Update on Screening 2016

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PMG Primary Care Service Line

Learning Objectives

- Review the list of USPSTF A & B recommendations
- Take a deeper dive into each of the A&B recommendations that were updated in the last year such as aspirin for ASCVD, depression screening, colon cancer screening, blood pressure screening, diabetes screening and tobacco use counseling
- Address JNC8 in light of review recent HTN studies
- Introduce the preventative services APP

The U.S. Preventive Services Task Force… Makes recommendations on clinical preventive services to primary care clinicians

The USPSTF scope for clinical preventive services includes:

Screening tests

Recommendations address only services offered in the primary care setting or services referred by a primary care physicians.

Recommendations apply to adults and children with no signs or symptoms.

Preventative medications

- The U.S. Preventive Services Task Force… Makes recommendations based on rigorous review of existing peer-reviewed evidence
- Does not conduct the research studies, but reviews & assesses the research
- Evaluates benefits and harms of each service based on factors such as age & sex
- Is an independent panel of non-Federal experts in prevention & evidenced-based medicine

- Recommendation Grades
- Letter grades are assigned to each recommendation statement. These grades are based on the strength of the evidence on the harms and benefits of a specific preventive service. http://www.uspreventiveservicestaskforce.org/uspstf/grades.htm
- Grade Definition
- **A** The USPSTF recommends the service. There is high certainty that the net benefit is substantial.
- **B** The USPSTF recommends the service. There is high certainty that the net benefit is moderate or there is moderate certainty that the net benefit is moderate to substantial.
- **C** The USPSTF recommends selectively offering or providing this service to individual patients based on professional judgment and patient preferences. There is at least moderate certainty that the net benefit is small.
- **D** The USPSTF recommends against the service. There is moderate or high certainty that the service has no net benefit or that the harms outweigh the benefits.
- **I** Statement The USPSTF concludes that the current evidence is insufficient to assess the balance of benefits and harms of the service. Evidence is lacking, of poor quality, or conflicting, and the balance of benefits and harms cannot be determined.

USPSTF A&B Recommendations

USPSTF A and B Recommendations

Topic	Description	Grade	Release Date of Current Recommendation
Abdominal aortic aneurysm screening: men	The USPSTF recommends one-time screening for abdominal aortic aneurysm by ultrasonography in men ages 65 to 75 years who have ever smoked.	B	June 2014[1]
Alcohol misuse: screening and counseling	The USPSTF recommends that clinicians screen adults age 18 years or older for alcohol misuse and provide persons engaging in risky or hazardous drinking brief behavioral counseling interventions to reduce alcohol misuse.	B	May 2013[1]
Aspirin preventive medication: adults aged 50 to 59 years with a ≥10% 10-year cardiovascular risk	The USPSTF recommends initiating low-dose aspirin use for the primary prevention of cardiovascular disease and colorectal cancer in adults aged 50 to 59 years who have a 10% or greater 10-year cardiovascular risk, are not at increased risk for bleeding, have a life expectancy of at least 10 years, and are willing to take low-dose aspirin daily for at least 10 years.	B	April 2016[1]
Bacteriuria screening: pregnant women	The USPSTF recommends screening for asymptomatic bacteriuria with urine culture in pregnant women at 12 to 16 weeks' gestation or at the first prenatal visit, if later.	A	July 2008
Blood pressure screening in adults	The USPSTF recommends screening for high blood pressure in adults aged 18 years or older. The USPSTF recommends obtaining blood pressure measurements outside of the clinical setting for diagnostic confirmation before starting treatment.	A	October 2015[1]
BRCA risk assessment and genetic counseling/testing	The USPSTF recommends that primary care providers screen women who have family members with breast, ovarian, tubal, or peritoneal cancer with one of several screening tools designed to identify a family history that may be associated with an increased risk for potentially harmful mutations in breast cancer susceptibility genes (*BRCA1* or *BRCA2*). Women with positive screening results should receive genetic counseling and, if indicated after counseling, BRCA testing.	B	December 2013[1]
Breast cancer preventive medications	The decision to initiate medication should engage in shared, informed decisionmaking with women who are at increased risk for breast cancer about medications to reduce their risk. For women who are at increased risk for breast cancer and at low risk for adverse medication effects, clinicians should offer to prescribe risk-reducing medications, such as tamoxifen or raloxifene.	B	September 2013[1]
Breast cancer screening	The USPSTF recommends screening mammography for women, with or without clinical breast examination, every 1 to 2 years for women age 40 years and older.	B	September 2002[1]

