#251 USPSTF Updates - Transcription

Sat, 2/13 11:31AM • 1:04:51

SUMMARY KEYWORDS

screening, patients, guidelines, age, recommendation, update, patient population, treatments, cytology, testing, screen, benefit, based, test, hepatitis c, cervical cancer, colonoscopy, harm, unhealthy, abnormal

SPEAKERS

Amber, Paul, Matt, Stuart

Paul 09:16

Sure. So, let's start with a case as we often do, so I'm going to paint a word picture for you is eight o'clock on a beautiful Monday morning we at Kashlak Northeast primary care clinic. The sun is shining, your email inbox is overflowing. Your clinic schedule is full of both new and familiar patients. The first patient of the day is Guy Delines he has a 35-year-old male with high blood pressure who's here for a follow up appointment after initiation of a new medication for blood pressure management. Blood Pressure today is 175, eshh, not 175. Its 125/70. He has been tolerating the new medication well and without any other acute complaints. Since you have a bit of extra time in the visit. You decided to use this opportunity to make sure that he is up to date with appropriate health screenings. You know that since his last visit the USPSTF has updated their guidelines for the screening of unhealthy drug use. So, before we get into that specific guideline itself, I wonder if you could just, Amber, give us a little bit of a baseline about who the United States Preventive Services Task Force are, what they do and kind of how they come up with their recommendations. And then maybe we can delve deeper into the newer recommendations they come up with, which is really sort of what we're hoping to talk about today.

Amber 10:18

Sure, so the USPSTF, or United States preventive service task force, which is a mouthful and hard to remember, is an independent and voluntary task force that actually is made up of experts in preventive medicine and evidence-based medicine. And I didn't realize this until a few years ago, when I was digging into a guideline that they actually are volunteers from all different areas of preventive medicine. So, it could be general internal medicine physicians, Family Medicine physicians, pediatricians, behavioral health experts, nurses, nursing obstetrics and gynecology, so really individuals from all different specialties, and they're tasked with making recommendations about prevention in a clinical context. So, they really are not doing any new studies. They're not doing any new research, but they are taking the existing research creating kind of evidence-based guidelines based on their overall assessment of benefits or harms of that screening or preventive treatment that they're assessing. You know, I think for me, there's two big points. So, first, is that their recommendations overall are for an

asymptomatic patient population. So, they're really trying to look at, you know, the average individual who's going to present to your clinic, and you're thinking about specific preventive services that would be applicable to them and their age range. And then the other is that, you know, when they are considering these preventive services, they're really just making a recommendation over, you know, how good is the evidence that's out there? And what is the tradeoff between benefits and harms of this service? They're not really considering costs at all in that preventive service. And that's not a factor in determining the recommendation that they make.

Paul 12:13
I think it is important to point out and I can't remember if this is this comes up later, but that the anything that has a B recommendation or above, if it's a preventive service, isn't it free for the patient?

Amber 12:24
Yeah, so, I guess free, may not be totally true, it probably depends on insurance and kind of copay status for that individual insurance. But when we talk about government subsidized insurance plans, like Medicaid and Medicare, generally, those preventive services, if they have a grade B or higher are covered preventive services.

Matt 12:45
Okay. So not free, but they're covered preventive services. So, missing? Probably, I misspoke. That's a big way to misspeak, too, if people are

Paul 12:55
Yeah, so, I guess that's it, this might be a good chance to ask them if you could just talk us through the grades themselves and exactly what we are to do with them and what they mean.

Amber 13:02
Yeah, so there are the grades. And I think before we get to the grades, it's probably important to just reflect on one other skill that they use, and that's levels of certainty. So, there are three levels of certainty that the USPSTF uses so low, moderate, and high. And each of those levels of certainty are really just based on how good the data is that's out there. So, if something gets a high level of certainty and the recommendation, and really what they're saying is that there are really consistent results from well-designed studies in a representative primary care population. Moderate means, you know, there's enough evidence out there that we can determine an impact. But maybe the studies aren't really the best design studies, maybe it's not completely generalizable to our patient population. But we can at least assess the service that we're recommending. And then low is basically saying, there's a lot of flaws, we don't have good data. And we can assess the impact of this service on overall outcomes for patients. And those levels of certainty matter because they use those with the assessment of the benefit to harm ratio of the service to determine the grade. So, A and B are basically the grades where you're going to say, "Yes, I'm going to do this." This is something you should offer. These are situations where there's either a moderate or high level of certainty. And we know that the benefits are likely to at least have a, you know, moderate, I guess I would say they would have at least some benefit over kind of harm. So the total benefit outweighs the harm in those instances. Grade C is really where you have to individualize to the patient population. So you need to look at the service that you're recommending,

and then you need to look at where The benefits are greatest for that service and then individualize that for the patient population in front of you. And then D is I think of just D for discouraged. So this is where we know that the harm is greater than the benefit. And I think of I don't know. So this is where we just can't fully assess the balance between benefit and harm, because there's not enough data out there. So overall, A and B, do it; C, talk to your patients; D, don't do it; I, I don't know, and probably really have to individualize any decisions you make about that service for your individual patient.

