

# Ep #157: The Primary Care Screening Guidelines You Must Know to Pass Your NP Boards



## Full Episode Transcript

With Your Host

**Anna Miller**

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Welcome to the *Real Deal Nurse Practitioner Club*, the podcast for nurses who are ready to pass their boards and thrive in their careers as real deal nurse practitioners. I'm Anna and I'm the Director of Nursing Content at Blueprint Test Prep. Whether you're deep in exam prep or stepping into practice, I've got you. It is time to become the confident, knowledgeable NP that you're meant to be. Let's dive in.

Hey everyone, welcome back to another episode. I'm Anna and I've got Courtney back with me today.

Courtney: Hey friends, I'm so happy to be here and today's topic is one of those things that feels a little dry at first, but it shows up on both boards and in clinical practice. And that is screening guidelines in primary care.

Anna: Exactly. We talked about hypertension recently and then today, we're going to hit all the high yield adult screening recommendations that you really need to know for those primary care NP boards. We're going to lean heavily on the USPSTF recommendations. But we'll briefly cover where other big organizations like the ACS or ACOG come into play. Also remember the CDC is a wonderful source.

And a little caveat here, with so many sources recommending guidelines, don't get lost trying to memorize all of them. Instead, focus on the common themes and remember that boards, they're not trying to trick you by answering between different guidelines, okay?

And another caveat before we jump in. This episode is not meant to be an exhaustive guideline review, nor is any of this medical advice, right? This is - I really want you to think of this as a guided highlight reel for the boards and what is currently on them as of this podcast in January 2026. If you want deeper dives, case-based examples, practice questions, then definitely check out our SMNP board review courses where we walk through this in way more detail. But Courtney, you ready?

Courtney: Let's do it.

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Anna: All right, before we dive into specific screenings, let's zoom out for just a second because boards also love to ask about levels of prevention and screenings fall into one of these levels. So Courtney, do you want to give a quick refresh?

Courtney: For sure. So think of prevention levels as three layers. So primary prevention, stopping or preventing the disease before it ever starts. So pair the Ps, primary and prevention. So examples are vaccines or smoking cessation or lifestyle counseling.

Secondary prevention is early detection before symptoms usually start, and this is where screening lives, as Anna had said. Pair the Ss, secondary and screening. So we're thinking mammograms, pap smears, colorectal cancer screening.

As for tertiary prevention, this is treating the disease to prevent complications. So pair the Ts, tertiary and treatment. So think of things like cardiac rehab after an MI or physical therapy after a stroke.

Anna: Yeah, absolutely. And let's kick off our discussion now with a really big one that's an emergent situation. And that's going to be an abdominal aortic aneurysm or AAA screen.

Courtney: Yes. So, AAA screening is for men aged 65 to 75 who have ever smoked. They get a one-time abdominal ultrasound to look for an aneurysm. That is a USPSTF recommendation with a positive net benefit because you are catching those silent aneurysms before they rupture.

Anna: Yeah, and we love to catch them before they become that emergent situation. Now, for women or for patients who do not smoke, the recommendations are more, it depends, or there's insufficient evidence as they say. But for the exams, they usually tend to stick to that classic, men aged 65 to 75 who ever smoked scenario.

Okay, next up, diabetes screening. The general consensus is to screen adults starting at age 35. Now, it might be earlier if they have risk factors

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like a BMI in the overweight or obesity categories, or if they have a history of gestational diabetes, for example. And we can use three tests here. There's the fasting plasma glucose, the hemoglobin A1C, or the two-hour oral glucose tolerance test.

Courtney: Yes, and so if you screen a patient and the results are normal, you re-screen around every three years. If they are abnormal, you can confirm with a second test preferably on a different day unless they are clearly symptomatic.

And so for boards, remember those diagnostic cutoffs. So for an A1C, we're looking at a 6.5% or higher for diabetes. For fasting glucose, it's 126 or higher. For the two-hour OGTT, that's 200 or higher. And then if you have a patient who is wildly symptomatic, so we're talking like polyuria, polydipsia, and they have a random glucose of 200 or higher, that we can typically use by itself to diagnose diabetes.

