



Complete Summary

GUIDELINE TITLE

Screening for bacterial vaginosis in pregnancy: recommendations and rationale.

BIBLIOGRAPHIC SOURCE(S)

Berg AO. Screening for bacterial vaginosis in pregnancy. Recommendations and rationale. Am J Prev Med 2001 Apr;20(3 Suppl):59-61. [5 references]

COMPLETE SUMMARY CONTENT

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SCOPE

DISEASE/CONDITION(S)

- Bacterial vaginosis
- Pregnancy

GUIDELINE CATEGORY

Prevention
Screening

CLINICAL SPECIALTY

Family Practice
Obstetrics and Gynecology

INTENDED USERS

Advanced Practice Nurses
Allied Health Personnel
Health Care Providers
Nurses

Physician Assistants
Physicians

GUIDELINE OBJECTIVE(S)

To present the recommendations for screening pregnant women for bacterial vaginosis.

TARGET POPULATION

Pregnant women at risk for bacterial vaginosis

INTERVENTIONS AND PRACTICES CONSIDERED

Laboratory testing for bacterial vaginosis by Gram stain of the vaginal discharge. Other clinical criteria might be used (such as vaginal pH, odor, consistency of the vaginal discharge, and the presence of clue cells on a microscopic examination of a wet mount).

MAJOR OUTCOMES CONSIDERED

- Rate of preterm premature rupture of membranes
- Preterm labor
- Incidence of preterm delivery
- Spontaneous abortion
- Rate of delivery of low birth weight infants
- Neonatal sepsis

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

The Evidence-based Practice Center staff searched the MEDLINE database for the years 1966 to 1999 for evidence on the key questions in their analytic framework. The Evidence-based Practice Center staff also used the Cochrane Library, reference lists of relevant reviews, and expert recommendations to identify additional papers. The search was updated monthly during the course of the project. They included only randomized controlled trials of bacterial vaginosis treatment during pregnancy that contained data on pregnancy outcomes and sufficient detail on subjects and methods to allow interpretation of results. The search identified 1,253 abstracts, 486 of which were included as possibly relevant. Of these, 178 were reviews, letters, or editorials, some of which we read for background and contextual information. Of the remaining 308 citations, 129 were about treatment of bacterial vaginosis, and of these, 28 were about treatment

during pregnancy. Full-text articles (if published) of these 28 studies were read to identify 12 randomized controlled trials, 11 in full text and 1 in abstract form. Because they did not contain data on pregnancy outcomes, 5 of the 12 were excluded and 1 was excluded because subjects were all hospitalized for preterm labor. One published study with complete data was identified from expert peer review. Experts in the field identified 2 additional studies in abstract form with preliminary data, for a total of 9 randomized controlled trials identified, 6 full-text and 3 abstracts. The National Institute of Child Health and Human Development (NICHD) Maternal-Fetal Medicine Network study, 1 of the 3 trials published in abstract form at the time of initial data analysis, was subsequently published in full manuscript form in March 2000. The Evidence-based Practice Center staff updated their analyses using the most recent data from this study. The other 2 studies were not available in manuscript form. These studies were excluded because sufficient information could not be obtained, through the abstracts or by contact with study authors, to assess study quality or to interpret results.

NUMBER OF SOURCE DOCUMENTS

1,253 abstracts were identified, 468 were reviewed; 28 full-text articles were read.

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 on a 3-point scale (good, fair, or 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 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.

Note: See the companion document titled "Current Methods of the U.S. Preventive Services Task Force: a Review of the Process" (Am J Prev Med 2001 Apr; 20[3S]:21-35) for a more detailed description of the methods used to assess the quality and strength of the evidence for the three strata at which the evidence was reviewed.

METHODS USED TO ANALYZE THE EVIDENCE

Meta-Analysis of Randomized Controlled Trials
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).

