Complete Summary

GUIDELINE TITLE

Preventing cancer, cardiovascular disease, and diabetes. A common agenda for the American Cancer Society, the American Diabetes Association, and the American Heart Association.

BIBLIOGRAPHIC SOURCE(S)

Eyre H, Kahn R, Robertson RM, Clark NG, Doyle C, Hong Y, Gansler T, Glynn T, Smith RA, Taubert K, Thun MJ. Preventing cancer, cardiovascular disease, and diabetes: a common agenda for the American Cancer Society, the American Diabetes Association, and the American Heart Association. Circulation 2004 Jun 29;109(25):3244-55. [145 references]

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GUIDELINE STATUS

This is the current release of the guideline.

COMPLETE SUMMARY CONTENT

SCOPE
METHODOLOGY - including Rating Scheme and Cost Analysis
RECOMMENDATIONS
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INSTITUTE OF MEDICINE (IOM) NATIONAL HEALTHCARE QUALITY REPORT CATEGORIES
IDENTIFYING INFORMATION AND AVAILABILITY

SCOPE

DISEASE/CONDITION(S)

- Cardiovascular disease, including diseases of the heart, hypertension, stroke, and peripheral vascular diseases
- Cancer
- Diabetes

GUIDELINE CATEGORY

Counseling
Prevention
Screening

CLINICAL SPECIALTY

Family Practice
Internal Medicine
Obstetrics and Gynecology
Preventive Medicine

INTENDED USERS

Advanced Practice Nurses
Nurses
Physician Assistants
Physicians
Public Health Departments

GUIDELINE OBJECTIVE(S)

To present a collaborative scientific statement on strategies for the prevention and early detection of cancer, cardiovascular disease, and diabetes

TARGET POPULATION

Adults in the United States

INTERVENTIONS AND PRACTICES CONSIDERED

Prevention/Screening

1. Lifestyle assessment and counseling
    - Tobacco cessation
    - Weight reduction for overweight and obese adults (calculation of body mass index [BMI])
    - Diet/nutrition/healthy eating
    - Physical activity
2. Screening for cardiovascular disease

    - Blood pressure screening for hypertension
    - Screening for dyslipidemia (lipid profile)
    - Screening for novel risk factors
    - Early and global assessment of risk (Framingham Risk Score)
3. Screening for cancer
    - Breast cancer screening (clinical breast examination and mammography)
    - Cervical cancer screening (cervical cytology smears and human papilloma virus [HPV] DNA testing with cytology)
    - Colorectal cancer screening with one or more of the following: fecal occult blood test, fecal immunochemical test, flexible sigmoidoscopy, double-contrast barium enema, colonoscopy
    - Prostate cancer screening (prostate-specific antigen test, digital rectal examination)
4. Screening for diabetes (fasting plasma glucose [FPG], 2 hour oral glucose tolerance test [OGTT])
5. Periodic preventive health encounters (office visits)

MAJOR OUTCOMES CONSIDERED

- Morbidity, disability, mortality, economic costs, and risk associated with cardiovascular disease, cancer, and diabetes
- Efficacy and cost-effectiveness of prevention and early detection measures

METHODOLOGY

METHODS USED TO COLLECT/SELECT EVIDENCE

Searches of Electronic Databases

DESCRIPTION OF METHODS USED TO COLLECT/SELECT THE EVIDENCE

Not stated

NUMBER OF SOURCE DOCUMENTS

Not stated

METHODS USED TO ASSESS THE QUALITY AND STRENGTH OF THE EVIDENCE

Not stated

RATING SCHEME FOR THE STRENGTH OF THE EVIDENCE

Not applicable

METHODS USED TO ANALYZE THE EVIDENCE

Review

DESCRIPTION OF THE METHODS USED TO ANALYZE THE EVIDENCE

Not stated

METHODS USED TO FORMULATE THE RECOMMENDATIONS

Not stated

RATING SCHEME FOR THE STRENGTH OF THE RECOMMENDATIONS

Not applicable

COST ANALYSIS

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

METHOD OF GUIDELINE VALIDATION

Internal Peer Review

DESCRIPTION OF METHOD OF GUIDELINE VALIDATION

This statement was approved by the American Heart Association Science Advisory and Coordinating Committee on May 6, 2004.

