



## Complete Summary

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### GUIDELINE TITLE

Lung cancer screening: recommendation statement.

### BIBLIOGRAPHIC SOURCE(S)

Lung cancer screening: recommendation statement. Am Fam Physician 2005 Mar 15;71(6):1165-8. [27 references] [PubMed](#)

U.S. Preventive Services Task Force. Lung cancer screening: recommendation statement. Ann Intern Med 2004 May 4;140(9):738-9. [2 references] [PubMed](#)

### GUIDELINE STATUS

This is the current release of the guideline.

This updates a previously published version: U.S. Preventive Services Task Force. Screening for lung cancer. In: Guide to clinical preventive services, 2nd ed. Baltimore (MD): Williams & Wilkins; 1996. p. 135-9.

## COMPLETE SUMMARY CONTENT

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## SCOPE

### DISEASE/CONDITION(S)

Lung cancer

### GUIDELINE CATEGORY

Prevention  
Screening

## **CLINICAL SPECIALTY**

Family Practice  
Internal Medicine  
Oncology  
Preventive Medicine  
Pulmonary 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) recommendation on screening for lung cancer and the supporting scientific evidence
- To update the 1996 recommendations contained in the *Guide to Clinical Preventive Services*, Second Edition

## **TARGET POPULATION**

Asymptomatic persons seen in primary care settings

## **INTERVENTIONS AND PRACTICES CONSIDERED**

Screening for lung cancer using low dose computerized tomography, chest x-ray, sputum cytology, or a combination of these tests

## **MAJOR OUTCOMES CONSIDERED**

- Sensitivity and specificity of screening tests
- Lung cancer mortality benefit

## **METHODOLOGY**

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

Hand-searches of Published Literature (Primary Sources)  
Hand-searches of Published Literature (Secondary Sources)  
Searches of Electronic Databases

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

**Note from the National Guideline Clearinghouse (NGC):** A systematic evidence review was prepared by the Oregon Health Sciences University

Evidence-based Practice Center (EPC) for the Agency for Healthcare Research and Quality (AHRQ) for use by the U.S. Preventive Services Task Force (USPSTF) (see the "Companion Documents" field).

### **Search Strategy**

The EPC review focused on the outcomes of screening in populations. EPC staff reviewed the MEDLINE and Cochrane databases from their inception through January 2003 using the search terms lung neoplasms, lung cancer, and any screening. The search strategy is detailed in Figure 1 of the Summary of Evidence companion document. To assure complete ascertainment, the bibliographies of reviews, editorials, book chapters, and letters discussing lung cancer screening were reviewed. In addition, a recent Cochrane review and analysis was reviewed for studies that might have been missed. EPC staff sought studies evaluating screening in the general population, as well as in high-risk populations, and included observational studies and clinical trials.

### **NUMBER OF SOURCE DOCUMENTS**

The literature search identified 809 citations and abstracts; 149 full-text papers were reviewed. Of these, 1 randomized trial of chest x-ray, in conjunction with a multiphasic screening program, and 5 randomized controlled trials (RCTs) of chest x-ray and/or sputum cytology screening for lung cancer were reviewed. In addition, 6 case-control studies, 1 non-RCT, and 4 older cohort studies were reviewed. Finally, 6 recent cohort studies of lung cancer screening with computerized tomography were reviewed.

### **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**

Review of Published Meta-Analyses  
Systematic Review with Evidence Tables

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

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

### **Data Extraction**

Observational studies with control groups and randomized trials evaluating disease specific mortality were evaluated for quality according to criteria created by the current USPSTF. To rate each of these studies, EPC staff reviewed all related articles describing the studies but did not query study authors. They also used studies of the various screening modalities to estimate the screening test characteristics of chest x-ray (CXR) and low dose CT. Finally, they used data from the screening studies when available, as well as clinical series, to evaluate some of the harms associated with screening and subsequent treatment.

Data were abstracted to data collection forms.

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

Balance Sheets  
Expert Consensus

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

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

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

"Outcomes tables" (similar to 'balance sheets') are the USPSTF's standard resource for estimating the magnitude of benefit. These tables, prepared by the topic teams for use at USPSTF meetings, compare the condition specific outcomes

expected for a hypothetical primary care population with and without use of the preventive service. These comparisons may be extended to consider only people of specified age or risk groups or other aspects of implementation. Thus, outcomes tables allow the USPSTF to examine directly how the preventive service affects benefits for various groups.

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

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

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

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

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

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

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

### **A**

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

## **B**

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

## **C**

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

## **D**

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

## **I**

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

## **COST ANALYSIS**

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 and the Agency for Healthcare Research and Quality send a draft systematic evidence review to 4 to 6 external experts and to federal agencies and professional and disease-based health organizations with interests in the topic. They ask the experts to examine the review critically for accuracy and completeness and to respond to a series of specific questions about the document. After assembling these external review comments and

documenting the proposed response to key comments, the topic team presents this information to the Task Force in memo form. In this way, the Task Force can consider these external comments and a final version of the systematic review before it votes on its recommendations about the service. Draft recommendations are then circulated for comment from reviewers representing professional societies, voluntary organizations and Federal agencies. These comments are discussed before the whole USPSTF before final recommendations are confirmed.

