Primary Care Update 2018

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November 16, 2018
IN ACP meeting
Cancer Screening

• ‘The USPSTF’s approach reflects the understanding that both “too little” and “too much” health care is not good.’

Topics

• What is new in screening?
  – Colon
  – Breast
  – Prostate
  – Lung
  – Cervical

• Immunization Tidbits
What Proves Cancer Screening Saves Lives?²

• 1. More cancers are detected in a screened population than in unscreened populations.
• 2. Screen detected cancers have a better 5 year survival rate than cancers detected because of symptoms.
• 3. Mortality rates are lower among screened persons than unscreened persons in a randomized trial.

Case

• 52 yo woman presented for her annual wellness visit. She agreed to the mammogram and pap smear.

• “I want to wait on the colonoscopy since I am just over 50.”

• How does some recent data help us respond to this?
Colorectal Cancer Screening

• Grade A by USPSTF 50 - 75 yo\textsuperscript{3}
• Just Do It!
• Why?
  – Second leading cause of death from cancer
  – 67.3\% of those eligible are up to date on screening\textsuperscript{4}
• What is new?
• Start screening average risk individuals at 45\textsuperscript{5}
• REALLY?

\textsuperscript{3}JAMA 2016;315(23):2564-2575.
\textsuperscript{4}https://www.cdc.gov/cancer/colorectal/pdf/QuickFacts-BRFSS-2016-CRC-Screening-508.pdf
\textsuperscript{5}CA Cancer J Clin 2018;68:250-281.
USPSTF Grades

- **A**: High certainty the net benefit substantial; offer service
- **B**: High certainty of moderate benefit or moderate certainty of moderate/substantial benefit; offer service
- **C**: Moderate certainty benefit is small; offer to selected patients
- **D**: Moderate or high certainty of no net benefit or harm outweighs benefit
- **I**: Evidence insufficient; patients need to understand uncertainty of risks vs benefits.

6https://www.uspreventiveservicestaskforce.org/Page/Name/grade-definitions
Colorectal Screening 45-49yo

- *Qualified* recommendation by American Cancer Society
  - What does *qualified* mean?
  - “Clear evidence of benefit but less certainty about balance of benefits and harms or about patients’ values and preferences”
  - “ACS does not apply cost and resource use as a decision making criterion”
ACS Guideline on Colorectal Cancer

• Extended analysis done for USPSTF in 2016
• Benefits addressed:
  – 1. Mortality reduction
    • Life Years Gained (LYG)
  – 2. Incidence reduction (less emphasized this time)
• Harms
  – 1. Complications of colonoscopy
  – 2. Follow-up of false positive
  – 3. Proxy for harm --- number of required colonoscopies
• Result
  – Calculate Efficiency Ratio: Burden/benefit
  – # of colonoscopies/LYG
Model Assumptions

- 100% adherence to all screening strategies
- USPSTF model used incidence of cancer in the pre-screening era
  - Why? Eliminates influence of screening on incidence
- ACS model
  - Incorporated rising incidence
Racial Disparity

- Higher than average incidence in some groups < 50 yo
  - Blacks
  - Alaska native
  - Increasing incidence in cohort < 50 yo

**FIGURE 1.** Trends in Colorectal Cancer Incidence Rates in Adults Younger Than Age 50 Years by Race, 1975 to 2014.
Trends in Colorectal Incidence \textsuperscript{5}

- CRC incidence increasing in successively younger birth cohorts
What Did This Model Tell Us?\(^5\)
Model – Estimated Benefits and Burdens of CRC Screening Strategies Starting at 45 yo vs. 50 yo