Breast cancer screening	The USPSTF recommends screening mammography for women, with or without clinical breast examination, every 1 to 2 years for women age 40 years and older.	B	September 2002[1]
Breastfeeding counseling	The USPSTF recommends interventions during pregnancy and after birth to promote and support breastfeeding.	B	October 2008
Cervical cancer screening	The USPSTF recommends screening for cervical cancer in women ages 21 to 65 years with cytology (Pap smear) every 3 years or, for women ages 30 to 65 years who want to lengthen the screening interval, screening with a combination of cytology and human papillomavirus (HPV) testing every 5 years.	A	March 2012[1]
Chlamydia screening: women	The USPSTF recommends screening for chlamydia in sexually active women age 24 years or younger and in older women who are at increased risk for infection.	B	September 2014[1]
Cholesterol abnormalities screening: men 35 and older	The USPSTF recommends screening men age 35 years and older for lipid disorders.	A	June 2008
Cholesterol abnormalities screening: men younger than 35	The USPSTF recommends screening men ages 20 to 35 years for lipid disorders if they are at increased risk for coronary heart disease.	B	June 2008
Cholesterol abnormalities screening: women 45 and older	The USPSTF strongly recommends screening women age 45 years and older for lipid disorders if they are at increased risk for coronary heart disease.	A	June 2008
Cholesterol abnormalities screening: women younger than 45	The USPSTF recommends screening women ages 20 to 45 years for lipid disorders if they are at increased risk for coronary heart disease.	B	June 2008
Colorectal cancer screening	The USPSTF recommends screening for colorectal cancer starting at age 50 years and continuing until age 75 years.	A	June 2016[1]
Dental caries prevention: infants and children up to age 5 years	The USPSTF recommends the application of fluoride varnish to the primary teeth of all infants and children starting at the age of primary tooth eruption in primary care practices. The USPSTF recommends primary care clinicians prescribe oral fluoride supplementation starting at age 6 months for children whose water supply is fluoride deficient.	B	May 2014[1]
Depression screening: adolescents	The USPSTF recommends screening for major depressive disorder (MDD) in adolescents aged 12 to 18 years. Screening should be implemented with adequate systems in place to ensure accurate diagnosis, effective treatment, and appropriate follow-up.	B	February 2016[1]
Depression screening: adults	The USPSTF recommends screening for depression in the general adult population, including pregnant and postpartum women. Screening should be implemented with adequate systems in place to ensure accurate diagnosis, effective treatment, and appropriate follow-up.	B	January 2016[1]
Diabetes screening	The USPSTF recommends screening for abnormal blood glucose as part of cardiovascular risk assessment in adults aged 40 to 70 years who are overweight or obese. Clinicians should offer or refer patients with abnormal blood glucose to intensive behavioral counseling interventions to promote a healthful diet and physical activity.	B	October 2015[1]