Recommendation of Others. Recommendations for screening for lung cancer from the following groups were discussed: the American Cancer Society; the American Academy of Family Physicians; and the Canadian Task Force on Preventive Health Care.

## RECOMMENDATIONS

### MAJOR RECOMMENDATIONS

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

The USPSTF concludes that the evidence is insufficient to recommend for or against screening asymptomatic persons for lung cancer with either low dose computerized tomography (LDCT), chest x-ray (CXR), sputum cytology, or a combination of these tests. **I recommendation.**

*The USPSTF found fair evidence that screening with LDCT, CXR, or sputum cytology can detect lung cancer at an earlier stage than lung cancer would be detected in an unscreened population; however, the USPSTF found poor evidence that any screening strategy for lung cancer decreases mortality. Because of the invasive nature of diagnostic testing and the possibility of a high number of false-positive tests in certain populations, there is potential for significant harms from screening. Therefore, the USPSTF could not determine the balance between the benefits and harms of screening for lung cancer.*

### Clinical Considerations

- The benefit of screening for lung cancer has not been established in any group, including asymptomatic high-risk populations such as older smokers. The balance of harms and benefits becomes increasingly unfavorable for persons at lower risk, such as nonsmokers.
- The sensitivity of LDCT for detecting lung cancer is 4 times greater than the sensitivity of CXR. However, LDCT is also associated with a greater number of false-positive results, more radiation exposure, and increased costs compared with CXR.
- Because of the high rate of false-positive results, many patients will undergo invasive diagnostic procedures as a result of lung cancer screening. Although the morbidity and mortality rates from these procedures in asymptomatic individuals are not available, mortality rates because of complications from surgical interventions in symptomatic patients reportedly range from 1.3 to

11.6%; morbidity rates range from 8.8 to 44%, with higher rates associated with larger resections.

- Other potential harms of screening are potential anxiety and concern as a result of false-positive tests, as well as possible false reassurance because of false-negative results. However, these harms have not been adequately studied.

### **Definitions:**

### **Strength of Recommendations**

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

#### **A**

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

#### **B**

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

#### **C**

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

#### **D**

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

#### **I**

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

### **Strength of Evidence**

The 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 U.S. Preventive Services Task Force (USPSTF) found fair evidence that screening with low dose computerized tomography, chest x-ray, or sputum cytology can detect lung cancer at an earlier stage than lung cancer would be detected in an unscreened population; however, the USPSTF found poor evidence that any screening strategy for lung cancer decreases mortality.

**POTENTIAL HARMS**

- Because of the high rate of false-positive results, many patients will undergo invasive diagnostic procedures as a result of lung cancer screening. Although the morbidity and mortality rates from these procedures in asymptomatic individuals are not available, mortality rates because of complications from surgical interventions in symptomatic patients reportedly range from 1.3 to 11.6%; morbidity rates range from 8.8 to 44%, with higher rates associated with larger resections.

- Other potential harms of screening are potential anxiety and concern as a result of false-positive tests, as well as possible false reassurance because of false-negative results. However, these harms have not been adequately studied.

## QUALIFYING STATEMENTS

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Recommendations made by the U.S. Preventive Services Task Force (USPSTF) are independent of the U.S. Government. They should not be construed as an official position of the 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  
Personal Digital Assistant (PDA) Downloads  
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)**

Lung cancer screening: recommendation statement. Am Fam Physician 2005 Mar 15;71(6):1165-8. [27 references] [PubMed](#)

U.S. Preventive Services Task Force. Lung cancer screening: recommendation statement. Ann Intern Med 2004 May 4;140(9):738-9. [2 references] [PubMed](#)

### **ADAPTATION**

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

**DATE RELEASED**

1996 (revised 2004 May)

**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**

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*\*Members of the Task Force 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 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.

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This is the current release of the guideline.

This updates a previously published version: U.S. Preventive Services Task Force. Screening for lung cancer. In: Guide to clinical preventive services, 2nd ed. Baltimore (MD): Williams & Wilkins; 1996. p. 135-9.

## **GUIDELINE AVAILABILITY**

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

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:

- Humphrey LL, Teutsch S, Johnson MS. Lung cancer screening with sputum cytologic examination, chest radiography, and computed tomography: an update for the U.S. Preventive Services Task Force. Ann Intern Med 2004 May 4;140(9):740-53.

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

- Humphrey LL, Johnson M, Teutsch S. Lung cancer screening: an update for the U.S Preventive Services Task Force. Rockville (MD); Agency for

Healthcare Research and Quality; 2004 May 3. 62 p. (Systematic Evidence Review No. 31).

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).

- Screening for lung cancer: recommendations from the U.S. Preventive Services Task Force. *Ann Intern Med* 2004 May 4;140(9):I88.

Electronic copies: Available from the [Annals of Internal Medicine Online Web site](#).

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

## **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 NGC summary was updated by ECRI on April 26, 2004. The information was verified by the guideline developer on April 27, 2004.

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