Paul 15:36
So that was incredibly helpful. Thank you for that. But I'm wondering how often these guidelines are updated?

Amber 15:41
Yeah, so I would say, on average, every five years, they're at least considered for update. That doesn't mean that everyone would get updated every five years. If there's not really any new evidence to review, then they may not update the recommendations. And I think we'll see that when we talk about unhealthy drug use, it really was several, several years, I think, almost 12 or 13 years before they did a formal update. And when they do earlier updates, it's usually because somebody has nominated a new topic for the taskforce, or they've requested an update. So you know, the USPSTF will consider any public requests for update, it doesn't mean that just because one of us goes on to the website and says, Hey, we want an update for breast cancer screening that they're going to do that tomorrow. But if they get enough public comments, or there's enough compelling evidence to say, maybe we should review sooner than the five years, they will do that.

Stuart 16:38
That actually is very helpful information, because I've been trying to figure out a way to push one thing forward for antenatal screening.

Matt 16:47
I think I know what that's about! Laughter

Stuart 16:48
I think you do to! Laughter

Matt 16:51
Iron Maybe?

Stuart 16:52
Maybe... Laughter

Matt 16:53
Amber, can you tell us what do you use to keep up with this? Is there an app? Is there? Do you just go to the USPSTF site? What do you think is the best way to keep on top of all this?

Amber 17:06

Yeah, I wish I had a really glamorous answer for this one. I think I sign up for the updates from the USPSTF. If you go to their website, there's an email listserv that you can click on. And then quite honestly, the other one is Twitter. I think like the med-ed community on Twitter tends to find these updates even faster than I can find them in my inbox at the end of the day. So usually, if there's something that's like, really big, that's happened, I'll see it on there for so I would say, if you are on Twitter, following the big organizations that make guidelines in your area, you know, your specialty is probably a great way to hear about these early.

Paul 17:46
Yeah, so it's one of the reasons I want to do this episode is because it seemed like USPSTF was working just overtime during COVID, which is the worst time to do it because I barely had an attention span before COVID. And now I have nothing at all. And as soon as that sort of took over my world, it seemed like Twitter had blown up because they made a bunch of recommendation updates and new recommendations. You had mentioned, the update to screening for unhealthy drug use, which is an update to a prior recommendation where I think they didn't determine there's a whole lot of benefit, but they couldn't determine substantial benefit to actually recommend it or not, if I'm understanding correctly. So I wonder if you couldn't talk us through what the update says in terms of screening for unhealthy drug use and what we're supposed to be doing now.

Amber 18:26
Yeah, so I think you're right. So the prior recommendation was a grade "I" which basically just meant that there was not enough data to make any conclusion over whether or not it would be beneficial to screen for unhealthy drug use in the primary care setting. And I will just say that this is different than, like screening for tobacco use or screening for alcohol use, which are separate guidelines. So we're not including those in this recommendation. And it's been I believe it's been 12 years since they updated this guideline, I can't remember if the first one was 2008 or 2007. But basically what's happened in that time is with any of these updates, there's just been a lot more data. So there's been about 12 studies that looked at 15 different screening tools that could be used in the primary care setting and various primary care settings to assess for unhealthy drug use. And so that's other you know, illicit drug use or prescribes medications that are used in a pattern that is not consistent with the way they were prescribed. So basically, that data showed that there is a net benefit to screening and offering interventions for treatment if they are available in your kind of primary care setting. And so I guess the that is a big If so, you know, they're saying screen everyone 18 years and older. But do it if you have services for diagnosis. treatment and appropriate care that can be offered to your patients. If you don't have those resources, there's no clear guideline on whether or not you should continue with screening.

Paul 20:12
So I think wasn't depression screening phrased in a similar way? Yes, previously, and I'm losing track, because I feel like they've just been updated so much. I think the prior depression recommendation was the same thing to screen if you can do something about it, otherwise, we don't know what to tell you.

Amber 20:26
Yeah. And I think that that's part of the reason that the guidelines were grade "I" guideline before is because we didn't know the impact of treatment. We didn't, we didn't have effective screening tools, we

didn't know the impact of treatment. And so they couldn't really say that there was any benefit at all. But now, the studies that have been done since that time show that really the screening tools are accurate for detecting unhealthy drug use. And so 1. we know there's a benefit of kind of a good screening tool. But then there have been enough studies that have shown a benefit both in terms of psychotherapy and pharmacotherapy, depending on unhealthy drug use that's identified.

Matt 21:09
So I think we should make let's bring this let's try to make this as concrete as possible so that it's kind of vague like these services. So they're, they're saying the skills or the services to provide effective treatment. So what specifically pushed them over into this is an opioid use disorder, because now so many more people hopefully are have buprenorphine waivers or ex waivers to prescribe buprenorphine? Is it? Is it the fact that we're now more comfortable treating alcohol use disorder? all the above? Why do you think that push them in this direction?