Falls prevention in older adults: exercise or physical therapy	The USPSTF recommends exercise or physical therapy to prevent falls in community-dwelling adults age 65 years and older who are at increased risk for falls.	B	May 2012
Falls prevention in older adults: vitamin D	The USPSTF recommends vitamin D supplementation to prevent falls in community-dwelling adults age 65 years and older who are at increased risk for falls.	B	May 2012
Folic acid supplementation	The USPSTF recommends that all women planning or capable of pregnancy take a daily supplement containing 0.4 to 0.8 mg (400 to 800 µg) of folic acid.	A	May 2009
Gestational diabetes mellitus screening	The USPSTF recommends screening for gestational diabetes mellitus in asymptomatic pregnant women after 24 weeks of gestation.	B	January 2014
Gonorrhea prophylactic medication: newborns	The USPSTF recommends prophylactic ocular topical medication for all newborns for the prevention of gonococcal ophthalmia neonatorum.	A	July 2011[1]
Gonorrhea screening: women	The USPSTF recommends screening for gonorrhea in sexually active women age 24 years or younger and in older women who are at increased risk for infection.	B	September 2014[1]
Healthy diet and physical activity counseling to prevent cardiovascular disease: adults with cardiovascular risk factors	The USPSTF recommends offering or referring adults who are overweight or obese and have additional cardiovascular disease (CVD) risk factors to intensive behavioral counseling interventions to promote a healthful diet and physical activity for CVD prevention.	B	August 2014[1]
Hearing loss screening: newborns	The USPSTF recommends screening for hearing loss in all newborn infants.	B	July 2008
Hemoglobinopathies screening: newborns	The USPSTF recommends screening for sickle cell disease in newborns.	A	September 2007
Hepatitis B screening: nonpregnant adolescents and adults	The USPSTF recommends screening for hepatitis B virus infection in persons at high risk for infection.	B	May 2014
Hepatitis B screening: pregnant women	The USPSTF strongly recommends screening for hepatitis B virus infection in pregnant women at their first prenatal visit.	A	June 2009
Hepatitis C virus infection screening: adults	The USPSTF recommends screening for hepatitis C virus (HCV) infection in persons at high risk for infection. The USPSTF also recommends one-time screening for adults for HCV infection to adults born between 1945 and 1965.	B	June 2013
High blood pressure in adults screening	The USPSTF recommends screening for high blood pressure in adults aged 18 years or older. The USPSTF recommends obtaining measurements outside of the clinical setting for diagnostic confirmation before starting treatment.	A	October 2015[1]
HIV screening: nonpregnant adolescents and adults	The USPSTF recommends that clinicians screen for HIV infection in adolescents and adults aged 15 to 65 years. Younger adolescents and older adults who are at increased risk should also be screened.	A	April 2013[1]
HIV screening: pregnant women	The USPSTF recommends that clinicians screen all pregnant women for HIV, including those who present in labor who are untested and whose HIV status is unknown.	A	April 2013[1]
Hypothyroidism screening: newborns	The USPSTF recommends screening for congenital hypothyroidism.	A	March 2008
Intimate partner violence screening: women of childbearing age	The USPSTF recommends that clinicians screen women of childbearing age for intimate partner violence, such as domestic violence, and provide or refer women who screen positive to intervention services. This recommendation applies to women who do not have signs or symptoms of abuse.	B	January 2013

