Complete Summary

GUIDELINE TITLE

Screening for thyroid disease: recommendation statement.

BIBLIOGRAPHIC SOURCE(S)

Screening for thyroid disease: recommendation statement. Ann Intern Med 2004 Jan 20;140(2):125-7. [6 references] PubMed

COMPLETE SUMMARY CONTENT

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

SCOPE

DISEASE/CONDITION(S)

Subclinical thyroid dysfunction including:

- Subclinical hypothyroidism (e.g., mildly elevated thyroid stimulating hormone [TSH] and normal thyroxine [T4] and triiodothyronine [T3] levels)
- Subclinical hyperthyroidism (e.g., low TSH and normal T4 and T3 levels)

GUIDELINE CATEGORY

Prevention
Screening

CLINICAL SPECIALTY

Endocrinology
Family Practice
Internal Medicine
Preventive Medicine

INTENDED USERS

Advanced Practice Nurses
Allied Health Personnel
Nurses
Physician Assistants
Physicians

GUIDELINE OBJECTIVE(S)

- To summarize the current U.S. Preventive Services Task Force (USPSTF) recommendations on screening for thyroid disease based on the USPSTF's examination of the supporting scientific evidence
- To update the 1996 recommendations contained in the Guide to Clinical Preventive Services, Second Edition

TARGET POPULATION

Asymptomatic, non-pregnant adults seen in primary care settings

Note: Individuals with symptoms of thyroid dysfunction, or those with a history of thyroid disease or treatment, are not the subject of these recommendations.

INTERVENTIONS AND PRACTICES CONSIDERED

Screening for thyroid dysfunction using the medical history, physical examination and thyroid function tests (e.g., thyroid stimulating hormone (TSH) test)

MAJOR OUTCOMES CONSIDERED

Key Question No. 1: What are the complications of subclinical thyroid dysfunction?

Key Question No. 2: What are the benefits of earlier treatment of subclinical hyperthyroidism and hypothyroidism?

Key Question No. 3: What are the adverse effects of treatment?

METHODOLOGY

METHODS USED TO COLLECT/SELECT EVIDENCE

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

DESCRIPTION OF METHODS USED TO COLLECT/SELECT THE EVIDENCE

Note from the National Guideline Clearinghouse (NGC): A systematic evidence review was prepared by the Oregon Health & Science University Evidence-based Practice Center (EPC) for the Agency for Healthcare Research and

Quality (AHRQ) for use by the U.S. Preventive Services Task Force (USPSTF) (see the "Companion Documents" field).

Search Strategy

In consultation with members of the USPSTF and an Institute of Medicine expert panel, EPC staff defined the population, interventions, and outcomes of interest and developed key questions to guide the literature review. They identified articles published before 1998 from the reference lists of previous reviews and by searching their own files of over 1,600 full-text articles from the period 1910 to 1998. They then searched MEDLINE® and EMBASE® from 1996 to February 2002, PREMEDLINE March 2002, and the Cochrane Library (2002, Issue 2) to identify additional articles. In a MEDLINE® search, the medical subject headings (MeSH) thyroid function tests and thyroid diseases were combined with the term mass screening, and the text words screening or case-finding. EPC staff conducted a separate search for controlled studies of the effect of thyroid-directed treatments on potential complications of subclinical thyroid disease, using the word levothyroxine in title, abstract, or keywords combined with terms for clinical trials. They also searched MEDLINE® from 1966-May 2002 for articles about the adverse effects of thyroid hormone replacement. Periodic hand searching of endocrinologic and major medical journals, review of the reference lists of retrieved articles, and suggestions from peer reviewers of earlier versions of this article supplemented the electronic searches.

Inclusion Criteria

EPC staff selected controlled trials of treatment of thyroid dysfunction that reported at least one health outcome (symptoms, cognitive function, or quality of life) or lipid levels. Broad inclusion criteria were used to get a picture of the benefits and adverse effects of treatment on patients with different degrees of thyroid dysfunction. Specifically, they included any trial that used TSH levels as a criterion for entry, in any population, including patients with known thyroid disease. They also identified observational studies of treatment for subclinical thyroid dysfunction; including recent studies that had not been included in previous meta-analyses.