For each study EPC staff measured the effect of treatment by calculating the difference in the rate of a pregnancy outcome in the treatment group minus the control group. This difference, also known as the absolute risk reduction (ARR), can be converted to a number needed to treat by taking its inverse. Using STATA™ software, EPC staff applied a stepwise procedure based on the profile likelihood method to assess heterogeneity, pool studies when appropriate, and calculate the mean and 90% confidence intervals (CIs). The stepwise procedure can either result in clusters of studies with similar results or one cluster where all studies have similar results.

To provide a clinical interpretation of the results, estimates derived from the meta-analysis and from a systematic review of studies of screening for bacterial vaginosis (BV) were used to construct a balance sheet that summarizes the benefits and harms of screening for BV in 1,000 high-risk women.

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

A

The U.S. Preventive Services Task Force (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 U.S. Preventive Services Task Force (USPSTF) recommends that clinicians provide [the service] to eligible patients. (The USPSTF found at least fair evidence that [the service] improves health outcomes and concludes that benefits outweigh harms.)

C

The U.S. Preventive Services Task Force (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 U.S. Preventive Services Task Force (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 U.S. Preventive Services Task Force (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 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 U.S. Preventive Services Task Force before final recommendations are confirmed.

Recommendations of Others. Recommendations for screening for bacterial vaginosis in pregnancy from the following groups were discussed: the Centers for Disease Control and Prevention, the American College of Obstetricians and Gynecologists, and a systematic review of randomized controlled trials of bacterial vaginosis treatment, completed for the Cochrane Collaboration.

RECOMMENDATIONS

MAJOR RECOMMENDATIONS

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

- The U.S. Preventive Services Task Force (USPSTF) concludes that the evidence is insufficient to recommend for or against routinely screening high-risk pregnant women for bacterial vaginosis. (See "Clinical Considerations" for discussion of populations at high risk.) I recommendation.

The U.S. Preventive Services Task Force (USPSTF) found good-quality studies with conflicting results, that screening and treatment of asymptomatic bacterial vaginosis in high-risk pregnant women reduces the incidence of preterm delivery. The magnitude of benefit exceeded risk in several studies, but the single largest study reported no benefit among high-risk pregnant women.

- The U.S. Preventive Services Task Force (USPSTF) recommends against routinely screening average-risk asymptomatic pregnant women for bacterial vaginosis. D recommendation.

There is good evidence that screening and treatment of bacterial vaginosis in asymptomatic women who are not at high risk does not improve outcomes such as preterm labor or preterm birth.

Clinical Considerations

- For women with a history of pre-term delivery, screening for bacterial vaginosis is an option.

A single previous episode of preterm delivery by itself may not reliably identify a population of women who will benefit from screening and treatment. Nevertheless, screening may be appropriate in specific circumstances. Studies demonstrating a benefit of screening and treatment were performed among populations of women at especially high risk of pre-term birth (35% to 57%). Clinicians should consider previous history of preterm delivery, other risk factors, and time of presentation in making the decision whether or not to screen for bacterial vaginosis in women at high risk.

- For clinicians electing to screen high-risk women, the optimal screening test is not certain.

Accepted clinical criteria for bacterial vaginosis include vaginal pH > 4.5, amine odor on the application of KOH (potassium hydroxide), appearance of a homogeneous vaginal discharge, and presence of clue cells on a microscopic examination of a wet mount. Presence of at least three of these four criteria is generally considered diagnostic of bacterial vaginosis. The use of more limited criteria (e.g., clue cells alone) has not been evaluated.

- Neither the optimal time to screen high-risk pregnant women nor the optimal treatment regimen for pregnant women with bacterial vaginosis is clear.

The three trials that demonstrated a reduction in preterm birth screened in the second trimester (13 to 24 weeks of pregnancy) and used various regimens of oral metronidazole alone or oral metronidazole and erythromycin.

- Treatment is appropriate for pregnant women with symptomatic bacterial vaginosis infection.

These women were excluded from most screening trials and may be at higher risk than those without symptoms. Treatment can relieve symptoms such as vaginal discharge.

