



## Complete Summary

---

### GUIDELINE TITLE

Screening for oral cancer: recommendation statement.

### BIBLIOGRAPHIC SOURCE(S)

U.S. Preventive Services Task Force (USPSTF). Screening for oral cancer: recommendation statement. Rockville (MD): Agency for Healthcare Research and Quality (AHRQ); 2004 Feb. 4 p. [3 references]

### GUIDELINE STATUS

This is the current release of the guideline.

This release updates a previously published guideline: U.S. Preventive Services Task Force. Guide to clinical preventive services. 2nd ed. Baltimore (MD): Williams & Wilkins; 1996. Chapter 16, Screening for oral cancer. p. 175-80.

## COMPLETE SUMMARY CONTENT

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

## SCOPE

### DISEASE/CONDITION(S)

Oral cancer

### GUIDELINE CATEGORY

Prevention  
Screening

### CLINICAL SPECIALTY

Family Practice  
Internal Medicine  
Oncology  
Otolaryngology  
Preventive Medicine

### **INTENDED USERS**

Advanced Practice Nurses  
Allied Health Personnel  
Nurses  
Physician Assistants  
Physicians

### **GUIDELINE OBJECTIVE(S)**

- To summarize the current U.S. Preventive Services Task Force (USPSTF) recommendations for the screening for oral cancer and the supporting scientific evidence
- To update the 1996 recommendations contained in the *Guide to Clinical Preventive Services*, Second Edition

### **TARGET POPULATION**

Adults seen in primary care settings

### **INTERVENTIONS AND PRACTICES CONSIDERED**

Screening for oral cancer with direct inspection and palpation of the oral cavity

### **MAJOR OUTCOMES CONSIDERED**

**Key Question 1:** Does screening for oral cancer lead to decreased morbidity and mortality from oral cancer?

**Key Question 2:** Is there new evidence of harms associated with screening for oral cancer?

**Key Question 3:** Are there effective treatments for mitigating the morbidity/mortality of oral cancer if lesions are identified earlier rather than later?

## **METHODOLOGY**

### **METHODS USED TO COLLECT/SELECT EVIDENCE**

Searches of Electronic Databases

### **DESCRIPTION OF METHODS USED TO COLLECT/SELECT THE EVIDENCE**

The search strategy for this brief update included a MEDLINE® review for English-language articles published between 1994 and 2001 on new direct evidence on the benefits and harms of screening and treatment for oral cancer. MEDLINE® was searched for articles focusing on meta-analysis, systematic reviews, randomized controlled trials (RCTs), and controlled trials reporting demonstrable health outcomes (morbidity and mortality) in humans. The Cochrane Library and National Guideline Clearinghouse™ were also searched for pertinent articles or recommendations.

The MEDLINE® search strategy combined the exploded Medical Subject Heading® (MeSH®) of Oral Neoplasm with Lip Neoplasm, Tongue Neoplasm, and Pharynx Neoplasm and crossed the result with Mass Screening, yielding 88 articles. These articles were further limited to RCTs by the exploded headings "randomized controlled trial/single-blind method/double blind method/random allocation." This approach identified one article. Limiting the search to reviews yielded 13 articles. A second search was conducted crossing the exploded Medical Subject Headings® (MeSH®) of Mouth Neoplasms or Oral Cancer with Therapeutics or Treatment, yielding 1,725 articles. Limiting the search to RCTs reduced the number of articles to 42. While none of these 42 addressed the key questions specifically, several were concerned with treatments for cancer precursors.

## **NUMBER OF SOURCE DOCUMENTS**

**Key Question 1** = 1 study

**Key Question 2** = 0 studies

**Key Question 3** = 0 studies

## **METHODS USED TO ASSESS THE QUALITY AND STRENGTH OF THE EVIDENCE**

Weighting According to a Rating Scheme (Scheme Given)

### **RATING SCHEME FOR THE STRENGTH OF THE EVIDENCE**

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

#### **Good**

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

#### **Fair**

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

#### **Poor**

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

## **METHODS USED TO ANALYZE THE EVIDENCE**

Systematic Review

## **DESCRIPTION OF THE METHODS USED TO ANALYZE THE EVIDENCE**

Not stated

## **METHODS USED TO FORMULATE THE RECOMMENDATIONS**

Balance Sheets  
Expert Consensus

## **DESCRIPTION OF METHODS USED TO FORMULATE THE RECOMMENDATIONS**

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

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

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

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

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

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

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

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

## **RATING SCHEME FOR THE STRENGTH OF THE RECOMMENDATIONS**

The U.S. Preventive Services Task Force (USPSTF) grades its recommendations according to one of five classifications (A, B, C, D, I) reflecting the strength of evidence and magnitude of net benefit (benefits minus harms):

### **A**

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

### **B**

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

### **C**

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

### **D**

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

## **I**

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

### **COST ANALYSIS**

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

### **METHOD OF GUIDELINE VALIDATION**

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

### **DESCRIPTION OF METHOD OF GUIDELINE VALIDATION**

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

Recommendations of Others. Recommendations regarding screening for oral cancer were considered from the following groups: the American Cancer Society, the Canadian Task Force on Preventive Health Care, and the American College of Obstetricians and Gynecologists.

