Health Check

LEADER'S GUIDE

PLANNING THE LESSON

To prepare this lesson, read this leader's guide and the publication MF-2357 Personal Medical Checkup. For your lesson, you may want to:

- review the material, which is in a question / answer format, found in this teaching guide.
- review the chart in the participant handout entitled "Major Screening Tests."
- organize the lesson to fit your teaching style.

Material needed:

- One copy for each participant of Personal Medical Checkup.
- A copy of the program evaluation at the end of this guide.

LESSON NOTES

- Many of us like to talk about our health. Be careful that the lesson doesn't turn into a sharing of health problems. You may have to redirect discussion if people start talking about surgery, cancer or past health exams.
- Any discussion of health clinicians should remain on a high level. Some people tend to blame the clinician for their health problems.

OBJECTIVES

At the conclusion of the lesson, participants will be able to:

- describe common screening tests.
- explain the importance of age, gender, family, and medical history in determining the frequency and types of tests used.
- explain why clinicians have moved away from annual medical exams.

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INTRODUCTION

The scope of medical checkups is a source of considerable disagreement. Some people believe everyone should have a yearly checkup; others think a medical checkup is needed only about every two to three years. Patients observe disagreement among health agencies and health professionals as to how often a particular screening test should be offered. In addition, there is disagreement in the medical community as to which screening tests are effective.

This lesson focuses on common screening tests professionals feel are essential in health management. The lesson relies heavily on recommendations of the U.S. Preventive Service Task Force* for medical checkup guidelines.

WHAT IS THE HISTORY OF THE MEDICAL EXAMINATION?

The periodic exam is believed to have its origin in June 1900, when Dr. George M. Gould suggested to the American Medical Association (AMA) that it was necessary to perform periodic medical examinations if physicians were to practice preventive medicine. In 1922, the AMA's House of Delegates authorized the preparation of routine medical checkup forms for doctors, followed by a physician's manual for routine health examinations. The routine forms and manual brought standardization to the exam. The regular examinations were strengthened by a 1947 recommendation that individuals over 35 have a yearly examination. In 1983, the AMA moved away from the yearly exam. Now the group suggests that patients have medical checkups every five years until age 40 and every one to three years thereafter.

WHY HAVE HEALTH CLINICIANS MOVED AWAY FROM THE ANNUAL MEDICAL EXAM?

Patients under 50 years of age are relatively free from disease that can be diagnosed by a physical exam. Most health problems must manifest themselves in the form of signs or symptoms before they can be recognized. In addition, some exams are not cost-effective. For example, a chest X-ray seldom reveals disease in younger patients, who are at low risk for such lung diseases as tuberculosis and cancer.

WHAT IS A SCREENING TEST?

Screening is an examination (or test) for early signs of a certain type of disease, even though there may be no symptoms. To learn who is more likely to get a particular disease, scientists have studied disease patterns in the population. This information helps clinicians recommend which patients should be screened for what types of diseases, and how often these tests should be done.

Not all screening tests are helpful, though, and some have risks. If your clinician suggests certain screening tests as part of your health care exam, this does not mean he or she thinks you have a particular disease. Screening tests are done when you have no symptoms. If you have symptoms of a particular disease, your clinician may order diagnostic tests to verify presence of the disease.

* U.S. Preventive Service Task Force is a panel of physicians under the direction of the U.S. Department of Health and Human Services. It studies the effectiveness of screening tests for early detection of disease.

Kansas State University Agricultural Experiment Station and Cooperative Extension Service

HEALTH CHECK

HOW OFTEN WILL YOUR CLINICIAN WANT YOU TO HAVE A HEALTH EXAMINATION?

The American Medical Association suggests that people have medical checkups every five years until age 40 and then every one to three years thereafter. Some clinicians use this rule of thumb: For individuals in their twenties — two exams during that time period; in their thirties — three exams; forties — four exams. An annual health exam is recommended for most patients after age 50.

WHAT MIGHT A PERSON EXPECT TODAY FROM A HEALTH EXAMINATION?

A health exam usually includes filling out a family history form, if one is not on file. The clinician will check eyes, ears, nose, throat, heart, height, weight, abdomen, lungs, neurological and skeletal systems, breast, cervix, and urinary tract. A urine specimen is used to test problems with kidneys, and a blood sample may be taken to check cholesterol levels and any iron deficiency.