<table>
<thead>
<tr>
<th>SCREENING TEST</th>
<th>LYG</th>
<th>NO. OF CSY</th>
</tr>
</thead>
<tbody>
<tr>
<td>CSY every 10 y, 45-75</td>
<td>429</td>
<td>5646</td>
</tr>
<tr>
<td>CSY every 10 y, 50-75</td>
<td>404</td>
<td>4836</td>
</tr>
<tr>
<td>CTC every 5 y, 45-75</td>
<td>390</td>
<td>2666</td>
</tr>
<tr>
<td>CTC every 5 y, 50-75</td>
<td>368</td>
<td>2430</td>
</tr>
<tr>
<td>FSIG every 5 y, 45-75</td>
<td>403</td>
<td>3761</td>
</tr>
<tr>
<td>FSIG every 5 y, 50-75</td>
<td>380</td>
<td>3426</td>
</tr>
<tr>
<td>FIT yearly, 45-75</td>
<td>403</td>
<td>2698</td>
</tr>
<tr>
<td>FIT yearly, 50-75</td>
<td>377</td>
<td>2402</td>
</tr>
<tr>
<td>HSgFOBT yearly, 45-75</td>
<td>403</td>
<td>3364</td>
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<tr>
<td>HSgFOBT yearly, 50-75</td>
<td>377</td>
<td>2956</td>
</tr>
<tr>
<td>mt-sDNA every 3 y, 45-75</td>
<td>376</td>
<td>2640</td>
</tr>
<tr>
<td>mt-sDNA every 3 y, 50-75</td>
<td>350</td>
<td>2331</td>
</tr>
</tbody>
</table>
So Which Test to Pick?

• Uptake in screening is better when:
  – 1. choice of stool testing or structural exam vs colonoscopy alone.
  – 2. Offering all the options creates confusion⁵
What Proves Cancer Screening Saves Lives?²

• 1. More cancers are detected in a screened population than in unscreened populations.

• 2. Screen detected cancers have a better 5 year survival rate than cancers detected because of symptoms.

• 3. Mortality rates are lower among screened persons than unscreened persons in a randomized trial.

What are Other Agencies Recommending?

• **US Multi-society Task Force 2017 guidelines**\(^6\)
  – Begin screening at 50
  – **EXCEPT** African American at 45
  – **Thorough** evaluation of colorectal bleeding in younger patients.
  – 3 tiers of testing
    • 1. Colonoscopy or FITq yr.
    • 2. CT colography q 5 yr or fecal DNA-FIT q 3 or sig q 5
    • 3. Capsule endoscopy

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\(^6\)Rex et al. *Gastroenterology* 2017
Why are we more concerned about mortality than incidence when screening for cancer?

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**Lead-time bias**

**Without screening**

- Cancer starts
- Dead at age 70 y
- 5-year survival = 0%

**With screening**

- Cancer diagnosed because of screening at age 60 y
- Dead at age 70 y
- 5-year survival = 100%
What Do Our European Colleagues Think? They are confused.  

- “Cancer screening involves a close balance of benefits of harms”
- Need to emphasize high quality randomized trials

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### Table. Colorectal Cancer Screening Strategies Recommended by the USPSTF and Their Recommended Use in Italy, Norway, Poland, Spain, and Sweden

<table>
<thead>
<tr>
<th>Screening Strategies Recommended by the USPSTF</th>
<th>Recommended in Italy, Norway, Poland, Spain, and Sweden</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Yes</td>
</tr>
<tr>
<td>FOBT</td>
<td>All countries</td>
</tr>
<tr>
<td>FIT</td>
<td>All countries</td>
</tr>
<tr>
<td>Colonoscopy</td>
<td>Poland</td>
</tr>
<tr>
<td>Sigmoidoscopy alone</td>
<td>Italy and Norway</td>
</tr>
<tr>
<td>Sigmoidoscopy plus FOBT/FIT</td>
<td>–</td>
</tr>
<tr>
<td>Computed tomography colonography</td>
<td>–</td>
</tr>
<tr>
<td>FIT DNA testing</td>
<td>–</td>
</tr>
</tbody>
</table>

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7Bretthauer, M. Ann Intern Med 2017;166:139-140.
My Take

• Concerns
  – Lack of economic assessment if applied broadly in the population
  – Over emphasis on the rising incidence
    • May skew appearance of benefit
    • Lead time bias
  – Lack of mortality data
  – False + rate with cologuard
• Encourage our patients to begin screening at least at 50 yo
• FIT/FOBT are NOT second class options
• If this year is busy, I get that, but do something
• Consider earlier screening esp in more at risk population eg African-American
Case

• 53 yo woman presents for a follow-up visit. She recently had a mammogram and opted for 3D mammography.
• Results: Almost entirely fatty. 5 mm asymmetry. BIRADS 0. Additional imaging required.
• Additional imaging showed no problem
• Relieved? Yes.
• Happy? No.
Breast Cancer

**USPSTF 2017**

- 40-49 yo Grade C-biennial
- 50-75 yo Grade B-biennial
- > 75 yo I
- Breast tomosynthesis, ultrasound, MRI for women with dense breasts – I
- Who? Average risk women
- Exclusion:
  - +family hx, genetic mutation, h/o chest irradiation

**ACS**

- 40-44 – shared decision making(SDM)
- 45-55 – annual
- 55+ - biennial or annual(SDM)

**Elsewhere**

- Australia like USPSTF
- Canada and WHO
  - Biennial 50-70
What about that “I” statement for additional imaging?