## **RECOMMENDATIONS**

### **MAJOR RECOMMENDATIONS**

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

The U.S. Preventive Services Task Force (USPSTF) concludes that the evidence is insufficient to recommend for or against routinely screening adults for oral cancer.  
**I Recommendation.**

*The USPSTF found no new good-quality evidence that screening for oral cancer leads to improved health outcomes for either high-risk adults (i.e., those over the age of 50 who use tobacco) or for average-risk adults in the general population. It is unlikely that controlled trials of screening for oral cancer will ever be conducted in the general population because of the very low incidence of oral cancer in the United States. There is also no new evidence for the harms of screening. As a result, the USPSTF could not determine the balance between benefits and harms of screening for oral cancer.*

### **Clinical Considerations**

- Direct inspection and palpation of the oral cavity is the most commonly recommended method of screening for oral cancer, although there are little data on the sensitivity and specificity of this method. Screening techniques other than inspection and palpation are being evaluated but are still experimental.
- Tobacco use in all forms is the biggest risk factor for oral cancer. Alcohol abuse combined with tobacco use increases risk.
- Clinicians should be alert to the possibility of oral cancer when treating patients who use tobacco or alcohol.
- Patients should be encouraged to not use tobacco and to limit alcohol use in order to decrease their risk for oral cancer as well as heart disease, stroke, lung cancer, and cirrhosis.

### **Definitions:**

### **Strength of Recommendations**

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

#### **A**

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

#### **B**

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

## **C**

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

## **D**

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

## **I**

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

### **Strength of Evidence**

The USPSTF grades the quality of the overall evidence for a service on a 3-point scale (good, fair, poor):

#### **Good**

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

#### **Fair**

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

#### **Poor**

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

### **CLINICAL ALGORITHM(S)**

None provided

## EVIDENCE SUPPORTING THE RECOMMENDATIONS

### TYPE OF EVIDENCE SUPPORTING THE RECOMMENDATIONS

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

## BENEFITS/HARMS OF IMPLEMENTING THE GUIDELINE RECOMMENDATIONS

### POTENTIAL BENEFITS

The USPSTF found no new good-quality evidence that screening for oral cancer leads to improved health outcomes for either high-risk adults (i.e., those over the age of 50 who use tobacco) or for average-risk adults in the general population. It is unlikely that controlled trials of screening for oral cancer will ever be conducted in the general population because of the very low incidence of oral cancer in the United States. There is also no new evidence for the harms of screening. As a result, the USPSTF could not determine the balance between benefits and harms of screening for oral cancer.

### POTENTIAL HARMS

Not stated

## QUALIFYING STATEMENTS

### QUALIFYING STATEMENTS

The U.S. Preventive Services Task Force recommendations are independent of the U.S. government. They should not be construed as an official position of Agency for Healthcare Research and Quality (AHRQ) or the U.S. Department of Health and Human Services.

## IMPLEMENTATION OF THE GUIDELINE

### DESCRIPTION OF IMPLEMENTATION STRATEGY

The experiences of the first and second U.S. Preventive Services Task Force (USPSTF), as well as that of other evidence-based guideline efforts, have highlighted the importance of identifying effective ways to implement clinical recommendations. Practice guidelines are relatively weak tools for changing clinical practice when used in isolation. To effect change, guidelines must be coupled with strategies to improve their acceptance and feasibility. Such strategies include enlisting the support of local opinion leaders, using reminder systems for clinicians and patients, adopting standing orders, and audit and feedback of information to clinicians about their compliance with recommended practice.

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

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

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

## **IMPLEMENTATION TOOLS**

Foreign Language Translations  
Patient Resources  
Pocket Guide/Reference Cards

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

## **INSTITUTE OF MEDICINE (IOM) NATIONAL HEALTHCARE QUALITY REPORT CATEGORIES**

### **IOM CARE NEED**

Staying Healthy

## **IOM DOMAIN**

Effectiveness  
Patient-centeredness

## **IDENTIFYING INFORMATION AND AVAILABILITY**

### **BIBLIOGRAPHIC SOURCE(S)**

U.S. Preventive Services Task Force (USPSTF). Screening for oral cancer: recommendation statement. Rockville (MD): Agency for Healthcare Research and Quality (AHRQ); 2004 Feb. 4 p. [3 references]

### **ADAPTATION**

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

### **DATE RELEASED**

1996 (revised 2004 Feb 24)

### **GUIDELINE DEVELOPER(S)**

United States Preventive Services Task Force - Independent Expert Panel

### **GUIDELINE DEVELOPER COMMENT**

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

### **SOURCE(S) OF FUNDING**

United States Government

### **GUIDELINE COMMITTEE**

U.S. Preventive Services Task Force (USPSTF)