Amber 21:43
Yeah, so what I guess what I would say is that of the studies that they looked at, so they actually, you know, from a pharmacotherapy standpoint, the only pharmacotherapy that was really looked at in the studies that helped to update this guideline was pharmacotherapy for opioid use disorder. So we're talking about naltrexone buprenorphine and methadone. And I think separate from this guideline update, we know that those pharmacotherapies are effective at decreasing relapse rate and increasing abstinence time and individuals who seek treatment for opioid use disorder. So that certainly is a very big component to the change in this guideline. Separate from that they did include studies that looked at non-opioid use disorder. So other, you know, illegal drug use or other drug use disorders, who were referred to drug treatment programs. And for those, they didn't have to include a pharmacotherapy component. And what they found is that whether it was brief, and they defined brief has really only one or two sessions of psychotherapy that were less than an hour long, or intensive, which meant two, one hour sessions, or more than two sessions was all you needed to be considered intensive treatment, both of those with a brief or intensive lead to an improvement in abstinence duration, both at three to four months and six to 12 months. And so I think that, you know, the, the driver here probably was the more effective treatment of opioid use disorder, because that was a bulk of the pharmacotherapy data. But there were several studies that showed effectiveness of both brief and intensive psychotherapy. And those psychotherapy methods involves kind of standard psychological methods like CBT, and motivational interviewing, at kind of improving abstinence rates.

Matt 23:43
So it sounds like we're gonna, we're gonna be screening. And if we feel comfortable treating opioid use disorder, and we're familiar with the resources for any kind of alcohol or drug treatment in our area, then it'd be reasonable to screen. One of the things I thought was interesting is that they actually included a statement that said to minimize the potential adverse effects such as stigma, labeling, or medico legal consequences of asking questions about drug use, and documenting and reporting answers, we should be aware of our state reporting requirements. That kind of scared me, I'm like, Am I gonna get someone in trouble by just writing that they like, I don't know, use cocaine once in the 80s or something like that?

Amber 24:26
Yeah, and, and I would imagine that that's really variable by state, as far as I know, you know, here at Kashlak in our home state, that there is no reporting requirement for substance use and access to medical records is very difficult for employers unless it was through, you know, some patient approved method of disclosing that information. So, you know, I haven't, I haven't been concerned about that when doing screening in in my primary clinic but I certainly think it's worth noting and making sure that there isn't any mandated reporting in your state. I just I have not heard of that.

Matt 25:08
That just seemed to me like I was like, what could be the potential harms with this? And that was that was one of the things listed in there. So

Paul 25:16
I think the wording of the screening, if I'm not mistaken, even specifies that don't do it. If there's a chance that will end up being punitive. Like I think they use the word punitive. So I actually I kind of love how thoughtful they are in terms of who should be screened, just to make sure that there are no harms that are coming from it.

Amber 25:28
Yes, and we should probably be really explicit and say that the guideline is for verbal screening, I think that's something that you could actually misinterpret. There is no indication for laboratory based screening for substance use disorder in the primary care setting. And I think that that is something that should be emphasized, this is purely verbal screening to you know, assess your patient's use of these substances. So,

Matt 25:54
Amber, we were talking about, you mentioned, there's a bunch of tools they looked at, and beforehand, you told us the NIDA quick screen is one. So and this is a I believe it's mostly a verbal thing that you can go through with the patients. Can you talk a little bit about how people might use that? Is that convenient to just pull up in the clinic? I haven't used it before, is it convenient to pull up and just go through with the person?

Amber 26:13
Yeah, so I think it's probably the easiest and quickest screening tool to use in the primary care setting. I think, anytime we're talking about doing more screening tests, in a busy clinic session, you want something that is only going to take, you know, five minutes to do for most patients, at most, because that's probably a quarter of your visit. So that National Institute on Drug Abuse, quick screen is basically just four questions. And they're asking about the use of alcohol, tobacco, non medical use of prescription drugs, and then illegal drugs. So if you think about it, when we talked about unhealthy drug use screening, we're not actually including tobacco and alcohol in that kind of recommendation, we know that there's a recommendation to screen all of our patients for tobacco use and alcohol. So you're kind of getting three of your guideline recommendations and one screening test. It is basically almost like a Likert based scale that your patients are reporting on. So it just asked in the past year, have they used any of those substances, and they say either never once or twice monthly, weekly, daily, and

really just a positive answer on any of those. So anything more than never is a positive screen. I actually don't do this with just a verbal screen, because the website for this is actually great. So if you go on to the NIDA website, and you test positive, it automatically takes you right into a separate screening tool called the Assist, which actually allows you to quantify use, and then it will give you an assessment of risk for your patient. And at the end actually gives you recommendations for treatment options. So if you're really you know, concerned about a patient, and you want to be able to screen and then quantify, you know how high risk they might be based on their current news, I would say go to the website, it's comprehensive.