Definitions:

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A

The U.S. Preventive Services Task Force (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 U.S. Preventive Services Task Force (USPSTF) recommends that clinicians provide [the service] to eligible patients. (The USPSTF found at least fair evidence that [the service] improves health outcomes and concludes that benefits outweigh harms.)

C

The U.S. Preventive Services Task Force (USPSTF) makes no recommendation for or against routine provision of [the service]. (The US Preventive Services Task Force 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 U.S. Preventive Services Task Force (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 U.S. Preventive Services Task Force (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.)

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, or 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 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 each recommendation is identified in the "Major Recommendations" field.

BENEFITS/HARMS OF IMPLEMENTING THE GUIDELINE RECOMMENDATIONS

POTENTIAL BENEFITS

Effectiveness of Treatment of Bacterial Vaginosis

Seven randomized controlled trials have evaluated the effect of various antibiotic treatments versus placebo on pregnancy outcomes among women with bacterial vaginosis: three studies enrolled only high-risk women (primarily history of prior preterm delivery), two reported results separately for women with and without a prior history of preterm delivery, and two enrolled average-risk women. Among four studies reporting results for average-risk women, there were no differences between control groups and treatment groups in rates of preterm delivery, preterm premature rupture of membranes, or delivery of low birth weight infants.

Five studies reported conflicting results among women at increased risk due to a history of preterm delivery in previous pregnancies. Oral antibiotic treatment reduced the incidence of preterm delivery before 37 weeks in three studies, which enrolled women at particularly high risk (incidence of preterm delivery in placebo groups 35% to 57%). In contrast, in a large multi-center, American trial completed in 1999, a different regimen of oral metronidazole provided no benefit for the subgroup of women who had a history of previous preterm delivery. A fifth small study reported no benefit of vaginal clindamycin among high-risk women.

Subgroups Most Likely to Benefit:

African-American women (bacterial vaginosis infection is more common among African-American women than Caucasian women).

POTENTIAL HARMS

Potential Adverse Effects of Screening and Treatment

Because bacterial vaginosis is common, screening and treatment could subject a substantial number of women to the inconvenience and minor side effects (primarily nausea) of taking metronidazole and other antibiotics during pregnancy. The regimens used to treat bacterial vaginosis are generally considered safe in pregnancy, but several studies raise the possibility of harms in some women or their infants. In 2 studies, a subgroup of women who did not have bacterial vaginosis but received treatment with metronidazole or clindamycin experienced trends toward higher incidence of preterm delivery before 34 weeks

gestation (12% to 13% versus 4% to 5%). In addition, neonatal sepsis was significantly increased among women receiving vaginal clindamycin.

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.

Neither the resources nor the composition of the U.S. Preventive Services Task Force (USPSTF) equip it to address these numerous implementation challenges, but a number of related efforts seek to increase the impact of future U.S. Preventive Services Task Force (USPSTF) reports. The U.S. Preventive Services Task Force (USPSTF) convened representatives from the various audiences for the [Guide](#) - clinicians, consumers and policy makers from health plans, national organizations and Congressional staff - about how to modify the content and format of its products to address their needs. With funding from the Robert Wood Johnson Foundation, the U.S. Preventive Services Task Force (USPSTF) and Community Guide effort have conducted an audience analysis to further explore implementation needs. The [Put Prevention into Practice](#) initiative at the Agency for Healthcare Research and Quality (AHRQ) has developed office tools such as patient booklets, posters, and handheld patient mini-records, and a new implementation guide for state health departments.

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 (USPSTF) materials and adapt them for their local needs. Online access to U.S. Preventive Services Task Force (USPSTF) products

also opens up new possibilities for the appearance of the third edition of the Guide to Clinical Preventive Services. Freed from having to serve as primary repository for all of U.S. Preventive Services Task Force work, the next Guide may be much slimmer than the almost 1000 pages of the second edition.

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.