Lung cancer screening	The USPSTF recommends annual screening for lung cancer with low-dose computed tomography in adults ages 55 to 80 years who have a 30 pack-year smoking history and currently smoke or have quit within the past 15 years. Screening should be discontinued once a person has not smoked for 15 years or develops a health problem that substantially limits life expectancy or the ability or willingness to have curative lung surgery.	B	December 2013
Obesity screening and counseling: adults	The USPSTF recommends screening all adults for obesity. Clinicians should offer or refer patients with a body mass index of 30 kg/m^2 or higher to intensive, multicomponent behavioral interventions.	B	June 2012[1]
Obesity screening and counseling: children	The USPSTF recommends that clinicians screen children age 6 years and older for obesity and offer them or refer them to comprehensive, intensive behavioral interventions to promote improvement in weight status.	B	January 2010
Osteoporosis screening: women	The USPSTF recommends screening for osteoporosis in women age 65 years and older and in younger women whose fracture risk is equal to or greater than that of a 65-year-old white woman who has no additional risk factors.	B	January 2012[1]
Phenylketonuria screening: newborns	The USPSTF recommends screening for phenylketonuria in newborns.	B	March 2008
Preeclampsia prevention: aspirin	The USPSTF recommends the use of low-dose aspirin (81 mg/d) as preventive medication after 12 weeks of gestation in women who are at high risk for preeclampsia.	B	September 2014
Rh incompatibility screening: first pregnancy visit	The USPSTF strongly recommends Rh (D) blood typing and antibody testing for all pregnant women during their first visit for pregnancy-related care.	A	February 2004
Rh incompatibility screening: 24–28 weeks' gestation	The USPSTF recommends repeated Rh (D) antibody testing for all unsensitized Rh (D)-negative women at 24 to 28 weeks' gestation, unless the biological father is known to be Rh (D)-negative.	B	February 2004
Sexually transmitted infections counseling	The USPSTF recommends intensive behavioral counseling for all sexually active adolescents and for adults who are at increased risk for sexually transmitted infections.	B	September 2014[1]
Skin cancer: behavioral counseling	The USPSTF recommends counseling children, adolescents, and young adults ages 10 to 24 years who have fair skin about minimizing their exposure to ultraviolet radiation to reduce risk for skin cancer.	B	May 2012
Tobacco use counseling and interventions: nonpregnant adults	The USPSTF recommends that clinicians ask all adults about tobacco use, advise them to stop using tobacco, and provide behavioral interventions and U.S. Food and Drug Administration (FDA)–approved pharmacotherapy for cessation to adults who use tobacco.	A	September 2015[1]
Tobacco use counseling: pregnant women	The USPSTF recommends that clinicians ask all pregnant women about tobacco use, advise them to stop using tobacco, and provide behavioral interventions for cessation to pregnant women who use tobacco.	A	September 2015[1]
Tobacco use interventions: children and adolescents	The USPSTF recommends that clinicians provide interventions, including education or brief counseling, to prevent initiation of tobacco use in school-aged children and adolescents.	B	August 2013
Syphilis screening: nonpregnant adolescents	The USPSTF recommends screening for syphilis infection in persons who are at increased risk.	A	June 2016[1]
Syphilis screening: pregnant women	The USPSTF recommends that clinicians screen all pregnant women for syphilis infection.	A	May 2009
Visual acuity screening in children	The USPSTF recommends vision screening for all children at least once between the ages of 3 and 5 years, to detect the presence of amblyopia or its risk factors.	B	January 2011[1]

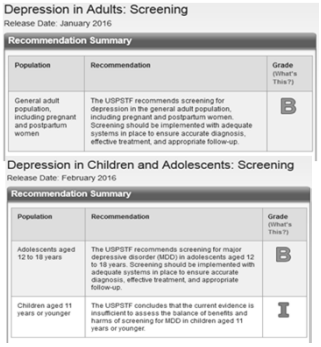
Colorectal Cancer Screening

- New recommendations published June 2016
- Grade A from age 50-75
- Multiple options for screening
- Grad C for ages 76-85 (individualize)

Table. Characteristics of Colorectal Cancer Screening Strategies[a]

Screening Method	Frequency[b]	Evidence of Efficacy	Other Considerations
Stool-Based Tests			
gFOBT	Every year	RCTs with mortality end points: High-sensitivity versions (eg, Hemoccult SENSA) have better test performance characteristics than older tests (eg, Hemoccult II)	Does not require bowel preparation, anesthesia, or transportation to and from the screening examination (test is performed at home)
FIT[c]	Every year	Test characteristic studies: Improved accuracy compared with gFOBT Can be done with a single specimen	Does not require bowel preparation, anesthesia, or transportation to and from the screening examination (test is performed at home)
FIT-DNA	Every 1 or 3 y[c]	Test characteristic studies: Specificity is lower than for FIT, resulting in more false-positive results, more diagnostic colonoscopies, and more harms associated with adverse events per screening test Improved sensitivity compared with FIT per single screening test	There is insufficient evidence about appropriate longitudinal follow-up of abnormal findings after a negative diagnostic colonoscopy; may potentially lead to overly intensive surveillance due to provider and patient concerns over the genetic component of the test
Direct Visualization Tests			
Colonoscopy[d]	Every 10 y	Prospective cohort study with mortality end point	Requires less frequent screening. Screening and diagnostic follow-up of positive results can be performed during the same examination.
CT colonography[e]	Every 5 y	Test characteristic studies	There is insufficient evidence about the potential harms of associated extracolonic findings, which are common
Flexible sigmoidoscopy	Every 5 y	RCTs with mortality end points: Modeling suggests it provides less benefit than when combined with FIT or compared with other strategies	Test availability has declined in the United States
Flexible sigmoidoscopy with FIT[c]	Flexible sigmoidoscopy every 10 y plus FIT every year	RCT with mortality end point (subgroup analysis)	Test availability has declined in the United States Potentially attractive option for patients who want endoscopic screening but want to limit exposure to colonoscopy