Paul 28:04
So we screen guy, he has not used any prescription drugs for non medical reasons or any illegal drugs for the past year. As you're completing your visit, you take your dedication to Brenda's medicine to the next level. And you're printing out a lab slip for Dave to receive screening for hepatitis C. So as a reminder, this is a patient who is 35 years old, it is the year of our Lord 2020 right now. But we are now screening for hepatitis C, I think largely based on an updated USPSTF recommendation. Could you talk us through that change and sort of why that actually happened? Yeah, so

Amber 28:34
the new recommendation is a great recommendation. So moderate level of evidence that the net effect is at least net benefit is at least moderate. to screen, everybody aged 18 to 79, at least one time for hepatitis C, the old screening recommendations for screening everybody who was born between the years of 1945 to 1965, at least once. So this expands the population that we're screening. And really similar to what we just spoke about with unhealthy drug use, you know, all of these screening recommendations when they get updated or based on evidence and new evidence that kind of surfaces that tells us about the screening benefits in different populations. So basically, we have better treatments now that are effective and safer than our older treatments before 2013. So, you know, overall, there are the treatments that we use now are direct acting antiviral treatments, and those regimens are shorter duration, they have fewer side effects and they have a higher rate of sustained viral kind of remission or essentially sustained virologic response. So the treatments are very, very good and the side effects from the those treatments are much less than the treatments that we had prior to 2013 In addition, what we know is that our prevalence of hepatitis C new hepatitis C infections is actually rising in individuals in their 20s and 30s in the United States, and some of that is associated with increased rates of IV drug use. So, you know, I think when you look at this, we're missing a population that would actually benefit from screening based on the old guidelines, and we now have an effective treatment that is less harmful to patients. If you take a look at just studies, overall, we know that the benefits of treating chronic hepatitis C far outweigh the risk of those treatments now with these new medications, and we know that not treating actually leads to a very high risk of hepatocellular, carcinoma and cirrhosis for our patients. And then the only other thing that I think stands out is the guy mind goes all the way up to the age of 79. And, you know, surprisingly, we don't see this a lot in studies is that the studies that looked at some of the newer direct acting, antivirals actually included patients up until their, like, early 80s. And that's how we know that treatments are safe up until that time. So the guideline recommendation of up to 79, is just to say that, if you screened by that age, you know, it's probably still safe and most average, you know, risk patient populations to go on to treatment. If they are positive, and we're screening with a Hep C antibody, and then the we're only doing the PCR test, if

that is positive as a confirmatory. Yeah, so I think that's exactly right. So you're doing basically antibody based testing as your initial screening tests, and then that should reflex to hepatitis C, like RNA based testing, and that RNA based testing could be qualitative or quantitative, depending on your lab.

Paul 31:52
It's a good chance now just to mention my biggest pet peeve. Whereas if someone has a positive hepatitis C antibody, you don't have to keep checking that you can please I beg of you. And then I think the other thing, and I'm not sure there's even a question here, but I think one of the other things that was interesting about this is reading through the justification for it, is it really seemed to address health on the individual level, like it really the idea is that there's this very treatable disease, it prevents hepatocellular carcinoma, but there didn't seem to be a lot of discussion about the population base level in terms of prevention of transmission among patients with injection drug use, or that kind of thing. Like that seems to not be even a consideration for the guideline, which I thought was interesting. But I guess now that based on what you told us before, is, I guess, in keeping with their overall philosophy, of really focusing on the primary care population, and not one specific niche patient population.

Amber 32:38
Yeah. And I think it gets into that kind of reflects on a question that often comes up, which is okay, we did this one time screening, should we keep screening? And I think the argument there is now you've moved beyond an average risk patient population the same way we would think of, you know, if I have a patient with an elevated BMI, and I get an emergency once, is that enough? Probably not. Right? That's a higher risk patient population by nature of their other health conditions. And I think for hepatitis C, we almost have to think about that the same way for, you know, IV drug use, they're not now no longer in that average risk patient population

Matt 33:14
and remind you that reinfection is possible even if they've been treated as well. Yes, yeah. Stuart, do you want to read the second case?

Stuart 33:22
Sure. So after we've talked about guy to the nth degree, you now have a another patient on your sunny Monday morning, Mr. Lyons, he snagged some cold coffee from the work room has a question the exact age of your beverage, which is kind of scary. You feel empowered by the goodness of preventive medicine scroll through even more guidelines through Twitter, in the hall on your way to the exam room, Miss Pat papilloma? Well, she's a healthy 24 year old female here for her yearly checkup. She has had her first pap smear at age 21. It showed no evidence of epithelium, malignancy or any other abnormalities. She remembers being told that she would need her next one three years later, as many of her friends have done. However, she was wondering if there are any other options for screening, or perhaps she could postpone testing altogether. Armed with your knowledge of screening guidelines, you feel prepared to advise this patient? So what are the most recent changes to the screening guidelines for cervical cancer? And have they been affected in this post COVID era? Yeah, so