This article was published jointly in 2004 in CA: A Cancer Journal for Clinicians (online: July 13, 2004; print: July 14, 2004); Diabetes Care (online: June 25, 2004; print: June 25, 2004), Circulation (online: June 15, 2004; print: June 29, 2004); and Stroke (online: June 24, 2004; print: June 24, 2004) by The American Cancer Society, the American Diabetes Association, and the American Heart Association.

RECOMMENDATIONS

MAJOR RECOMMENDATIONS

Opportunities for Primary and Secondary Prevention

Primary Prevention

Tobacco

Much is known about strategies that can prevent the initiation of tobacco use among young people and promote successful cessation. Despite this, vigorous advocacy is needed to create and sustain effective tobacco-control programs. Comprehensive tobacco-control programs include restrictions on advertising and promotion of tobacco, increases in excise taxes, measures to reduce access to tobacco by minors, education and counter-advertising, clean air laws, and readily available treatment for tobacco dependence. States such as California and

Massachusetts that have created strong tobacco-control programs have seen accelerated declines in smoking prevalence, cardiovascular mortality, and lung cancer incidence at younger ages.

Counseling by medical caregivers can profoundly increase smokers' motivation to stop using tobacco. Advice from a physician to stop smoking should be accompanied by informed guidance in the use of prescription and nonprescription nicotine-replacement products and other pharmacological and behavioral therapies. There are well-defined guidelines to assist the health care provider in treating tobacco dependence. A "teachable moment" may occur during hospitalization for ischemic heart disease or other morbidity potentially related to smoking. However, counseling and pharmacological interventions are currently underutilized. Further training of individual clinicians and changes in health systems are needed to ensure that appropriate treatment for tobacco dependence is both required and rewarded.

Overweight and Obesity

Cancer Risk

Although it is not clear whether losing weight reduces the risk of cancer, there are physiological mechanisms that suggest weight loss may be beneficial because overweight or obese individuals who lose weight intentionally have reduced levels of circulating glucose, insulin, bioavailable estrogens, and androgens. Despite some uncertainty about weight loss and cancer risk, it is nonetheless clear that individuals who are overweight or obese should be strongly encouraged and supported in their efforts to reduce their weight.

Diabetes Risk

Weight reduction, often achieved by the combination of reduced caloric intake and increased physical activity, has been shown to reduce the risk of diabetes and decrease insulin resistance, as well as to improve measures of glycemia and dyslipidemia in diabetics. According to evidence from studies in Finland and the United States, 30 minutes of daily physical activity has been endorsed as part of a healthy lifestyle to reduce the risk of diabetes. The consistency of this recommendation, along with similar recommendations for reducing cancer and cardiovascular risks, suggests the potential for simplified health education messages about physical activity and disease prevention. The proven benefit of weight loss and physical activity strongly suggests that lifestyle modification should be the first choice to prevent or delay diabetes and to more effectively manage disease in individuals with diabetes. Even modest weight loss (5 to 10% of body weight) and modest physical activity (30 minutes daily) can have a positive impact on diabetes risk and management.

Nutrition

Although much remains to be learned about the role of specific nutrients or combination of nutrients in decreasing the risk of chronic disease, dietary patterns are emerging as an important consideration. Dietary patterns that emphasize whole-grain foods, legumes, vegetables, and fruits and that limit red meat, full-fat dairy products, and foods and beverages high in added sugars are associated with

decreased risk for a variety of chronic diseases. It also is critically important that individuals limit their overall caloric intake and become physically active to help maintain a healthy body weight.

Although there is widespread confusion about how the public should achieve energy balance, it is clear that balance between caloric intake and expenditure is the critical factor in maintaining a healthy body mass index (BMI).