- 1. 3-d mammography or breast tomosynthesis
- 2. Dense breasts – do they warrant an ultrasound?
- 3. Where does the issue of overdiagnosis enter the equation?

Overdiagnosis:
- “The detection of a (histologically confirmed) cancer through screening that would not otherwise have been diagnosed in a person’s lifetime had screening not been done”.¹

¹ Ann Intern Med 2018;169:36-43.
Overdiagnosis bias

Without screening

1000 people with progressive cancer

5 years later

400 alive
600 dead

5-year survival = \frac{400}{1000} = 40% 

With screening

2000 people with nonprogressive cancer

5 years later

2000 alive

5-year survival = \frac{2400}{3000} = 80% 

1000 people with progressive cancer

400 alive
600 dead
Advanced Imaging Techniques

• 3-D (Breast Tomosynthesis) as compared to 2-D
  – 2 x radiation (more so with dense or thick breasts)
  – Higher detection rate
  – Lower false positive rate
  – Better Positive predictive value
  – Per 1000 screens 16 fewer recalls and 1.2 more invasive cancers

• No large prospective studies with *survival* outcomes
What About Dense Breasts?

• Potential strategy
  – Dense breasts with negative mammogram
    Breast ultrasound
    False positives, need for bx

Cost, anxiety, radiation, some cancers found

More false positives + more biopsies + a few more cancers = ? Life Years Gained

Public perception: A cancer found = A good thing
Is it?
Talking Points for Supplemental Screening

- How does breast density affect risk?
- Patient profile:
  - 47 yo Pre-menopausal
  - Menarche 14
  - First baby 23
  - Negative Family hx
- Breast Density
  - “C”- like 2nd degree relative with breast cancer
  - “D” – same as 1st degree relative

10 year risk of breast cancer/1000 women

Talking Points for Supplemental Screening

- Calculate Breast Cancer risk
  - If Lifetime < 15% no additional screening
- Screening Interval
  - Dense breasts
    - Consider annually
  - BUT
    - 2/1000 deaths averted
    - Cost
      - False positives
- Have the conversation about screening methods
  - Mammography does save lives
  - 3-D
    - Lower false positive, more $$
    - Ongoing trial
Talking Points for Supplemental Screening

- “What is your understanding of the benefits vs. harms?”
- “What are your personal values and goals for screening?”
Breast Cancer Screening

• If we start a screening program will the number of small cancers rise or fall?
• Screening should detect more small cancers.
• With that screening program what should happen to the number of large tumors?
• Incidence of larger tumors should decrease over time.
• Key: should detect early stage and prevent advanced disease
Denmark Cohort\textsuperscript{9}

\textbf{Number of breast cancers per 100 000 women}

\textbf{Years of follow-up}

\textbf{Screening amts}

\textbf{No screening amts}

\textsuperscript{9}Ann intern Med 2017;166:313-323.
Breast-Cancer Tumor Size, Overdiagnosis, and Mammography Screening Effectiveness\textsuperscript{10}

- Compared tumor size and incidence in 2 time periods
  - Pre-screening (1975-1979)
  - 2000-2002 (10 year follow-up data available)

- Results
  - Increased detection of small (<2 cm tumors)
    - 36% → 68%
  - Large tumor decrease:
    - 64% → 32%

Figure 1. Temporal Relationship between the Introduction of Screening Mammography and Increased Incidence of Invasive Breast Cancer.
Trends

- Absolute numbers:
  - Large tumors: 30 fewer/100,000
  - Small tumors: 162 more/100,000
Change in Size-Specific Case Fatality Rate

**Relative risk** of death from breast cancer (%)

**Large Tumors**
- ≥5.0 cm: Relative risk = 0.79 (95% CI, 0.74–0.84)
- 3.0–4.9 cm: Relative risk = 0.70 (95% CI, 0.65–0.75)
- 2.0–2.9 cm: Relative risk = 0.58 (95% CI, 0.53–0.62)