Amber 34:28

this is a great time to remember that, despite how much we just spoke about USPSTF, that USPSTF is not the only group that will give us guidelines and make recommendations about screening and preventive services. And I think just as we mentioned, with USPSTF, every group is going to have their own priorities. That's going to help to drive their guidelines. So the American Cancer Society, the American College of Obstetrics and Gynecology, they're all Going to use kind of their preferences, their societal preferences and goals to help drive their recommendations based on their evidence review. So understanding the body that's putting out the recommendations can help you to interpret them for your patients when they show up in the clinic. And the example I always use for this is, you know, the American Cancer Society is going to prioritize finding and treating cancer, right, their goal is to kind of eradicate cancer as much as they can. And they're going to prioritize that at the expense of probably more false positive, you know, test results than maybe another body would. So the US Preventive Services Task Force is going to look at overall benefit and harm. And their goal is not complete eradication of a disease if that means there's more false positives or more harm, whereas, you know, maybe the American Cancer Society is going to tolerate a little higher rate of false positives if it means detecting more cancer earlier on. So with that background, I think the easiest way to understand the changes that the American Cancer Society made is to really understand where we started with USB STF. So I might just mention those guidelines first, which were updated in 2018. And then we can kind of compare them to the American Cancer Society. So in 2018, USPSTF basically added one additional screening option to their cervical cancer screening guidelines for women between the ages of 30 to 65. So the guidelines have always recommended cytology only based screening every three years, or cytology with CCO tests for HPV for Wim every five years for women between the ages of 30 to 65. In 2018, USPSTF added on primary high risk HPV testing only every five years, meaning you did not need to do cytology testing with him. And any of those screening modalities was considered to be equivalent for women between the ages of 30 and 65. In 2020, the American Cancer Society came out and updated their guidelines and kind of made a mess of all of the old guidelines. So I think there's four big take home points from it. So the first is they increased the starting age of screening to 25. So they basically said, Stop screening between 21 and 24. The second big takeaway was they said that primary HPV testing every five years until the age of 65, should be the preferred method of screening for all women who are undergoing cervical cancer screening. They added the caveat of if you don't have access to primary HPV testing, then you could do code testing every five years, or cytology only every three years. But they heavily emphasize that this is a transitional recommendation and that everybody, over time should be moving to primary HPV based testing every five years. And then the final kind of update that they gave was kind of clear guidelines on when we should stop screening after the age of 65.

Stuart 38:19
Which says what that if there's no ascus or abnormal cells, you just stop screening, is it? That's good, is that correct?

Amber 38:27
Yeah, it's a little, it's a little bit more detailed. But that's essentially the takeaway. So basically, you have to have normal screening for the 10 years prior. So that means you have to have either two negative code tests, or three negative cytology only screens within the 10 years prior to stopping. And you could not have had ci n two or higher in the 25 years prior to stopping. And,

Stuart 38:57
boy, it's gonna be hard to data mine that in my EMR. Yeah. Yeah.

Matt 39:01
Yeah. How do you hit it? That's it. That brings up a good point. Amber, how are you fact checking out yourself for when people are 65?

Amber 39:08
Yeah, obviously, if you have any Mr. It's much easier. So for me, I have a specific filter on my results in my EMR that looks at cytology, cytology only, which is now going to be obsolete, because we're moving away from cytology, but that's what I used to use to pull up and be able to quickly see what results were available. Quite honestly, it's very labor intensive. A lot of times it's just writing and tracking these results over time. And using that, to help guide your decision making, but it can be really challenging when your patients have fragmented care if they're not always coming to you for this testing.

Matt 39:49
I dream of a future where like some of these things that would be super useful uses of technology to say something redundant, it would just I just it would be so great. Just be like chart Tell me has this person had a colonoscopy? I know there's a million nooks and crannies where this code ICP or pap or HPV could be hiding.

Stuart 40:09
It's so funny because that's actually been available since HL seven was standard 1980s. Because that's how it's billed to the insurance company. So if you have access to the actual database for HL seven data, you can actually query that specific thing.

Matt 40:25
And why aren't we doing this too? Because? Because make it or look through like,

Stuart 40:29
because EMR is the developers for EMRs have a financial incentive not to offer interoperability? I'm sorry. It's the truth.

Matt 40:41
From the episode, are they gonna like short circuit or podcast?

Stuart 40:45
No, if they want to put a target on me Go ahead, because that is the absolute truth. There is a financial incentive not to offer interoperability. So each EMR takes the HL seven data and like comes up with their own language.

Matt 41:00
There is I knew you were I knew you were there. Still.

Paul 41:02
There we go. Hey, we woke up Great.

Stuart 41:05
Well, it upsets me because I everything you're talking about, I can do, but the EMR doesn't do it. I have to do it on my own.

Matt 41:14
Yeah. Amber, tell me it seems like the change was made maybe for at least two reasons. One being the HPV vaccine. Now the people the benefits of that are sort of catching up and there's less disease. Can you talk what was the what was the rationale for raising the age to 25? Yeah, I