The physician may request additional tests, depending on age, gender, medical history and family history. A chest X-ray, EKG, rectal examination or stress test may be ordered. The clinician may suggest lifestyle changes and call for health interventions.

SPECIFIC TESTS

Please refer to the "Major Screening Tests" portion of the fact sheet as we review some of the more common screening tests.

LET'S LOOK FIRST AT BLOOD PRESSURE SCREENING. WHO NEEDS THE SCREENING? HOW OFTEN?

Periodic screening for hypertension is recommended for all adults. The regularity of blood pressure screening is left to clinical discretion. Current expert opinion is that adults who are believed to have normal blood pressure should receive blood pressure measurements at least once every two years. If your blood pressure moves up toward the high range, your clinician will want to check it more often. Measurement of blood pressure during office visits is also recommended for children and adolescents.

Blood pressure cuff remains the most appropriate screening test for hypertension. The patient can be the source of misleading readings due to posture and arm position. Biological factors that can cause faulty readings include anxiety, meals, tobacco, alcohol, temperature changes, exertion and pain. Due to these limitations, it is recommended that hypertension be diagnosed only after more than one elevated reading is obtained on each of three separate visits over a period of one to several weeks or in a different environment.

BLOOD CHOLESTEROL SCREENING

Periodic screening for high blood cholesterol is recommended for all men ages 35-65 and women ages 45-65. There is insufficient evidence to recommend for or against routine screening of people without symptoms who are over age 65. Recommendations to screen healthy men and women ages 65-75 may be made on other grounds. There is also insufficient evidence to recommend for or against screening in children, adolescents or young adults. Recommendations can be made for screening adolescents and young adults with risk factors for coronary disease.

SCREENING FOR CERVICAL CANCER

Routine screening for cervical cancer with Pap testing is recommended for all women 18 years of age or who are or have been sexually active and who have a cervix. Pap smears should be repeated at least every 3 years. There is insufficient evidence to recommend for or against an upper age limit for Pap testing, but recommendations can be made on other grounds to discontinue regular testing after age 65 in women who have had regular previous screening in which the smears have been consistently normal. Women can work with the clinician to make this decision.

Approximately 16,000 cases of cervical cancer are diagnosed each year, and about 4,800 women die from this disease annually. The lifetime risk of dying from cervical cancer in the United States is 0.3 percent. The five-year survival rate is about 90 percent for women with localized cervical cancer; it is considerably lower (about 14 percent) for those with advanced disease.

SCREENING FOR BREAST CANCER

Routine screening for breast cancer every one to two years, with mammography alone or mammography and annual clinical breast examination, is recommended for women age 50-69. There is insufficient evidence to recommend for or against routine mammography or clinical breast examination for women age 40-49 or age 70 and older, although recommendations for high-risk women age 40-49 and healthy women age 70 and older may be made on other grounds. Work with your clinician to make this decision.

In 1995, there were an estimated 182,000 new cases of breast cancer diagnosed and 46,000 deaths from this disease in American women. Approximately 32 percent of

all newly diagnosed cancers in women are cancers of the breast, the most common cancer diagnosed in women. The annual incidence of breast cancer increased 55 percent between 1950 and 1991. The incidence in women during the period 1987-1991 was 110 per 100,000.

SCREENING FOR COLORECTAL CANCER

Screening for colorectal cancer is recommended for individuals age 50 and older, with annual fecal occult blood testing and sigmoidoscopy every three to 10 years, on professional advice. Clinicians study the health of the rectum and colon with a viewing tube called an endoscope. This lighted viewing tube is used to examine the rectum and lower portion of the large intestine (sigmoidoscopy) and the entire large intestine (colonoscopy).

PROSTATE SCREENING

The prostate specific antigen (PSA) test measures the increased level of protein antigen usually present when there is a cancer tumor. There are questions of what to do if the test is positive, but no cancer is found. The protein antigen rises with some urinary tract infections. A very high level of antigen usually means the cancer is large and has already spread. Small elevations may not mean anything and are very hard to interpret. A level below 4 Ng / ml (nanograms per milliliter) is normal. A level between 4 and 10 Ng / ml is considered elevated. A level higher than 10 Ng / ml is a strong indication of cancer. The patient may choose to go through expensive testing or surgery to see if it is cancer. (University of California at Berkeley Wellness Letter, July 1995)

The digital rectal exam is performed by a doctor through the rectum to examine the lower part of the prostate gland. The prostate gland is examined for abnormalities. The prostate in older patients is often enlarged, stiff and inflexible. Nodules on the prostate raise the question of cancer. Prostate cancer is the most common non-skin cancer in American men. After lung cancer, it accounts for more cancer deaths in men that any other single cancer site. Prostate cancer accounted for an estimated 244,000 new cases and 40,400 deaths in the United States in 1995.