To assess the prevalence of thyroid disease and the causal relationships between thyroid dysfunction and potential complications, EPC staff used the following sources:

- Previous meta-analyses and systematic reviews
- More recent cross-sectional, cohort, and case-control studies of the prevalence of overt or subclinical thyroid dysfunction
- Cross-sectional and longitudinal studies of the relationship between an elevated or low TSH to potential complications of subclinical hypothyroidism or subclinical hyperthyroidism

For these categories of studies, EPC staff included studies in the general adult population, a demographic segment of the adult population, or among patients seen in the general clinic setting. They excluded studies of screening for congenital or familial thyroid disorders and studies of screening in inpatients, institutionalized patients, and series of patients seen in specialized referral clinics

for depression or obesity. Finally, they identified observational studies of the long-term adverse effects of levothyroxine therapy. They excluded studies of suppressive doses of thyroxine; to be included, the study had to include at least some patients that were taking replacement doses of thyroxine.

NUMBER OF SOURCE DOCUMENTS

Not stated

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

Good

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

Fair

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

Poor

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

METHODS USED TO ANALYZE THE EVIDENCE

Review of Published Meta-Analyses
Systematic Review with Evidence Tables

DESCRIPTION OF THE METHODS USED TO ANALYZE THE EVIDENCE

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

Data Extraction

EPC staff used predefined criteria from the USPSTF to assess the internal validity of trials, which were rated as "good," "fair," or "poor." They rated the applicability of each study to screening. They also abstracted information about its setting, patients, interventions, and outcomes. When possible, EPC staff recorded the difference between the probability of a response in the treatment and control groups for each complication studied.

Preparation of the Systematic Evidence Review

Staff of the Agency for Healthcare Research and Quality (AHRQ) and the Institute of Medicine, members of the USPSTF, and members of an Institute of Medicine expert panel reviewed the draft and made editing suggestions.

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 5 classifications (A, B, C, D, I) reflecting the strength of evidence and magnitude of net benefit (benefits minus harms):

A

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

B

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

C

The USPSTF makes no recommendation for or against routine provision of [the service]. The USPSTF found at least fair evidence that [the service] can improve

health outcomes but concludes that the balance of benefits and harms is too close to justify a general recommendation.

D

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

I

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

COST ANALYSIS

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

METHOD OF GUIDELINE VALIDATION

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

DESCRIPTION OF METHOD OF GUIDELINE VALIDATION

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

Recommendations of Others. Recommendations for screening for thyroid disease from the following groups were discussed: the American Thyroid Association; the Canadian Task Force on the Periodic Health Examination; the American College of Physicians, the American Association of Clinical Endocrinologists; the American College of Obstetricians and Gynecologists and the American Academy of Family Physicians.

RECOMMENDATIONS

MAJOR RECOMMENDATIONS

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

The USPSTF concludes the evidence is insufficient to recommend for or against routine screening for thyroid disease in adults.

I recommendation

The USPSTF found fair evidence that the thyroid stimulating hormone (TSH) test can detect subclinical thyroid disease in people without symptoms of thyroid dysfunction, but poor evidence that treatment improves clinically important outcomes in adults with screen-detected thyroid disease. Although the yield of screening is greater in certain high-risk groups (e.g., postpartum women, people with Down syndrome, and the elderly), the USPSTF found poor evidence that screening these groups leads to clinically important benefits. There is the potential for harm caused by false positive screening tests; however, the magnitude of harm is not known. There is good evidence that over-treatment with levothyroxine occurs in a substantial proportion of patients, but the long-term harmful effects of over-treatment are not known. As a result, the USPSTF could not determine the balance of benefits and harms of screening asymptomatic adults for thyroid disease.