Amber 41:32
would say that the HPV vaccine probably had more of an impact on getting rid of the cytology based screen. Particularly and the age, I think portion of it, but certainly for the cytology, because what we know is that HPV vaccination started around 2007. I would say that uptake initially was shaky. Not many people actually chose to get the vaccine initially. But over time, once they expanded the age range to lower age ranges for patients, they, the rates of vaccination have increased significantly. And if you actually look at population data now, about 50% of women between the ages of 18 to 26, have had at least one HPV vaccination. And if you look at younger populations, like women between the ages of 13 to 17, is about two thirds, who've gotten at least one HPV vaccination. So the rates have really, really increased. And I don't think we know the full impacts of that, you know, the impact of vaccination on high risk HPV rates just yet for that population. But we do know that the incidence of cervical cancer is declining with increasing HPV vaccination, cytology based screening, basically is less efficient in vaccinated patient populations, because it disproportionately detects changes or minor abnormalities that are associated with HPV types that are a lower risk for cancer. And so when you think about it, you know, if you're doing cytology only, and you're finding these mild abnormalities, I can think of all these patients that we get, they get, ask us and then ask us again, and then they go for a colposcopy, and it's normal. And then you screen them again. And they have asked us again, and you're kind of in this conundrum of like, what am I doing with screening, you know, if you continue to have high rates of vaccination, there's a chance that you're going to get a higher rate of these kind of mild abnormalities with a lower overall risk of HPV that is meaningful, or I guess, has a high rate of leading to cervical cancer. So it's, it's a combination of, you know, over time, you're going to get more and more false positives in a vaccinated patient population, just because of the changes that cytology detects, which tend to be these more mild changes.

Matt 44:04
Is this practice changing for you? Are you going to start doing at age 25, the HPV test alone and just stopped doing the cytology?

Amber 44:14
Yeah, you know, the age portion of this is interesting to me, because I think when we think about the age 21 to 24, you know, I guess when you think about cervical cancer screening over a longer period of

time, we used to start at 18. And that got pushed to 21. And now we're kind of pushing to 25. The incidence of cancer in women aged 21 to 24 is low, you know, of all of the cervical cancers that we see in the United States, only 1% of them are in women aged 21 to 24. And then when you look at actual cancer deaths in that age range, it's less than 1% of the total cervical cancer deaths in the United States. So it really is a very, very small proportion of the cervical cancer that we See. And I think if you combine that with the fact that we have higher transient infections in that age range and women between the age of 21 to 24, it kind of pushes me towards not wanting to screen that population, because they have a very low risk for cancer, they have a higher risk of these transient infections that are likely going to clear on their own. And we know that the more procedures that we do to the cervix, the higher risk of future obstetric complications for those patients. So to me, it's a really low value age range to screen. And so stopping screening between 21 to 24, I think is going to be easier for me than probably a lot of patients who are accustomed to screening. But that I think I would adapt pretty easily. I think the hard part is thinking about using this HPV based testing for women between the ages of 25 to 29.

Paul 45:57
We I think we touched a little bit on why guidelines diverge and sort of based on the emphasis of the various societies that actually generate them. But I think I'd like to hear a little bit more about how you choose which guideline to follow. I think we touched on that a little bit. But I feel like oftentimes, it's not unusual to have guidelines that conflict a little bit from each other. So for you, in the primary care setting, how are you choosing sort of different specialty study guidelines versus USPSTF versus personal practice? Is there Do you have a certain algorithm or a certain way that you sort of look at these broadly?

Amber 46:29
Yeah, I would say, you know, overall, I think the, the tough truth of screening guidelines is you almost just have to get comfortable with reading and interpreting the data summaries that they provide with their guidelines. And it would be much easier to just be able to read the recommendation and apply the recommendation universally. But I think this is what happens is you get different recommendations. And for me, I have to understand like why there's a difference there. This is a perfect example of where from a cervical sand cervical screening standpoint, I'm happy to kind of get rid of my screening from 21 to 24. But then, when I start to think about women aged 25 to 29, I think about how, you know, you're putting those individuals through a test that is much more sensitive for cervical cancer, but actually carries a higher rate of false positives. And so there is a potential for more harm in that population from adjusting this guideline. And so when I'm weighing these, in my mind, I'm really trying to think about my individual patients in front of me, and I think, you know, this is kind of the nuance of primary care is that there's probably no wrong answer, as long as you're doing some screening for these women. The most sensitive screening tests, I think, we know is HPV based screening. But if I have a patient who I know, is going to be much more affected by the harm of an abnormal test result, which I think is a real harm. I think sometimes we say it and kind of brush it off. But I think we all can think of patients who have had an abnormal test result that ends up being fine. But the time in between, you know, that colposcopy or that confirmatory test is really stressful for them. I have to weigh that as I apply kind of the screening guidelines. So for me, you know, for cervical cancer, I look at the data and I say, What am I really trading off here? I think if I was asked how I would apply this to my own practice, I would say I would

adopt the you know, my personal opinion is I would adopt that 25 starting age for screening, and then 25 to 29. The HPV only screening or co test based screening may have to be more individual patient preference, understanding the trade off of you know, a more sensitive task but this higher risk of false positives.

Matt 48:56
Paul, should we move on so, I guess she we had the conversation she opted for the HPV test to start at age 25. And her fingers crossed there's no false positives for her.

Paul 49:10
So thank you for your well wishes for Ms. Paloma. But let's just say something would come back abnormal Amber, are there any apps or any tools that you use to sort of deal with the results of these?

