Screening for Oral Cancer: Recommendation Statement: United States Preventive Services Task Force

United States Preventive Services Task Force

Citation

United States Preventive Services Task Force. *Screening for Oral Cancer: Recommendation Statement: United States Preventive Services Task Force*. The Internet Journal of Otorhinolaryngology. 2003 Volume 3 Number 1.

Abstract

Figure 3

Agency for Healthcare Research and Quality

Figure 2

US Department of Health and Human Services

SUMMARY OF RECOMMENDATION

The U.S. Preventive Services Task Force (USPSTF) concludes that the evidence is insufficient to recommend for or against routinely screening adults for oral cancer. I recommendation.

- The USPSTF found no new good-quality evidence that screening for oral cancer leads to improved health outcomes for either high-risk adults (ie, those over the age of 50 who use tobacco) or for average-risk adults in the general population. It is unlikely that controlled trials of screening for oral cancer will ever be conducted in the general population because of the very low incidence of oral cancer in the United States. There is also no new evidence for the harms of screening. As a result, the USPSTF could not determine the balance between benefits and harms of screening for oral cancer.

CLINICAL CONSIDERATIONS

- Direct inspection and palpation of the oral cavity is the most commonly recommended method of screening for oral cancer, although there are little data on the sensitivity and specificity of this method. Screening techniques other than inspection and palpation are being evaluated but are still experimental.
- Tobacco use in all forms is the biggest risk factor for oral cancer. Alcohol abuse combined with tobacco use increases risk.
- Clinicians should be alert to the possibility of oral cancer when treating patients who use tobacco or alcohol.
- Patients should be encouraged to not use tobacco and to limit alcohol use in order to decrease their

risk for oral cancer as well as heart disease, stroke, lung cancer, and cirrhosis.

Corresponding author: Ned Calonge, MD, MPH, Chair, U.S. Preventive Services Task Force, c/o Program Director, USPSTF, Agency for Healthcare Research and Quality, 540 Gaither Road, Rockville, MD 20850, e-mail: uspstf@ahrq.gov.

FIND MORE INFORMATION ABOUT

{image:3}

Agency for Healthcare Research and Quality
http://www.ahrq.gov/

APPENDIX A

U.S. PREVENTIVE SERVICES TASK FORCE RECOMMENDATIONS AND RATINGS

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

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

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

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

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

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

APPENDIX B

U.S. PREVENTIVE SERVICES TASK FORCE STRENGTH OF OVERALL 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.

References

1. U.S. Preventive Services Task Force. Guide to Clinical Preventive Services. 2nd ed. Washington, DC: Office of Disease Prevention and Health Promotion, 1996. [ACTIVE WEBLINK TO 1996 RECOMMENDATION]
2. Harris RP, Helfand M, Woolf SH, Lohr KN, Mulrow CD, Teutsch SM, Atkins D, for the Methods Word Group, third U.S. Preventive Services Task Force. Current methods of the U.S. Preventive Services Task Force: a review of the process. Am J Prev Med 2001;20(3S):21-35.
3. Screening for Oral Cancer: brief evidence update for the U.S Preventive Services Task Force. Agency for Healthcare Research and Quality. 2004. Available at http://www.preventiveservices.ahrq.gov.

Author Information

United States Preventive Services Task Force
Agency for Healthcare Research and Quality , US Department of Health and Human Services