<table>
<thead>
<tr>
<th>PMID</th>
<th>First Author</th>
<th>Title</th>
<th>Year</th>
<th>Study Type</th>
<th>Type</th>
<th>RF5-SR</th>
<th>Setting</th>
<th>Study Eligibility Criteria</th>
<th>Number of Studies (n)</th>
<th>Main Study Objective</th>
<th>Target Population</th>
<th>Patient Characteristics</th>
</tr>
</thead>
</table>
| 17606543 | Haney EM     | Screening and treatment for lipid disorders in children and adolescents: systematic evidence review for the US Preventive Services Task Force | 2007 | SR         | None     | Q6     | USA     | Mult Settings             | 1966-Sept 2005       | Synthesize the published evidence regarding the effectiveness of selecting, testing, and managing children and adolescents with dyslipidemia in the course of routine primary care | Pediatric/Young Adults | NR

**Interv. Type:** Physical activity  
**Interv. Characteristics:**  
- Risk factors that might contribute to a risk-assessment tool have not been studied adequately  
- Family-history questions are not standardized and have limited diagnostic accuracy  
- Evidence for risk factors other than family history for predicting dyslipidemia in children is strongest for overweight, but the magnitude of the effect of overweight on lipid levels, and the potential impact of incorporating overweight into a screening strategy for dyslipidemia, has not been addressed  
- Multiple other risk factors such as diet, physical inactivity, and aerobic capacity/fitness have not been evaluated adequately to assess their contribution to dyslipidemia or usefulness as screening tools either alone or in combination  
- Currently recommended screening strategies have low adherence by providers and limited compliance by parents and children

**Examined Interv. Characteristics:**  
- Drug treatment  
- Dietary counseling  
- Physical activity  

**Examined Interv. Results/Conclusions:**  
- Statins are effective for reducing TC and LDL-C levels in children with FH; it is not clear how this efficacy translates to children with milder and/or non-monogenic dyslipidemia, and it is not known how frequently these medications are used in children without FH in practice  
- Intensive dietary counseling and follow-up can result in improvements in lipid levels, but these results have not been sustained after the cessation of the intervention  
- The few trials of exercise are of fair-to-poor quality and show little or no improvements in lipid levels for children without monogenic dyslipemias  
- Studies not of sufficient duration to determine long-term effects of either short or extended use of drug treatments

**Examined Interv. Limitations of Studies:**  
- Studies not of sufficient duration to determine long-term effects of either short or extended use of drug treatments  
- Adverse effects of screening for dyslipidemia have not been studied adequately  
- Studies are often for treating TC and LDL-C levels, while the primary focus should be on triglycerides, non-HDL cholesterol, and the low-density lipoprotein to high-density lipoprotein ratio  
- Interventions among overweight children need to be examined  
- Exercise alone reverses childhood metabolic syndrome  
- The few trials of exercise are of fair-to-poor quality and show little or no improvements in lipid levels for children without monogenic dyslipidemia  
- Studies not of sufficient duration to determine long-term effects of either short or extended use of drug treatments

**Main Reported Findings by Critical Question:**  
- Evidence for risk factors other than family history for predicting dyslipidemia in children is strongest for overweight, but the magnitude of the effect of overweight on lipid levels, and the potential impact of incorporating overweight into a screening strategy for dyslipidemia, has not been addressed  
- Multiple other risk factors such as diet, physical inactivity, and aerobic capacity/fitness have not been evaluated adequately to assess their contribution to dyslipidemia or usefulness as screening tools either alone or in combination  
- Currently recommended screening strategies have low adherence by providers and limited compliance by parents and children