Amber 49:20
Yeah, so probably the easiest to use is the ASCCP website. So if you go to app.asc.org that is the easiest. But basically, they have a mobile app that you would pay for or you can use their web app for free. And the best thing about that is you can actually put in your patients last two pap results, and it will take you through an algorithm to tell you what their screening recommendation would be. And all of that is based on expert consent. a consensus guidelines for abnormal test results. So it's convenient. It allows you to incorporate different testing modalities. So let's say our patient had cytology only seven years ago and then had, you know, this new HPV only testing for her most recent tasks, you could combine those different results to get a recommendation for the next interval screen.

Paul 50:27
Excellent. All right, so perfect. We'll keep moving on with our busy clinic day, we welcome Miss Paloma out the door. And we still have a few minutes to tackle or looming EMR inbox at the top of the queue is a message from a longtime patient of yours. And this is an all time name. Jimmy Haustra. Oh boy, so happy right now. He is a lovely, healthy, 46 year old gentlemen, you can't be 46 and a gentleman. That's just that's not… He's just a 46 year old guy who read online that the guidelines for screening for colorectal cancer have recently changed. And they're now recommending screenings as early as age 45. He has no acute GI complaints, nothing systemic, that's worrisome at all. However, one of his close friends was recently diagnosed with colorectal cancer. And he's now wondering about your thoughts about starting his screening earlier. So can you tell us what sort of changes if any have actually happened with the colorectal cancer screening guidelines, then we can take it from there. Yeah, so

Amber 51:22
the USPSTF. guidelines haven't changed just yet. So this can get confusing. But in October of this year, they released their draft recommendations. And basically, if we think back to the beginning, when we talked about, you know, how the panel works, and how people can make recommendations for earlier reviews. Basically, the USPSTF did a full evidence review over the past year or so looking at updated evidence for colorectal cancer screening in, you know, average risk adults in the United States. And at the end of that they compile all that evidence, and they give us a draft recommendation where they give us a grade and their recommendation. But before they publish, that they actually put it up for Public Comment Commentary. And so basically, that draft recommendation is published so that everybody

can look at it, look at the evidence that they've reviewed, and then make comments about whether or not they agree or disagree or have other things that they would like, added for review prior to the final recommendation. And so, for the colorectal cancer screening guidelines, the public commentary period is now closed. So what that means is they've already taken in all those comments, and now we're just waiting for them to fully publish their final recommendation.

Paul 52:43
So I guess two questions that I can you and the first one is probably not a fair one. But can you think of a time where a draft was put out for public comment, the comment the public one bananas, and then they just changed their minds and did not and then putting out the draft in a finished form? Like I'm trying to think of an episode and I can't

Amber 52:58
Yeah, I mean, I the most controversial updates I think of are really the breast cancer screening guidelines. But that I think, was more like the American Cancer Society guidelines were different and more discussion over the interval for screening. I don't actually believe that that led to a real change in the final recommendation. So not off the top of my head, I think of anywhere they actually change the recommendation. In the end.

Matt 53:24
When I was reading about this, there was a website I came across, it's called fight colon cancer.org. We're fight colorectal cancer.org. And one of the things they were saying is that this is going to by lowering the age, you will make 19 million more people eligible for colorectal cancer screening. And one of the things that I thought was really interesting was they were calling and this was not done yet, but they were calling for them to, to pay for follow up colonoscopies for screening colonoscopies that were abnormal, and not calling them diagnostic colonoscopies, because I guess there's a difference in the payment cost for patients. And I just thought that was super interesting kind of goes back to the previous comments where you're talking about how screening, screening is covered. But I guess if someone gets shunted into one of these pathways where they have abnormal testing, it may not be and they're saying that if it's linked to a screening, it should continue to be considered screening.

Amber 54:21
Yeah, and I think that really depends on ensure and how they cover some of these tests, you know, before. And I would say even now, when I think about whether or not this would actually change my practice, in general, when I think about these, like updates until they're final, we oftentimes don't change our practice fully because insurance won't actually cover these tests. And so when you think about screening of 45 year olds, who may be very interested in colorectal cancer screening, if they're going to pay out of pocket for a colonoscopy, that's a lot of money and prior to the age of 50, for most of our patients, you actually have to You know, order a diagnostic colonoscopy to even get it approved with some symptom for the patient taking them out of that average risk patient population. So these guidelines are actually really, really important and necessary to even allow for screening in kind of expanded patient populations. Because without them, there isn't an option for most patients.

Matt 55:23

Stuart, I know you wanted to bring up.

Stuart 55:25
I just want I just wanted to say that I hate to be the poor soul who had to go through all the public comments for colorectal cancer screening for this year. Because I just imagine that there were 10s upon 1000s of comments about Chadwick Boseman. I just, at least that's the way I'm imagining it in my mind's eye.

Amber 55:45
Yeah, I guess I would actually say like, the one part of this screening guideline that a lot of people could easily tie to Chadwick Boseman, and would advocate for is that changing this guideline probably will help if assuming that the adoption of screening was universal. And we really screened everyone between ages 45 to 50, that changing this screening guideline would actually help to decrease disparities and colorectal cancer outcomes. So, you know, there, there is an argument that like you could actually have an impact on disparities for black patients, if we screened sooner between the ages of 45 and 50.

Matt 56:30
Excellent. So Jimmy, may have a colonoscopy coming his way? covered by insurance if this recommendation goes through?