Clinical Considerations

- Subclinical thyroid dysfunction is defined as an abnormal biochemical measurement of thyroid hormones without any specific clinical signs or symptoms of thyroid disease and no history of thyroid dysfunction or therapy. This includes individuals who have mildly elevated TSH and normal thyroxine (T4) and triiodothyronine (T3) levels (subclinical hypothyroidism), or low TSH and normal T4 and T3 levels (subclinical hyperthyroidism). Individuals with symptoms of thyroid dysfunction, or those with a history of thyroid disease or treatment, are excluded from this definition and are not the subject of these recommendations.
- When used to confirm suspected thyroid disease in patients referred to a specialty endocrine clinic, TSH has a high sensitivity (98%) and specificity (92%). When used for screening primary care populations, the positive predictive value (PPV) of TSH in detecting thyroid disease is low; further, the interpretation of a positive test result is often complicated by an underlying illness or by frailty of the individual. In general, values for serum TSH below 0.1 mU/L are considered low and values above 6.5 mU/L are considered elevated.
- Clinicians should be aware of subtle signs of thyroid dysfunction, particularly among those at high risk. People at higher risk for thyroid dysfunction include the elderly, post-partum women, those with high levels of radiation exposure (>20 mGy), and patients with Down syndrome. Evaluating for symptoms of

hypothyroidism is difficult in patients with Down syndrome because some symptoms and signs (e.g., slow speech, thick tongue, and slow mentation) are typical findings in both conditions.

- Subclinical hyperthyroidism has been associated with atrial fibrillation, dementia, and, less clearly, with osteoporosis. However, progression from subclinical to clinical disease in patients without a history of thyroid disease is not clearly established.
- Subclinical hypothyroidism is associated with poor obstetric outcomes and poor cognitive development in children. Evidence for dyslipidemia, atherosclerosis, and decreased quality of life in adults with subclinical hypothyroidism in the general population is inconsistent and less convincing.

Definitions:

Strength of Recommendations

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

A

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

B

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

C

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

D

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

I

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

Strength of Evidence

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

Good

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

Fair

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

Poor

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

CLINICAL ALGORITHM(S)

None provided

EVIDENCE SUPPORTING THE RECOMMENDATIONS

TYPE OF EVIDENCE SUPPORTING THE RECOMMENDATIONS

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

BENEFITS/HARMS OF IMPLEMENTING THE GUIDELINE RECOMMENDATIONS

POTENTIAL BENEFITS

Screening

The U.S. Preventive Services Task Force (USPSTF) found fair evidence that the thyroid stimulating hormone test can detect subclinical thyroid disease in people without symptoms of thyroid dysfunction.

Treatment

A potential benefit of treating subclinical hypothyroidism is to prevent the spontaneous development of overt hypothyroidism, but this potential benefit has

not been studied in clinical trials. If the potential benefit suggested by data from a longitudinal survey is real, the USPSTF estimates that in a reference population of 1,000 women screened, 3 cases of overt hypothyroidism would be prevented in 5 years, but 40 people would have taken medication for 5 years without a clear benefit.

Subgroups Most Likely to Benefit

The yield of screening may be greater for certain high-risk groups (e.g., postpartum women, people with Down syndrome, and the elderly).

POTENTIAL HARMS

The potential harms of screening and treatment are principally the adverse effects of antithyroid drugs, radioiodine, thyroid surgery, and thyroid replacement therapy if detection and early treatment for subclinical disease are unnecessary. People with a false positive thyroid stimulating hormone (TSH) test result (more common in those with a severe underlying illness or those who are frail or elderly) may be subjected to unnecessary treatment or may have adverse psychological consequences (e.g., labeling). The U.S. Preventive Services Task Force reviewed only the adverse effects of levothyroxine (LT4) replacement therapy for mild thyroid failure and potential adverse effects of long-term treatment. These adverse effects were not carefully assessed in the randomized trials. Although some studies have suggested that women with a low TSH as a result of taking thyroid hormone replacement are at higher risk of developing osteoporosis, a recent systematic review did not support this finding. Overtreatment with LT4 is a potential risk: about 1 in 4 patients receiving LT4 are maintained unintentionally on doses sufficient to fully suppress TSH. Data from the Framingham Study suggest that 1 excess case of atrial fibrillation might occur for every 114 patients treated with LT4 sufficient to suppress TSH.