Abbreviations: FIT=fecal immunochemical test; FIT-DNA=multitargeted stool DNA test; gFOBT=guaiac-based fecal occult blood test; RCT=randomized clinical trial.



Depression in Adults: Screening

Release Date: January 2016

Recommendation Summary

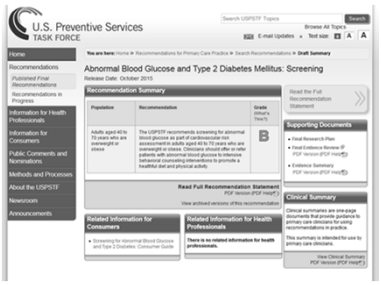
Population	Recommendation	Grade (What's This?)
General adult population, including pregnant and postpartum women	The USPSTF recommends screening for depression in the general adult population, including pregnant and postpartum women. Screening should be implemented with adequate systems in place to ensure accurate diagnosis, effective treatment, and appropriate follow-up.	B

Depression in Children and Adolescents: Screening

Release Date: February 2016

Recommendation Summary

Population	Recommendation	Grade (What's This?)
Adolescents aged 12 to 18 years	The USPSTF recommends screening for major depressive disorder (MDD) in adolescents aged 12 to 18 years. Screening should be implemented with adequate systems in place to ensure accurate diagnosis, effective treatment, and appropriate follow-up.	B
Children aged 11 years or younger	The USPSTF concludes that the current evidence is insufficient to assess the balance of benefits and harms of screening for MDD in children aged 11 years or younger.	I



U.S. Preventive Services TASK FORCE

Abnormal Blood Glucose and Type 2 Diabetes Mellitus: Screening

Release Date: October 2015

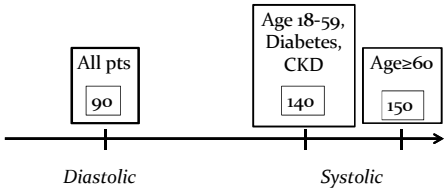
Recommendation Summary

Clinical Summary

What's up with hypertension?

- USPSTF Recommends screening for high blood pressure in adults aged 18 and older. The USPSTF recommends obtaining measurements outside of the clinical setting for diagnostic confirmation before starting treatment.
- JNC 8
- SPRINT TRIAL
- HOPE-3 TRIAL

JNC8: BP Goals



JNC8: Initial Preferred Meds

Preferred

ACE | ARB | CCB | Thiazide

ACE | ARB

CCB | Thiazide

CKD ≤75

African American Descent, Without CKD

SPRINT Trial

SPRINT: A Trial of Intensive Blood Pressure Lowering

Allan S. Brett, MD reviewing The SPRINT Research Group. N Engl J Med 2015 Nov 9. Chobanian AV. N Engl J Med 2015 Nov 9

Treating to a systolic target of 120 mm Hg lowered the incidence of adverse cardiovascular events in a high-risk population.

For years, clinicians have debated how far to lower blood pressure (BP) in hypertensive patients. The multicenter Systolic Blood Pressure Intervention Trial (SPRINT) now provides some guidance.