Amber 56:39
Yeah, and the only other caveat, I'll just add briefly is that the recommendation is not just for colonoscopy, I know we tend to think of that only, but when we're thinking about cost, and maybe how cost could change drastically if we start screening everyone between 45 to 50. Really, we don't know what screening modality is most effective. And so right now, the guidelines are for any of the screening modality so colonoscopies fit testing, fecal occult blood testing, etc. So, so we could potentially have lower costs, if you know, people were doing shed or Pico cold blood testing in that time period. But

Matt 57:20
so I had one, one or two rapid fire questions for you, when someone comes in and asks you to screen them for a cancer that we don't have a test a screening evidence for? How do you handle that, like someone's like, I want you to screen me for ovarian cancer, because I had a great aunt who had ovarian cancer.

Amber 57:39
Yeah, usually a long discussion. So oftentimes, I will be honest, and just say, we're not very good at screening for that cancer, or the things that we can do, don't actually help us to find that cancer. And, and may actually, you know, depending on what they're asking for, may actually cause more harm, or my may find things that really aren't a problem at all for you. I think of this the most with women who still think that they need a Pap test after age 65, or who are asking for like a regular pelvic exam, when they come in, I will say I am happy to do a pelvic exam as part of your like annual exam. But I want you to understand that this is not going to help us to find, you know, ovarian cancer sooner or earlier. In in most patients and so I don't want you to think that this, you know, is a screening test that is helpful in

that sense. And quite honestly, for most patients for something like that, you know, women will say, Well, you know what, I don't really want a pelvic exam. So if you're not, if you're going to do a pelvic exam, and it's not helping to find anything, then why are we doing it? So there's nothing glamorous just a conversation.

Matt 58:54
And Paul was telling me about patients coming in. Paul, you want to talk about this? The this this blast, like shotgun style screening for patients?

Paul 59:07
Oh, yeah, I mean, it's not a terribly exciting story. But I just I fairly recently had a bananas patient form that the patient brought in on behalf of his employer. And apparently, you get some sort of rebate or incentive for actually getting different types of screening done. And this was even more exotic than the carotid intimal thickness screening that you can get in some van that's parked outside, those

Matt 59:25
are the ones they get, were often the person that's like I had triple A, and they did they did like all this, a triple A screening and carotid intima thickness, Abi is all this all this stuff.

Paul 59:36
And maybe a dexa scan, which you could also possibly use, which is always nice, but like most of the stuff, but this patient was things like digital rectal examination for prostate cancer and depression screening and vision check and depression screening. So some of the evidence based some of it less so and it was just sort of this bizarre checklist where he was just incentivized to give his doctor to check it, which is just very interesting. So it was sort of tricky navigating that because I certainly want everyone have as much money as they can possibly get. But also, I don't want to put them through unnecessary testing or things that are not going to further their health. So it's just a weird situation.

Amber 1:00:08
Yeah, I fortunate in that I have not seen one of those forms in some time. But I know exactly what you're talking about. I mean, honestly, sometimes I will tell patients, you know, every test that we do, there is a reason that somebody wants that test done. And so, you know, especially if there are tests looking at like asymptomatic carotid artery stenosis or things like that, you know, there's some intervention that could be done if we find something abnormal. But if you're feeling well, what's the point of finding something abnormal? If we know that that's not going to help you? I mean, I don't know that that's convincing for everyone. But maybe one out of five or 10, it might be. It's the same way. The same way I try to convince people not to get MRI. So I always say, Do you want a surgery on your back for you know, something that's really not causing you enough symptoms to warrant a surgery? And I think it's a challenging conversation, but

Matt 1:01:05
The therapeutic MRI for chronic low back pain, one of my favorites? Well, I think probably we should ask you for take home points. And thank you for your time. So tell the audience if they remember

nothing else about from this show? What are you know, two or three things you'd want them to remember?

Amber 1:01:25
Yeah, I love good take home points. So I would say that preventive medicine is complex. And it's not as simple as just knowing what the guidelines are, but really trying to understand who's making the guidelines that you're using, and what the net benefit and harm is to screening in your population. And then I would say of the big topics we talked about, we should be screening all of our adults for unhealthy drug use, that for our female patients, we should be reconsidering the age that we start cervical cancer screening, and we should be moving towards more HPV based testing, whether that's primary HPV testing, or HPV co testing with cytology. And then I would say in terms of colorectal cancer screening, stay tuned. And I'm sure that in future episodes, you all will be debating the effects and impact of adjusting our colorectal cancer screening guidelines.

Matt 1:02:27
All right. And Amber. Finally, did you want to plug anything?

Amber 1:02:32
Yeah, is it cheesy to say primary care? Really, I think that for all of our trainees, both students and residents who are listening, the most exciting and nuanced medicine, I think happens in primary care. And unfortunately, you will, we don't get to spend as much time there as we would like. So, I would just encourage everyone to take every opportunity to spend time in longitudinal primary care, and really delve deeper into understanding preventive medicine because it's a powerful tool for helping our patients.

Matt 1:03:03
All right, excellent.

Transcribed by MJ Allen, DO