**Small Tumors**
- 1.0–1.9 cm: Relative risk = 0.38 (95% CI, 0.34–0.42)
- <1.0 cm: Relative risk = 0.26 (95% CI, 0.21–0.32)
- In situ: Relative risk = 0.47 (95% CI, 0.32–0.71)

Lower case fatality rate predominantly reflects improved treatment for large tumors and combined effect of lead time, length, and overdiagnosis biases for small tumors.
My Take on Breast Cancer Screening

- Concerns:
  - Overdiagnosis
  - Costs: financially and emotionally
- Waiting for more long term data to guide decision making
- Dense breasts?
- Higher risk?
- Pre-mammogram conversation
- Future: we need to find the “just right”

Risks

Benefits
Prostate Cancer Screening: What do we do in 2018?

Benefits

Risks

Finding cancers

Treating Cancers

SE of treatment

1990s
2009

PLCO trial

- Randomized 77,000
  - Men 55-74
- Results
  - More cancers detect in screened population
    - 2820 screened group
    - 2322 control
  - No difference in disease specific mortality at 7 years
- Problem!!!
  - Contamination of control group
  - Scheduled vs. opportunistic screening


ESPSC trial

- Randomized 182,000 men
  - Men 50-74 yo
- Study group
  - PSA drawn every 4 years
- Results
  - 20% relative risk reduction in cancer mortality
  - 27% reduction in screened population
- 8.8 years of follow-up
- NNS = 1410 to save 1 life
- 48 cancers detected per life saved

2012 USPSTF – “D” for PSA testing

Benefits

- 20% relative risk reduction of mortality
- ARR = 7 prostate cancer deaths/10,000 men

Harms

- Harms of biopsy
- Overdiagnosis
- Harms of Treatment
2018 – “C” USPSTF

Benefits

55yo - 69 yo
Grade C

- Increased Mortality benefit in ERSPC trial
- Prostatectomy/ Rad tx decreased mortality
- Reconciled PLCO/ERSPC data showed similar RRR
  NNS: 781
  NNDx: 27

Harms

≥70 yo - D

- Increased Mortality benefit in ERSPC trial
- Prostatectomy/ Rad tx decreased mortality
- Reconciled PLCO/ERSPC data showed similar RRR
- Overdiagnosis, Treatment side effects
- Biopsies- 1 out 4 bx + for cancer
- PSA Anxiety/Active surveillance anxiety

11AMA 2018;319(18):1914-1931.
Prostate cancer is common

Some die from prostate cancer

Screening saves some lives

Most low risk cancers are treated

Treatment can lead to complications

Goal: find and treat aggressive cancers before it spreads

Some cancers don’t have to be treated and can be carefully watched

You may face pressure from family or physicians to treat it

Facts about screening:

Prostate cancer is common

Some die from prostate cancer

Screening saves some lives

Most low risk cancers are treated

Treatment can lead to complications

14 Ann Intern Med 2014;161:441-442
The PSA Conversation

- If you would be uncomfortable knowing you have a cancer and not treating it, screening may not be for you.
- If you are confident you would only accept treatment for aggressive cancer and wouldn’t be worried about living with low risk disease then you’re a good candidate for screening.
- Ask:
  - Did that make sense?
  - What are your preferences?
What is a Reasonable Strategy for Prostate Cancer Screening\textsuperscript{13}

- Back off from frequent testing
  - Q 2-4 years
- Have the Conversation
- “..recommendations specify either too little information to allow patients to make a decision or so much that it overwhelms their ability to decide rationally”. \textsuperscript{14}
- Stop screening $\geq$ 70
  - Those who have the least to gain
- Other options:
  - Reflex biomarkers before biopsy
  - Manage low grade disease conservatively


\textsuperscript{17}Ann Intern Med 2014;161:441-442
Lung Cancer Screening

- #1 in mortality for men and women
- Grade “B” – USPSTF
- Screening criteria
  - 55-79yo
  - 30 pack year smoking hx
  - Quit < 15 years ago
- Disease specific reduced mortality with screening
- How do we REALLY inform our patients?
Lung Cancer Screening

• Study looking at different decision models\textsuperscript{15}
  – Performed best PLCO\textsubscript{2012} and Bach model

• \url{http://nomograms.mskcc.org/Lung/Screening.aspx}

• Recurrent Themes
  • Conversation
  • Finding the population who can benefit from screening
  • Risk/benefit analysis