What are the risks?

Cancer of the prostate is rare in young men but becomes more common with age. It occurs in fewer than one man in 10,000 from age 40 to 50. Risk increases with age, beginning at age 50, and is also higher among African American men. It is slow growing and can metastasize (spread) if it goes undetected.

THYROID DISEASE

Routine screening for thyroid disease is not recommended for asymptomatic children or adults. Clinicians should be alert to subtle symptoms and signs of thyroid dysfunction when examining patients. Examples of such symptoms include easily becoming fatigued, weight gain, dry skin or hair, cold intolerance, difficulty concentrating, depression, nervousness and palpitations.

GLAUCOMA SCREENING

Individuals who are over 65, have severe myopia or diabetes, or who are African American should be evaluated by an eye specialist. Many eye specialists advise screening all adults starting at age 40. Glaucoma is a disorder defined by slowly progressive loss of vision associated with characteristic signs of damage to the optic nerve. Increased pressure inside the eye is common in glaucoma and is believed to contribute in damaging the optic nerve. Glaucoma is the second leading cause of irreversible blindness in the United States and the leading cause among African Americans.

PREVENTION

Clinicians have been incorporating prevention into medical practice for the past 30 to 40 years. Infectious diseases such as poliomyelitis—which once occurred in regular epidemic waves (more than 18,300 cases in 1954)—have become rare in the United States as a result of childhood immunization. Only three cases of paralytic poliomyelitis were reported in the nation in 1993, none due to the wild virus.

Before rubella vaccine became available, rubella epidemics occurred regularly in the United States every six to nine years; a 1964 outbreak resulted in more than 12 million rubella infections, 11,000 fetal losses, and about 20,000 infants born with congenital rubella syndrome (deafness, eye defects, cardiac defects, neurologic abnormalities). The incidence of rubella has decreased 99 percent since 1969, when the vaccine first became available. Similar trends have occurred with diphtheria, pertussis, and other once-common childhood infectious diseases.

Although immunization and screening tests remain important preventive services, the most promising role for prevention in current medical practice may lie in changing the personal health behaviors of patients long before clinical disease develops. Approximately half of all deaths occurring in the United States may be attributed to external factors: tobacco, alcohol, and illicit drug use; diet and activity patterns; motor vehicles; and sexual behavior. All are potentially preventable by changes in personal health practices.

COMMUNITY SERVICE ACTIVITIES

- Create a media awareness campaign to encourage people to visit their clinician for a checkup.
- Assist the health department in screening activities.
- Organize a screening activity for a group of people in the community who may be difficult to reach. It may be a church group or individuals who are not available for screenings at regular clinic hours.

PROGRAM EVALUATION

At the end of the program, ask participants to complete copies of the program evaluation. Return the completed evaluation to your county agent.

PROGRAM EVALUATION

County: _____ Date: _____

HEALTH CHECK

Circle your answers to questions I through III:

I. How do you rate this program in general?

- Met my expectations EXCELLENT GOOD FAIR POOR
- Subject matter EXCELLENT GOOD FAIR POOR
- Usable information EXCELLENT GOOD FAIR POOR

II. As a result of this program:

- I gained knowledge MUCH SOME LITTLE NONE
- I will use the information MUCH SOME LITTLE NONE

III. As a result of this program, do you have an improved understanding of:

- History of the medical examination YES NO
- Screening tests and why they are used YES NO
- The type of screening tests you may be asked to take during your next medical exam YES NO
- How often your clinician will want you to have a medical exam YES NO
- The counseling topics that may be discussed by your clinician YES NO

IV. Additional comments / suggestions:

REFERENCES:

Guide to Clinical Preventive Services, 2nd Edition, Internal Medical Publishing, Inc., Alexandria, Va.

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