Anna: Yeah, and those numbers are really easy points if you've got them memorized. So if you don't, make some flashcards and then you'll ace that question on the exam. But now let's move on to osteoporosis.

Courtney: Yeah, so from a board's perspective, the big one to know is to screen all women 65 years or older and screen them for osteoporosis with a DEXA scan, or you'll see that abbreviated as a DXA. For postmenopausal women who are younger than 65, we screen if they're at an increased risk of fractures, which is usually determined by an assessment tool like FRAX. Keep in mind that guidelines differ a bit for men, so boards typically focus on the guidelines for women.

Anna: Yep. And now I'm going to switch gears again. Mental health. Most exams focus on adult recommendations, so that's all we're going to cover here today. The USPSTF recommends screening all adults for depression and anxiety. For depression, you can use the PHQ-2, and then you can move on to that PHQ-9 if it's positive. For anxiety, we have something

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similar. You can use the GAD-2, and then you can move on to the more in-depth GAD-7 if that GAD-2 is positive.

Courtney: Yes, and remember, even though routine universal suicide screening isn't strongly recommended at this time, if your patient reports suicidal ideation on a depression screen, that is a stop and address this right now moment. So assess their safety, consider emergency care or an urgent mental health referral. That is not something we push to a future visit.

Anna: Yeah, absolutely. Now, what about substance use, Courtney?

Courtney: Yes, so for adults, including patients who are pregnant, we should screen for tobacco, unhealthy alcohol use, and drug use.

Anna: All right, now let's go ahead and move on to cancer screening. And I know we're moving fast today, but we really just want to kind of cover those high yield points for your exams.

So let's start with colorectal cancer. The USPSTF recommends screening average risk adults from age 45 to 75. And there are several options here too. Ultimately, when you're in practice, the best screening test for a patient really depends on their individual clinical picture and their risks. It could be the colonoscopy every 10 years, the annual FIT, the FIT with DNA like Cologuard every three years, or even like a flexible sigmoidoscopy in some cases.

Boards are not going to get too nitty gritty here, and really the screening colonoscopy every 10 years is the best place to focus for the exams. And now let's move on to lung cancer screening. Courtney, what is the recommendation here?

Courtney: Yes, so the USPSTF recommends annual low-dose CT scans for adults aged 50 to 80 with a 20 pack-year or more smoking history who currently smoke or have quit within the last 15 years. And so you should

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stop screening if they have not smoked for 15 years, if they develop a condition limiting life expectancy, or they can't tolerate curative surgery.

I know that feels like a lot, but it will be very straightforward on your boards. And so they will typically give you a question like a 62-year-old patient with a 30 pack-year smoking history who quit five years ago and ask if they qualify for screening, and that would be an easy yes in your head.

Anna: Yeah, absolutely. Do not overthink these. Don't get lost in the details for the exam, okay? They're not trying to trick you. They're just trying to make sure you're going to be safe and competent entering practice. And they also realize that different practices are going to use different guidelines that they go by and that you'll be able to verify these by looking them up when you're in practice. But let's talk about breast cancer screening. This is another one where guidelines vary a bit by organization. Again, board's not testing you in the gray areas.

Courtney: Exactly. So the different groups like the USPSTF, ACOG, ACS, they all have slightly different intervals, but a safe board's anchor here is for average risk women. Think starting mammograms at age 40, continue every one to two years until age 74. So the scenario again will be pretty clear. Average risk woman, no BRCA mutation, no chest radiation history, someone who needs a screening mammogram.

Anna: Absolutely. All right, let's talk about cervical cancer next. Another one with so many different organizations. But Courtney, let's do what we just did with breast cancer again. What are the key points to remember here?

Courtney: Yes, and so remember, the guidelines vary a bit. However, most of the main organizations agree to start screening at age 21. And so from 21 to 29, a Pap smear alone is recommended every three years. Now, once a patient hits age 30, they have some options. And so that's going to be either a Pap smear every three years or high-risk HPV testing every five years or co-testing every five years. Screening for cervical cancer typically

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stops at 65 if they've had adequate prior screening and no high-risk history, or earlier if they've had a total hysterectomy for benign reasons.