\textsuperscript{15} Ann Intern Med 2018;169:10-19.
• 18th most common cause of cancer deaths in US

• Cervical Cancer Deaths
  – US
    • Poor women
    • Women from communities of color
    • Non-US born women
    • Women living in rural and remote settings
  – Worldwide
    • Greater mortality rate in low resource countries

16 JAMA.2018;320(7)647-649.
Cervical Cancer

- Screening trends
  - Less frequent
- Screening recs the same for HPV vaccine recipients
- 21-29 yo –
  - Grade A: cytology alone q 3 years
- 30-65 – Options: all grade A
  - Cytology q 3 yrs
  - Co-testing q 5(hrHPV + cytology)
  - What is new?
    - HrHPV q 5 years
- <21 and >65 yo - D

\[^{16}\text{JAMA.2018;320(7)674-686.}\]
Comparison\textsuperscript{16}

- hrHPV or Co-testing vs. cytology alone
  - More sensitive in detecting CIN 3+
    - Save one additional life per 1000 women screened
  - Cost: more procedures

- Bottom Line:
  - \textbf{ANY} of the 3 strategies are beneficial compared with no screening

- Caveats:
  - HIV, Immunosuppression, DES exposure, h/o high grade cervical lesion or cervical Ca

- Future
  - ? Self sampling at home
When to Stop?\textsuperscript{16}

Precancerous lesion?
Follow for 20 years

“ Adequate prior screening”
• 3 negative cytology in previous 10 years
• 2 negative co-testing

Stop at 65 yo

New partner after screening stopped?
No need to resume
What to Do with +HPV test?

Primary HPV Screening → 12 other hrHPV + → Cytology

Type 16/18 Positive → Colposcopy

≥ASC-US → NILM

Follow up in 12 months

Negative → Routine Screening

My Take Cervical Cancer Screening

• HPV only *is* an option
• Guidelines of other organizations need to “catch up” to clarify how to triage the +HPV result
• Look for further iterations of this and possible home based testing in the future
When Do We Stop Screening

• Or better yet, how do we have the conversation about stopping screening.
• Case:
  – 65 yo presents for her “new to MD” visit. Her demographics make eligible for screenings like low dose lung CT, mammography, colonoscopy.
  – We *could* order all sorts of tests.
  – But *should* we?
Communication Study\textsuperscript{17}

- Cross-sectional survey of US adults $\geq 65$ yo
- 881 respondents
- Randomized to questions:
  - Breast/prostate or
  - Colorectal
- Who?
  - 77\% white, 9\% african-american
  - 66\%
    - Mammogram or PSA in previous 2 years or
    - Colonoscopy within 10 years

\textsuperscript{17}Schoenborn, N et al. \textit{JAMA Onc} 2018;4(8):1126-1128.
**Baseline Perspective**

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>No. (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Screening attitude: “I plan to get screened for breast/prostate/colorectal cancer for as long as I live”</td>
<td></td>
</tr>
<tr>
<td>Strongly agree</td>
<td>81 (7.9)</td>
</tr>
<tr>
<td>Somewhat agree</td>
<td>219 (24.0)</td>
</tr>
<tr>
<td>Neither agree nor disagree</td>
<td>260 (29.3)</td>
</tr>
<tr>
<td>Somewhat disagree</td>
<td>190 (22.9)</td>
</tr>
<tr>
<td>Strongly disagree</td>
<td>76 (10.4)</td>
</tr>
<tr>
<td>Not applicable owing to history of cancer</td>
<td>52 (5.5)</td>
</tr>
</tbody>
</table>
Figure. Relative Preference of 881 Older Adults Regarding 13 Phrases a Clinician May Use to Explain Stopping Routine Cancer Screening

Explanation

Your other health issues should take priority
Colonoscopy is not recommended for you by medical guidelines
You are unlikely to benefit from the colonoscopy
We usually stop doing colonoscopies at your age
You are at high risks for harms from the colonoscopy
We should focus on quality of life instead of looking for cancer
The colonoscopy can lead to unnecessary tests or treatments
The colonoscopy would not help you live longer
The colonoscopy can be very uncomfortable
The colonoscopy can be very inconvenient to complete
The doctor does not mention colonoscopy
You may not live long enough to benefit from the colonoscopy
The doctor does not give an explanation

Standardized Score
What is New In Vaccines this Year?