Cardiovascular Diseases

It is difficult to obtain randomized, controlled data on the long-term effects of nutritional components or even patterns, but there is good evidence that following a healthful eating plan can reduce several of the recognized risk factors for cardiovascular diseases. Although it rarely is possible to define with precision the contribution of single nutrients (with notable exceptions, such as sodium), good evidence indicates that a nutritionally balanced diet plays an important role in maintaining a healthy weight and can have a favorable impact on blood pressure and plasma lipids. Sodium restriction combined with increased consumption of fiber, fruit, vegetables, and calcium was more effective than sodium restriction alone in reducing hypertension in the Dietary Approaches to Stop Hypertension (DASH) study. Excessive intake of fat, saturated fat, trans fats, or cholesterol is associated with an increased risk for coronary artery disease and should be avoided.

Cancer

Until more is known about the specific components of diet that influence cancer risk, current recommendations are to consume a mostly plant-based diet that includes at least 5 servings of vegetables and fruits each day; to choose whole-grain carbohydrate sources over refined sources; and to limit intake of saturated fat, alcohol, and excess calories.

Diabetes

Achieving energy balance and maintaining a healthy body weight are critical for the prevention and treatment of type 2 diabetes, and limiting saturated fat intake can help to prevent the vascular complications of diabetes. Higher consumption of whole grains and dietary fiber is associated with reduced risk of diabetes in some studies. The evidence that micro-nutrients influence the risk of diabetes is limited, although some studies suggest that certain micronutrients may affect glucose and insulin metabolism.

Physical Activity

Supporting evidence continues to accumulate that physical activity reduces chronic disease risk, both directly, through its impact on hormones, and indirectly, though its impact on weight control.

Cardiovascular Disease

Prospective epidemiological studies of occupational and leisure-time physical activity have consistently documented a reduced incidence of coronary artery disease and stroke in the more physically active and fit individuals. Conversely, physical inactivity has been recognized as an important risk factor for cardiovascular disease. Although it interacts with other risk factors (e.g., by increasing the tendency to overweight), its effect is independent of other risk factors. Although the beneficial effect of exercise is "dose related," increasing with duration and amount of energy expended, increasing physical activity even by the modest amount of 30 minutes at least 5 days per week has been documented to reduce risk for cardiovascular events. Because this exercise can be moderate in effort and can be broken up into smaller time periods, it is within the reach of nearly everyone. However, creating the habit of seeking more exercise in our increasingly sedentary population will be challenging and will require a concerted, ongoing effort.

Cancer

Currently, it is recommended that individuals be at least moderately active for 30 minutes or more on 5 or more days per week. Moderate to vigorous activity for at least 45 minutes on 5 or more days per week may further reduce the risk of breast and colon cancers and also may reduce the risk of kidney, endometrial, and esophageal cancers.

Screening and Secondary Prevention

Because reducing risk of disease does not eliminate risk of disease, early detection of some chronic conditions has the potential to alter the natural history of disease. For cancer, cardiovascular disease, and diabetes, screening for risk or early manifestations of disease can reduce incidence and mortality through recommendations for altered lifestyles, pharmacological interventions, treatment of precursor lesions, or earlier treatment of the disease itself.

Cardiovascular Disease

Hypertension

Blood pressure is easily assessed in the office, and a panoply of medications can provide excellent control. As a preventive measure, blood pressure control is critical and must be addressed more effectively.

Dyslipidemia

Attention must be given not only to screening for this important risk factor (elevated cholesterol) but also to increasing compliance with lipid-lowering regimens.

Novel Risk Factors

Considerable attention has been given to additional factors that may help in the prognostication of risk, including but not limited to the measurement of plasma homocysteine, high-sensitivity C-reactive protein, and more detailed lipoprotein

panels, as well as the imaging determination of vascular calcium. Several newer markers have been shown in small studies to offer some further prognostic information about the imminent occurrence of cardiovascular events. Although the utility of these risk factors is still being determined, it is important to realize that the conventional risk factors account for the great majority of the risk that can be determined and that it is in fact unusual to find patients with cardiovascular disease and none of the established risk factors.