RELATED QUALITY TOOLS

- [Pocket Guide to Good Health for Adults](#)
- [A Step-by-Step Guide to Delivering Clinical Preventive Services: A Systems Approach](#)
- [Screening for Bacterial Vaginosis in Pregnancy. What's New from the Third USPSTF.](#)

INSTITUTE OF MEDICINE (IOM) NATIONAL HEALTHCARE QUALITY REPORT CATEGORIES

IOM CARE NEED

Staying Healthy

IOM DOMAIN

Effectiveness

IDENTIFYING INFORMATION AND AVAILABILITY

BIBLIOGRAPHIC SOURCE(S)

Berg AO. Screening for bacterial vaginosis in pregnancy. Recommendations and rationale. Am J Prev Med 2001 Apr;20(3 Suppl):59-61. [5 references]

ADAPTATION

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

DATE RELEASED

1996 (revised 2001 Apr)

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 USPSTF do not necessarily reflect policy of the U.S. Department of Health and Human Services (DHHS) or DHHS agencies.

SOURCE(S) OF FUNDING

United States Government

GUIDELINE COMMITTEE

U.S. Preventive Services Task Force (USPSTF)

COMPOSITION OF GROUP THAT AUTHORED THE GUIDELINE

The U.S. Preventive Services Task Force (USPSTF) consists of 13 experts from the specialties of family medicine, pediatrics, internal medicine, obstetrics and gynecology, geriatrics, preventive medicine, public health, behavioral medicine, and nursing. Members of the Task Force were selected from more than 80 nominees, based on recognized expertise in prevention, evidence-based medicine, and primary care.

Names of members: Alfred O. Berg, MD, MPH (Chair); Janet D. Alan, PhD, RN, CS, FAAN (Vice-Chair); Paul Frame, MD; Charles J. Homer, MD, MPH; Tracy A. Lieu, MD, MPH; Cynthia D. Mulrow, MD, MSc; Carole Tracy Orleans, PhD; Jeffrey F. Peipert, MD, MPH; Nola J Pender, PhD, RN, FAAN; Harold C Sox, Jr., MD; Steven M. Teutsch, MD, MPH; Carolyn Westhoff, MD, MSc; Steven H Woolf, MD, MPH

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.

GUIDELINE STATUS

This is the current release of the guideline.

This guideline updates a previously issued version: In: Guide to clinical preventive services. 2nd ed; Baltimore (MD): Williams & Wilkins; 1996.

GUIDELINE AVAILABILITY

Electronic copies: Available from [AJPM \(American Journal of Preventive Medicine\) Online](#). Additional information is available from the [U.S. Preventive Services Task Force \(USPSTF\) Web site](#) and the [National Library of Medicine's Health Services/Technology Assessment Text \(HSTAT\) 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).

AVAILABILITY OF COMPANION DOCUMENTS

The following are available:

Evidence Reviews:

- Guise J-M, Mahon SM, Aickin M, Helfand M, Peipert JF, Westhoff C. Screening for bacterial vaginosis in pregnancy. Am J Prev Med 2001 Apr; 20(3S): 62-72. [41 references]
- Screening for bacterial vaginosis in pregnancy. Rockville (MD): Agency for Healthcare Research and Quality (AHRQ), 2001. (Systematic evidence review; no. 3) [60 references] (Electronic copies are only available in a downloadable format from the [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. 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 the [USPSTF Web site](#).

Additional Implementation Tools:

- A step-by-step guide to delivering clinical preventive services: a systems approach. Rockville (MD): Agency for Healthcare Research and Quality (AHRQ), 2001. 189 p. (Pub. No. APPIP01-0001). Electronic copies available from the [AHRQ 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 Preventive Services Selector, an application for Palm Pilots and other PDA's, is also available from the [AHRQ Web site](#).
- Screening for bacterial vaginosis in pregnancy. What's new from the third USPSTF. Rockville (MD): Agency for Healthcare Research and Quality; 2001 Apr. Electronic copies: Available from [USPSTF Web site](#).

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](#).

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

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

NGC STATUS

This summary was completed by ECRI on April 6, 2001. The information was verified by the guideline developer as of April 10, 2001.

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