QUALIFYING STATEMENTS

QUALIFYING STATEMENTS

The U.S. Preventive Services Task Force recommendations are independent of the U.S. government. They do not represent the views of the Agency for Healthcare Research and Quality (AHRQ), the U.S. Department of Health and Human Services, or the U.S. Public Health Service.

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 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 reports. The U.S. Preventive Services Task Force convened representatives from the various audiences for the Guide "Put Prevention Into Practice. A Step-by-Step Guide to Delivering Clinical Preventive Services: A Systems Approach"--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 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 materials and adapt them for their local needs. Online access to U.S. Preventive Services Task Force products also opens up new possibilities for the appearance of the 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

INSTITUTE OF MEDICINE (IOM) NATIONAL HEALTHCARE QUALITY REPORT CATEGORIES

IOM CARE NEED

Staying Healthy

IOM DOMAIN

Effectiveness

IDENTIFYING INFORMATION AND AVAILABILITY

BIBLIOGRAPHIC SOURCE(S)

Screening for thyroid disease: recommendation statement. Ann Intern Med 2004 Jan 20;140(2):125-7. [6 references] PubMed

ADAPTATION

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

DATE RELEASED

1996 (revised 2004 Jan 20)

GUIDELINE DEVELOPER(S)

United States Preventive Services Task Force - Independent Expert Panel

GUIDELINE DEVELOPER COMMENT

The U.S. Preventive Services Task Force (USPSTF) is a Federally-appointed panel of independent experts. Conclusions of the U.S. Preventive Services Task Force do

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

SOURCE(S) OF FUNDING

United States Government

GUIDELINE COMMITTEE

U.S. Preventive Services Task Force (USPSTF)

COMPOSITION OF GROUP THAT AUTHORED THE GUIDELINE

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*Members of the Task Force at the time this recommendation was finalized. For a list of current Task Force members, go to www.ahrq.gov/clinic/uspstfab.htm.

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 release updates a previously published guideline: U.S. Preventive Services Task Force. Guide to clinical preventive services. 2nd ed. Baltimore (MD): Williams & Wilkins; 1996. Chapter 20, Screening for thyroid disease. p. 209-18.

GUIDELINE AVAILABILITY

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

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

AVAILABILITY OF COMPANION DOCUMENTS

The following are available:

Evidence Reviews:

- Helfand, M. Screening for subclinical thyroid dysfunction in non-pregnant adults: a summary of the evidence for the U.S. Preventive Services Task Force. Ann Intern Med 2004 Jan;140(2):128-41.

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

- Helfand, M. Screening for thyroid disease. Rockville (MD); Agency for Healthcare Research and Quality; 2004 Jan. (Systematic Evidence Review No. 23).

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

Background Articles:

- Woolf SH, Atkins D. The evolving role of prevention in health care: contributions of the U.S. Preventive Services Task Force. Am J Prev Med 2001 Apr;20(3S):13-20.
- Harris RP, Helfand M, Woolf SH, Lohr KN, Mulrow, CD, Teutsch SM, Atkins D. Current methods of the U.S. Preventive Services Task Force: a review of the

process. Methods Work Group, Third U.S. Preventive Services Task Force. Am J Prev Med 2001 Apr;20(3S):21-35.
- Saha S, Hoerger TJ, Pignone MP, Teutsch SM, Helfand M, Mandelblatt JS. The art and science of incorporating cost effectiveness into evidence-based recommendations for clinical preventive services. Cost Work Group of the Third U.S. Preventive Services Task Force. Am J Prev Med 2001 Apr;20(3S):36-43.

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

The following is also available:

- 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.

PATIENT RESOURCES

The following are 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.

- Screening for Thyroid Disease: A Recommendation from the U.S. Preventive Services Task Force. Summary for Patients. Ann Intern Med 2004 Jan 20;140(2):58I

  Electronic copies: Available from the Annals of Internal Medicine Online.

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

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

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NGC STATUS

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