Early and Global Assessment of Risk

Because many risk factors can be modified or even abolished by appropriate treatment, whether accomplished by the choice of a healthy lifestyle or by medications, early recognition of these risk factors is essential. The American Heart Association (AHA) recommends that adults have risk assessed at age 20 and then at additional intervals (refer to the Figure in the original guideline document). In addition, because an individual´s risk is determined by multiple factors and the benefit of interventions depends on the level of risk, a global or multiple-risk factor assessment is an even better guide to providing that individual with the care that has the greatest benefit and the lowest risk. The Framingham Risk Score is the best available current approach, and although it was derived from a specific geographic area and thus may not apply to all populations, its performance within subgroups has been assessed and is good.

Cancer

The following guidelines pertain to adults who are not measurably at elevated risk for one or more cancers because of known or suspected hereditary for familial cancer syndromes, prior history of cancer, or other risk factors that so significantly elevate risk that recommendations for average-risk adults are inappropriate.

Breast Cancer

Average-risk women should begin regular mammography at age 40 and should have a mammogram at least annually thereafter. The American Cancer Society (ACS) recommends that women ages 20 to 39 have a clinical breast examination every 3 years and annual exams beginning at age 40. As long as a woman is in good health and would be a candidate for treatment, she should continue to be screened with mammography. The decision to stop screening should be individualized on the basis of the potential benefits and risks of screening in the context of overall health status and longevity.

Cervical Cancer

Guidelines for cervical cancer screening reflect the current understanding of the underlying epidemiology of cervical intraepithelial neoplasia and offer alternative strategies based on new screening and diagnostic technologies that have emerged since the late 1980s.

The ACS recommends that cervical cancer screening should begin approximately 3 years after the onset of vaginal intercourse but no later than 21 years of age.

Cervical screening should be performed annually until age 30 with conventional cervical cytology smears or every 2 years until age 30 with liquid-based cytology. After age 30, screening may continue every 2 to 3 years for those women who have had 3 consecutive, technically satisfactory, normal/negative cytology results. Human papilloma virus (HPV) DNA testing with cytology also is reasonable for screening women 30 years of age and older as an alternative to cytology alone, with HPV DNA testing and conventional or liquid-based cytology done every 3 years. HPV testing more frequently than every 3 years is discouraged. Women 70 years of age and older with an intact cervix may choose to cease cervical cancer screening if they have had both of the following: 3 or more documented, consecutive, technically satisfactory, normal/negative cervical cytology tests, and no abnormal/positive cytology tests in the 10-year period before age 70.

Colorectal Cancer

Strong direct and inferential evidence indicates that screening for colorectal cancer and adenomatous polyps reduces both mortality from and incidence of this disease.

The ACS recommends that adults at average risk should begin colorectal cancer screening at age 50, using one of the following 5 options for screening: (1) annual fecal occult blood test or fecal immunochemical test; (2) flexible sigmoidoscopy every 5 years; (3) annual fecal occult blood test or fecal immunochemical tests pus flexible sigmoidoscopy every 5 years; (4) double-contrast barium enema every 5 years; or (5) colonoscopy every 10 years. More intensive surveillance is recommended for individuals at increased or high risk because of personal history or inherited predisposition to colorectal cancer.

Prostate Cancer

The ACS recommends that the prostate-specific antigen test and digital rectal examination should be offered annually in the context of shared decision-making beginning at age 50 to men who have a life expectancy of at least 10 years. Men at higher risk, including men of African descent (specifically, sub-Saharan African descent) and men with a first-degree relative diagnosed at a young age (i.e., <65 years) should begin testing at age 45.

Diabetes

Prediabetes

Prediabetes is diagnosed in an individual who has a fasting plasma glucose (FPG) between 100 and 125 mg/dL (i.e., impaired fasting glucose [IFG]) or a 2 hour value in the oral glucose tolerance test (OGTT) between 140 and 199 mg/dL (i.e., impaired glucose tolerance [IGT]).