SPRINT researchers enrolled 9361 patients (age, ≥50) with systolic BP of 130 to 180 mm Hg and high cardiovascular (CV) risk (defined as one or more of these: known symptomatic or asymptomatic CV disease, chronic kidney disease [CKD] with glomerular filtration rate [GFR] 20–59 mL/minute/1.73 m^2, 10-year Framingham CV risk ≥15%, or age ≥75). Patients with diabetes and stroke were excluded. Patients were randomized to either intensive or standard treatment (systolic BP targets, 120 or 140 mm Hg, respectively). The protocol included general guidelines for choice of antihypertensive agents, but researchers were permitted discretion in choosing drug regimens. Diuretics, angiotensin-converting-enzyme inhibitors or angiotensin-receptor blockers, calcium-channel blockers, and β-blockers were used extensively. During the trial, intensive- and standard-treatment patients required averages of three and two drugs, respectively.

The trial was terminated early after median follow-up of 3.3 years, during which participants' average systolic BPs were 121.5 mm Hg and 134.6 mm Hg in the intensive- and standard-treatment groups, respectively. The primary composite outcome (myocardial infarction [MI], non-MI acute coronary syndrome, stroke, heart failure, or CV-related death) occurred in 5.2% of intensive-treatment patients and 6.8% of standard-treatment patients (P<0.001). Relative reductions in this outcome were similar in subgroups of patients with CKD and of patients older than 75. Two individual components of the composite outcome were significantly lower with intensive treatment — heart failure (1.3% vs. 2.1%) and CV-related death (0.8% vs. 1.4%). All-cause mortality also was significantly lower with intensive treatment (3.3% vs. 4.5%).

Several serious adverse events were significantly more common with intensive than with standard treatment. Incidences of hypotension, syncope, and electrolyte abnormalities were each about 1 percentage point higher, and incidence of acute kidney injury was about 2 percentage points higher. Among patients without CKD at baseline, the incidence of a >30% decline in GFR was significantly greater with intensive treatment (3.8% vs. 1.1%).

HOPE-3 Trial

HOPE-3: A Primary Cardiovascular Prevention Trial in People at Intermediate Risk

Allan S. Brett, MD reviewing Lonn EM et al. N Engl J Med 2016 Apr 2. Yusuf S et al. N Engl J Med 2016 Apr 2. Yusuf S et al. N Engl J Med 2016 Apr 1. Cushman WC and Ong ST. N Engl J Med 2016 Apr 1.

Rosuvastatin lowered the incidence of CV-related death, myocardial infarction, or stroke by 1 percentage point during 5 years of treatment.

The Heart Outcomes Prevention Evaluation (HOPE)-3 is an international randomized trial conducted in 21 countries; China, India, Colombia, Argentina, and Canada contributed the most participants. The trial included 12,705 people (age, ≥65 for women, and ≥55 for men) without known cardiovascular (CV) disease who were considered to be at intermediate risk by virtue of meeting at least one inclusion criterion: Elevated waist-hip-ratio, HDL cholesterol level <39 mg/dL (men) or <50 mg/dL (women), current or recent smoking, prediabetes or diet-controlled diabetes, premature coronary disease in first-degree relatives, or early renal dysfunction. Most participants had at least two risk factors.

In a 2×2 factorial design, each participant received daily rosuvastatin (10 mg) or placebo, plus daily candesartan/hydrochlorothiazide (16 mg/12.5 mg) or placebo. At baseline, mean LDL cholesterol level was 128 mg/dL and mean blood pressure (BP) was 138/82 mm Hg. During median follow-up of 5.6 years, key findings were as follows:

