y; may be longer w less aggressive ca
- Use a risk calculator: eprognosis
Risk Calculator

1. How old is your patient?

2. What is the sex of your patient?

3. What is your patient's BMI?

4. Which best describes your patient’s health in general?

5. Does your patient have chronic lung disease, such as emphysema or chronic bronchitis?
SHARED DECISION-MAKING

• Introduce Choice
• Describe Options
• Help Patient Explore Preferences and Make INFORMED Decisions
• Respect What Matters Most to Patients
Avoid language like “probable,” “unlikely,” “rare”
Avoid listing rates
Absolute risk may be understood better
Place risk in context, specify time period
Compare the risk to other risks
Present it in a way that is relevant to individual
Concrete, vivid examples
Out of 1,000 women...

- From 40 to 49 years old:
  - 15 will develop breast cancer
  - 2 will die of breast cancer
  - 20 will die of other causes

- From 50 to 59 years old:
  - 30 will develop breast cancer
  - 5 will die of breast cancer
  - 50 will die of other causes

- From 60 to 69 years old:
  - 40 will develop breast cancer
  - 7 will die of breast cancer
  - 125 will die of other causes

- From 70 to 79 years old:
  - 45 will develop breast cancer
  - 9 will die of breast cancer
  - 300 will die of other causes
Take Home Points

• If you screen, you **will** find disease
• Screening tests have risks as well as benefits
• An effective screening test reduces DEATH and DISABILITY from a disease – its purpose is NOT to just find disease early
• These are guidelines, not rules; discuss screening pros and cons with your patients.
• ASSESS patient preferences
• Help them make Informed Decisions