• Influenza
  – Nasal spray-live attenuated is back
• Hepatitis B
• Zoster
Hepatitis B

5 currently licensed recombinant vaccines

• 3 dose series – 0, 2, 6 months
• 70-90% efficacy

Heplisav-B(HepB-CpG)

• 2 dose series- 0,1 month
• ≥18 yo
HepBsAg
• 90-100% efficacy
• Yeast derived vaccine

• BOTTOM line:
  – Better efficacy
  – Easier schedule
  – Watch for more guidance

https://www.cdc.gov/mmwr/volumes/67/wr/mm6715a5.htm
Preventing Herpes Zoster

**Zoster vaccine (Zostavax) ZLV**
- Live attenuated
- Who?
  - > 60 (per ACIP; though FDA approved for > 50 yo)
- One shot regimen

**Zoster vaccine (Recombinant) (Shingrix) RZV**
- Though recombinant the ACIP still only recommends this for immunocompetent patients.
- Who? > 50 yo
- Two shot regimen
  - 0 and 2-6 months
- Why?
  - More effective esp. in the older populations (>80)
- Problems?
  - More local reactions
RZV Studies

**ZOE-50**[^18]
- RCT
- 15,411 participants
- Similar vaccine efficacy in different age groups
  - 50s, 60, 70s, 80+
  - 90% +
- 3.2 yrs of follow-up
- NNT: 11.7

**Zoe-70**[^19]
- RCT
- 13,900 participants
- Efficacy
  - Zoster: 91.3%
  - PHN: 88.8%
- NNT: 12

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Recombinant Vaccine Talking Points \(^{18,19}\)

- There ARE local reactions
  - For every 3 patients vaccinated, 2 will have a local reaction

- There ARE systemic reactions
  - 1 out of 4 will experience fever, myalgias, headaches
  - NNH 70+: For every 25 patients vaccinated, approximately one will need to stay home from work and rest due to systemic symptoms
  - NNH 50+: More in younger cohort
    - NNH 50+ = 7

- RZV one is MUCH more efficacious than ZLV
  - Approx 90% protection for our very elderly > 80 (compared to 18%)

- 2 Shot series

- **KEY:** UPFRONT education
Common Questions

• I already had the zostavax? Do I need this vaccine?
  – IF it has been greater than 2 months, then the patient should receive the recombinant vaccine

• Does this vaccine prevent post-herpetic neuralgia (PHN)?
  – Live vaccine data:
    • Incidence of zoster was cut in half and the risk of PHN was cut in 2/3
  – Yes, but.........
  – The benefit of RZV is largely driven by its benefit in preventing zoster in the first place. In the studies the numbers for PHN were quite low.
More Details About RZV

• **Cost**\(^\text{20}\)
  – Insurance companies have one year to decide about coverage
  – $280 for 2 shot series vs. $220 for zostavax
  – Medicare
    • Likely to be under part D

• **Storage**
  – Standard Vaccine refrigerator

• **Remaining questions**
  – Immunosuppressed?
  – Boosters?

Pneumococcal Vaccination (ACIP)
Immunocompetent***

PPSV 23
- CHF
- COPD
- Tobacco
- DM
- Chronic liver disease

> 12 months

PCV 13*
- 65 yo
- At least 12 months after PPSV 23

> 5 years

PPSV 23
- 5 years after PPSV23
- AND 1 year after PPSV 23

> 12 months

* = PCV13 before 65 include: CSF leak, Cochlear implants, SS disease, asplenia, one time

** = Exclusion include (not exhaustive: chronic renal failure, HIV, leukemia, lymphoma
Charge

• With so much conversation about wellness in medicine. What constitutes wellness?

• Beyond Burnout\textsuperscript{21}
  
  — “To overcome epidemic burnout, to quell the incomprehensible rate of depression and suicide among our colleagues, we can start by acknowledging it.”

\textsuperscript{21}Hurnikowski, C. \textit{JAMA} 24/31 2018;320: 343-344.
Summary

• Updates
  – Colorectal screening
  – Breast cancer screening
  – Prostate
  – Lung
  – Cervical cancer: HPV only q 5 is an option
  – Stopping screening
• Keep in mind the risk of overdiagnosis
  – Need to keep looking for that sweet spot between risks and harms
• Immunizations: RZV is “in”
• Lastly, expand your life beyond medicine. Let that other part of your life breathe.
• Credits