- Compared with placebo, rosuvastatin lowered mean LDL cholesterol level by 35 mg/dL, and the antihypertensive drugs lowered mean systolic/diastolic BP by 6/3 mm Hg.
- The first coprimary outcome (CV-related death, nonfatal stroke, or nonfatal myocardial infarction [MI]) occurred significantly less frequently with rosuvastatin than with placebo (3.7% vs. 4.8%); absolute reductions were 0.3%, 0.4%, and 0.5% for CV-related death, MI, and stroke, respectively.
- Overall, candesartan/hydrochlorothiazide did not significantly lower the incidence of the first coprimary outcome compared with placebo (4.1% vs. 4.4%); however, it did lower the incidence in a subgroup with highest baseline systolic BP (>143 mm Hg; 4.8% vs. 6.5%).
- Overall, outcomes with rosuvastatin plus candesartan/hydrochlorothiazide were not significantly better than outcomes with rosuvastatin alone.
- All-cause mortality was not lowered by active therapies compared with placebo.
- Neither treatment increased risk for diabetes; a small excess of muscle pain was noted with rosuvastatin and dizziness with candesartan/hydrochlorothiazide.

Low Dose Aspirin for Primary Prevention

- USPSTF B for ASCVD and colorectal CA in pts age 50-59.
- Must meet all of the following:
- 10 years ASCVD risk of 10%
- 10 year life expectancy and willing to take ASA for 10yrs
- No recent GI bleed, no PUD, no anticoagulation or anti-platelets agents
- Grade C for age 60-69 (individualize)
- Grade I for less than 50 or >70

Recommendation Summary

Population	Recommendation	Grade (What's This?)
Adults aged 50 to 59 years with a ≥10% 10-year CVD risk	The USPSTF recommends initiating low-dose aspirin use for the primary prevention of cardiovascular disease (CVD) and colorectal cancer (CRC) in adults aged 50 to 59 years who have a 10% or greater 10-year CVD risk, are not at increased risk for bleeding, have a life expectancy of at least 10 years, and are willing to take low-dose aspirin daily for at least 10 years.	B
Adults aged 60 to 69 years with a ≥10% 10-year CVD risk	The decision to initiate low-dose aspirin use for the primary prevention of CVD and CRC in adults aged 60 to 69 years who have a 10% or greater 10-year CVD risk should be an individual one. Persons who are not at increased risk for bleeding, have a life expectancy of at least 10 years, and are willing to take low-dose aspirin daily for at least 10 years are more likely to benefit. Persons who place a higher value on the potential benefits than the potential harms may choose to initiate low-dose aspirin.	C
Adults younger than 50 years	The current evidence is insufficient to assess the balance of benefits and harms of initiating aspirin use for the primary prevention of CVD and CRC in adults younger than 50 years.	I
Adults aged 70 years or older	The current evidence is insufficient to assess the balance of benefits and harms of initiating aspirin use for the primary prevention of CVD and CRC in adults aged 70 years or older.	I

See the Clinical Considerations section for guidance on aspirin dosage.

ASK WELL

Ask Well: Taking a Daily Aspirin

By RONI CARYN RABIN MAY 6, 2016 5:40 AM 72

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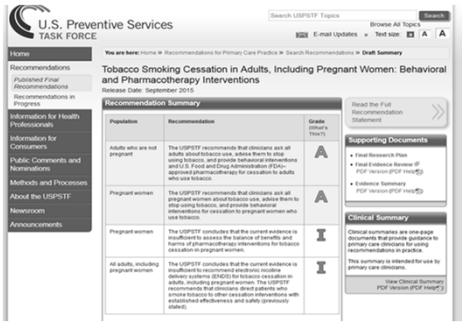
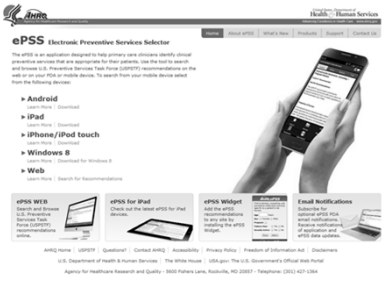
What's the latest advice on taking a daily aspirin?

Reader Question • 1308 votes

Adults ages 50 to 69 who are at high risk for heart attack or stroke should take a daily low-dose aspirin to prevent both heart attacks and strokes as well colorectal cancer. That's the latest advice from the United States Preventive Services Task Force, an influential expert panel that published a final recommendation last month in Annals of Internal Medicine.



The USPSTF APP



Thank You