The current evidence suggests that opportunistic screening to detect prediabetes (IFG or IGT) should be considered in individuals $\geq$45 years of age, particularly in those with a BMI $\geq$25 kg/m^2. Screening also should be considered for people who are <45 years of age who are overweight if they have another risk factor for diabetes (e.g., family history, hypertension, dyslipidemia). Asian Americans

should be considered for screening at lower level of BMI (e.g., 23 kg/m^2). No data support screening children for IFG or IGT, although there are recommendations for screening children for diabetes.

Screening should be performed with either the FPG test or 2-hour OGTT, although the former is the preferred test. If possible, the FPG test should be given in the morning because afternoon values tend to be lower. Given the age-related incidence of diabetes and the rate of progression to diabetes in normoglycemic middle-aged subjects, repeat testing at 3-year intervals seems reasonable.

The case for screening is strengthened by the fact that screening will detect not only cases of IFG or IGT but also cases of undiagnosed diabetes. Thus, policies to identify individuals for whom it is appropriate to initiate a diabetes-prevention strategy also will identify individuals who should receive treatment for diabetes. Furthermore, because individuals with IFG, IGT, or undiagnosed diabetes are at high risk for cardiovascular disease, their identification should herald increased surveillance and treatment for hypertension, dyslipidemia, and tobacco use.

Office Visit

Although many unanswered questions remain about the science underlying recommendations for behaviors and interventions in chronic disease prevention and control, considerable evidence supports the importance of avoiding tobacco use; increasing physical activity; maintaining a BMI <25 kg/m^2; eating a nutritionally balanced diet; and getting screened for diabetes, cardiovascular disease, and cancer. Although the importance of prevention and early detection generally is understood, inadequacies in the structure and organization of health care delivery, along with competing societal influences, detract from the adequate delivery of and reimbursement for preventive services. As a result, the delivery of preventive care emphasizes the use of opportunities for prevention during acute and chronic illness encounters, (i.e., opportunistic preventive care). The model of opportunistic prevention has emerged as a replacement for the annual physical examination, which several evidence-based reviews determined had little empirical evidence of value. Although the opportunistic model acknowledges the important role of the primary care provider as the most influential factor in preventive care, the need to treat illness(es) in an encounter and simultaneously identify and prioritize opportunities for prevention counseling and early detection results in disappointing and erratic opportunities for adherence with recommended guidelines. The weak accomplishments of the encounter-based approach to prevention have been documented in numerous studies.

Although the logic for the annual checkup may have been successfully challenged, the unintended consequence is that there currently are no recommendations for intervals for periodic preventive health encounters with asymptomatic adults. If the traditional annual checkup cannot be supported, then it is important to identify which preventive health tests and counseling (on the basis of age, gender, and risk) for otherwise healthy individuals would contribute to greater progress toward preventive health goals. For example, as noted above, because essential hypertension is manifest at varying ages and is usually asymptomatic, otherwise healthy patients need regular and ongoing blood pressure screening to determine when and if they become hypertensive, especially if opportunistic visits are infrequent. If prehypertension is identified, lifestyle modification should be

instituted, and follow-up is needed to judge effectiveness. If a blood pressure of 140/90 mm Hg or greater is found, frequent office visits will be needed early in treatment for adjustment of lifestyle modifications and/or medications until an optimal blood pressure is reached.

The time has come to identify age- and gender-appropriate models for periodic health maintenance visits and to delineate a visit schedule based on age, gender, and other relevant considerations. It also is important to recognize that clinicians must be fairly reimbursed for encounter-based preventive care, for visits devoted exclusively to prevention and early detection, and for the costs of office systems that improve efficiency and adherence to preventive care. The ambitious health-promotion and disease-prevention goals set by our organizations simply cannot be met unless we acknowledge the critically important and influential role of an individual´s primary care provider and provide the incentive, guidance, and opportunity for regular periodic preventive health examinations.

CLINICAL ALGORITHM(S)

None provided

EVIDENCE SUPPORTING THE RECOMMENDATIONS

TYPE OF EVIDENCE SUPPORTING THE RECOMMENDATIONS

The type of supporting evidence is not specifically stated for each recommendation.