### **COMPOSITION OF GROUP THAT AUTHORED THE GUIDELINE**

*Task Force Members\**: Alfred O. Berg, MD, MPH, Chair, USPSTF (Professor and Chair, Department of Family Medicine, University of Washington, Seattle, WA); Janet D. Allan, PhD, RN, CS, Vice-chair, USPSTF (Dean, School of Nursing, University of Maryland Baltimore, Baltimore, MD); Ned Calonge, MD, MPH (Acting Chief Medical Officer, Colorado Department of Public Health and Environment, Denver, CO); Paul Frame, MD (Tri-County Family Medicine, Cohocton, NY, and Clinical Professor of Family Medicine, University of Rochester, Rochester, NY); Joxel Garcia, MD, MBA (Deputy Director, Pan American Health Organization,

Washington, DC); Russell Harris, MD, MPH (Associate Professor of Medicine, Sheps Center for Health Services Research, University of North Carolina School of Medicine, Chapel Hill, NC); Mark S. Johnson, MD, MPH (Professor of Family Medicine, University of Medicine and Dentistry of New Jersey-New Jersey Medical School, Newark, NJ); Jonathan D. Klein, MD, MPH (Associate Professor, Department of Pediatrics, University of Rochester School of Medicine, Rochester, NY); Carol Loveland-Cherry, PhD, RN (Executive Associate Dean, School of Nursing, University of Michigan, Ann Arbor, MI); Virginia A. Moyer, MD, MPH (Professor, Department of Pediatrics, University of Texas at Houston, Houston, TX); C. Tracy Orleans, PhD (Senior Scientist, The Robert Wood Johnson Foundation, Princeton, NJ); Albert L. Siu, MD, MSPH (Professor of Medicine, Chief of Division of General Internal Medicine, Mount Sinai School of Medicine, New York, NY); Steven M. Teutsch, MD, MPH (Senior Director, Outcomes Research and Management, Merck & Company, Inc., West Point, PA); Carolyn Westhoff, MD, MSc (Professor of Obstetrics and Gynecology and Professor of Public Health, Columbia University, New York, NY); and Steven H. Woolf, MD, MPH (Professor, Department of Family Practice and Department of Preventive and Community Medicine and Director of Research Department of Family Practice, Virginia Commonwealth University, Fairfax, VA)

*\*Member of USPSTF at the time this recommendation was finalized.* For a list of current Task Force members, go to [www.ahrq.gov/clinic/uspstfab.htm](http://www.ahrq.gov/clinic/uspstfab.htm).

## **FINANCIAL DISCLOSURES/CONFLICTS OF INTEREST**

The U.S. Preventive Services Task Force (USPSTF) has an explicit policy concerning conflict of interest. All members and Evidence-based Practice Center (EPC) staff disclose at each meeting if they have an important financial conflict for each topic being discussed. Task Force members and EPC staff with conflicts can participate in discussions about evidence, but members abstain from voting on recommendations about the topic in question.

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

## **GUIDELINE STATUS**

This is the current release of the guideline.

This release updates a previously published guideline: U.S. Preventive Services Task Force. Guide to clinical preventive services. 2nd ed. Baltimore (MD): Williams & Wilkins; 1996. Chapter 16, Screening for oral cancer. p. 175-80.

## **GUIDELINE AVAILABILITY**

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

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

## AVAILABILITY OF COMPANION DOCUMENTS

The following are available:

Evidence Reviews:

- Screening for oral cancer: a brief evidence update for the U.S. Preventive Services Task Force. Rockville (MD): Agency for Healthcare Research and Quality (AHRQ), 2004 Feb. 4 p.

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

Background Articles:

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

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

The following are also available:

- The guide to clinical preventive services, 2006. Recommendations of the U.S. Preventive Services Task Force. Rockville (MD): Agency for Healthcare Research and Quality (AHRQ), 2006. 228 p. Electronic copies available from the [AHRQ Web site](#).
- A step-by-step guide to delivering clinical preventive services: a systems approach. Rockville (MD): Agency for Healthcare Research and Quality (AHRQ), 2002 May. 189 p. Electronic copies available from the [AHRQ Web site](#). See the related QualityTool summary on the [Health Care Innovations Exchange Web site](#).

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

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

## **PATIENT RESOURCES**

The following is available:

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

Electronic copies: Available from the [U.S. Preventive Services Task Force \(USPSTF\) Web site](#). Copies also available in Spanish from the [USPSTF Web site](#). See the related QualityTool summary on the [Health Care Innovations Exchange Web site](#)

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

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

## **NGC STATUS**

This summary was completed by ECRI on June 30, 1998. The information was verified by the guideline developer on December 1, 1998. This summary was updated by ECRI on April 8, 2004. The updated information was verified by the guideline developer on April 22, 2004.

## **COPYRIGHT STATEMENT**

Requests regarding copyright should be sent to: Gerri M. Dyer, Electronic Dissemination Advisor, Agency for Healthcare Research and Quality (formerly the Agency for Health Care Policy and Research), Center for Health Information Dissemination, Suite 501, Executive Office Center, 2101 East Jefferson Street, Rockville, MD 20852; Facsimile: 301-594-2286; E-mail: [gdyer@ahrq.gov](mailto:gdyer@ahrq.gov).

## **DISCLAIMER**

## **NGC DISCLAIMER**

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

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

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

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

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

© 1998-2008 National Guideline Clearinghouse

Date Modified: 11/3/2008