Anna: Absolutely. And we can't forget about prostate cancer screening. Although I will say this one is a little bit more nuanced when you get into practice. Now, the USPSTF does not recommend routine PSA screening for men over 70. But for ages 55 to 69, PSA screening is really a shared decision-making recommendation. There is not a you must screen everybody rule here.

Boards here often want you to recognize that the PSA, it is a sensitive test, but it's not specific. And what I mean by that is the PSA can be elevated in things like BPH, prostatitis, or even if they've had a recent infection. So it doesn't always mean prostate cancer. And therefore, over-diagnosis and over-treatment can be real concerns. And so really shared decision-making is that key phrase that you want to know for average risk men in that 55 to 69 range.

Now, for men at a higher risk, such as those with a family history, some guidelines suggest considering earlier discussion. But boards are going to keep it broad, so we're not going to get lost in those details. But let's move on to some key points about hepatitis and HIV screening.

Courtney: Yes. And so for hepatitis B, the USPSTF recommends screening people at increased risk, such as those who inject drugs or people with HIV. The CDC goes a little bit further and recommends one-time screening for all adults 18 and older, regardless of vaccine status. So for hepatitis C, both the USPSTF and the CDC recommend one-time screening for all adults with repeat testing for those who have risk factors.

As for HIV, both organizations agree that everyone should be screened at least once in adolescence and early adulthood. So we're thinking around 13 to 15 depending on the guidelines. Remember, boards will stick to the principle: universal one-time HIV screen with more frequent testing in higher risk patients. And so for HIV, the preferred screening test is now a

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fourth generation HIV-1/2 antigen antibody immunoassay. And I know that sounds like a lot, but just remember it's that fourth generation that tests both the antigen and antibodies.

Anna: Yeah, and let's not forget about pregnancy here because HIV is another one of those that we want tested in pregnancy. And so before we finish today's episode, let's just hit a couple of pregnancy screening highlights to be aware of. So really at that first or one of the very first prenatal visits, think about screening for STIs like chlamydia, gonorrhea, syphilis. Think about hepatitis B. Sometimes they'll also screen for hepatitis C. They'll screen for HIV, and they often collect a urine culture looking at that asymptomatic bacteriuria.

Also, you're likely going to assess rubella and varicella immunity if the status is unclear. And those vaccines are given postpartum if they're needed because remember those are live vaccines that we're not going to give during pregnancy, but it's good to know what their immunity status is.

And then later in pregnancy, there's a couple big ones just to be aware of. And that's going to be that gestational diabetes screening, which typically takes place between 24 and 28 weeks. And then near the end of pregnancy, they have the screening for group B strep, and that's typically done at about 36 to 37 weeks.

Courtney: Yes, and don't forget postpartum depression screening. It's not always spelled out in detail on boards, but it is very, very important for safe primary care practice.

Anna: Okay, that was a lot. We went rapid fire, but really when you're studying screening guidelines, focus on a few main things, right? Focus on who to screen, what test to use, how often. Just think about that in broad terms and don't get lost in those nitty gritty details, right? Boards are not trying to trick you with obscure guideline conflicts. If you know the core screening patterns, you're going to be in really good shape to critically think through and answer those questions.

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Courtney: Yeah, and remember, this episode is more of a high yield overview. In our full NP board prep courses, we go deeper into the nuances between organizations like for breast cancer or cervical cancer screening, how the guidelines show up in practice questions, and how to prioritize what's worth memorizing versus what's okay to just recognize. So if you're feeling like, okay, I kind of get it, but I need a refresh before testing, definitely check those out.

Anna: Absolutely. And if you found this helpful, share it with a friend or a classmate. Check out our courses like Courtney mentioned for deeper content breakdowns that are really specifically focused on the exams and tons of practice questions. But you all have got this. We will see you in our next episode. We have a mini episode coming out next week, and then our next full episode is going to dive into some lessons that we wished we knew when we were starting out as a new NP. But we'll see you next time.

Thanks for listening to another episode of the *Real Deal Nurse Practitioner Club*. If you want more information about the different types of support that we offer to students and new nurse practitioners, you can visit [npreviews.com](https://npreviews.com). We'll see you next week.