BENEFITS/HARMS OF IMPLEMENTING THE GUIDELINE RECOMMENDATIONS

POTENTIAL BENEFITS

- Stimulation of substantial improvements in primary prevention and early detection through collaboration between key organizations, greater public awareness about healthy lifestyles, legislative action that results in more funding for and access to primary prevention programs and research, and reconsideration of the concept of the periodic medical checkup as an effective platform for prevention, early detection, and treatment
- Reduced morbidity and premature mortality from cancer, cardiovascular disease, and diabetes
- Reduced human and economic cost of cancer, diabetes, and cardiovascular diseases
- Reduced individual and collective risk of cancer, diabetes, and cardiovascular diseases

POTENTIAL HARMS

Not stated

IMPLEMENTATION OF THE GUIDELINE

DESCRIPTION OF IMPLEMENTATION STRATEGY

The collaboration among the American Cancer Society (ACS), American Diabetes Association (ADA), and American Heart Association AHA offers several unique new opportunities to advance a collective cause for prevention and early detection of cancer, heart disease, and diabetes. First and foremost, this collaboration holds the potential to achieve greater progress in health promotion and disease prevention. Second, against the background of what is often decried as a bewildering, inconsistent, and competing number of messages about health, the joint promotion of a set of core recommendations that could reduce individual and collective risk could be a unifying force for action and advocacy for individuals, families, communities, healthcare professionals, and other organizations. In particular, the common themes outlined in the guidelines provide a new opportunity for clinicians to focus on important risk factors that, if avoided or modified, could have beneficial effects for reducing incidence of and premature mortality from the leading chronic conditions. Third, the guideline developers see an opportunity to stimulate new initiatives that could improve healthcare delivery, such as a greater emphasis on the importance of taking detailed family histories to identify familial patterns of disease, or to stimulate new directions in health promotion. For example, it is time that the United States population was directly informed that being overweight is hazardous to your health. Fourth, this collaboration offers new opportunities for collective advocacy by organizations at the local level, with the potential for being more influential in local policies, such as smoke-free ordinances, enforcement of restrictions on tobacco sales to minors, promotion of good nutrition and physical activity in schools and throughout communities, and promotion of safe venues for physical activity. Finally, national and statewide goals for health are rarely proscriptive, and thus progress toward those goals rarely results in a deliberate, mission-oriented, collective effort. Indeed, for some health indicators, the goals serve only as a reminder of how little progress is being made or how much ground is being lost.

INSTITUTE OF MEDICINE (IOM) NATIONAL HEALTHCARE QUALITY REPORT CATEGORIES

IOM CARE NEED

Staying Healthy

IOM DOMAIN

Effectiveness
Patient-centeredness

IDENTIFYING INFORMATION AND AVAILABILITY

BIBLIOGRAPHIC SOURCE(S)

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ADAPTATION

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

DATE RELEASED

2004 Jun 29

GUIDELINE DEVELOPER(S)

American Cancer Society - Disease Specific Society
American Diabetes Association - Professional Association
American Heart Association - Professional Association

SOURCE(S) OF FUNDING

American Heart Association; American Diabetes Association; American Cancer Society

GUIDELINE COMMITTEE

ACS/ADA/AHA Collaborative Writing Committee

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FINANCIAL DISCLOSURES/CONFLICTS OF INTEREST

The American Heart Association made every effort to avoid any actual or potential conflicts of interest that could arise as a result of an outside relationship or a personal, professional, or business interest of a member of the writing panel. Specifically, all members of the writing group were required to complete and submit a Disclosure Questionnaire showing all such relationships that might be perceived as real or potential conflicts of interest.

GUIDELINE STATUS

This is the current release of the guideline.

GUIDELINE AVAILABILITY

Electronic copies: Available from the American Heart Association Web site

Print copies: Available from the American Heart Association, Public Information, 7272 Greenville Ave, Dallas, TX 75231-4596; Phone: 800-242-8721

AVAILABILITY OF COMPANION DOCUMENTS

None available

PATIENT RESOURCES

None available

NGC STATUS

This summary was completed by ECRI on October 21, 2004. The information was verified by the guideline developer on November 29, 2004.

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