The American College of Physician just published an article in the Annals of Internal Medicine which contained a list of medical screening test and procedures which are of questionable value for various reasons. Often they are redundant or wouldn't change treatment. Sometimes they are tests which are more expensive but give no better information than less expensive tests. If you find yourself in one of these situations ask your doctor if the test is really necessary or if there is a less expensive test which can give the same information.

1. Repeating screening ultrasonography for abdominal aortic aneurysm following a negative study

2. Performing coronary angiography in patients with chronic stable angina with well-controlled symptoms on medical therapy or who lack specific high-risk criteria on exercise testing

3. Performing echocardiography in asymptomatic patients with innocent-sounding heart murmurs, most typically grade I–II/VI short systolic, midpeaking murmurs that are audible along the left sternal border

4. Performing routine periodic echocardiography in asymptomatic patients with mild aortic stenosis more frequently than every 3–5 y

5. Routinely repeating echocardiography in asymptomatic patients with mild mitral regurgitation and normal left ventricular size and function

6. Obtaining electrocardiograms to screen for cardiac disease in patients at low to average risk for coronary artery disease

7. Obtaining exercise electrocardiogram for screening in low-risk asymptomatic adults

8. Performing an imaging stress test (echocardiographic or nuclear) as the initial diagnostic test in patients with known or suspected coronary artery disease who are able to exercise and have no resting electrocardiographic abnormalities that may interfere with interpretation of test results

9. Measuring brain natriuretic peptide in the initial evaluation of patients with typical findings of heart failure

10. Annual lipid screening for patients not receiving lipid-lowering drug or diet therapy in the absence of reasons for changing lipid profiles

11. Using MRI rather than mammography as the breast cancer screening test of choice for average-risk women

12. In asymptomatic women with previously treated breast cancer, performing follow-up complete blood counts, blood chemistry studies, tumor marker studies, chest radiography, or imaging studies other than appropriate breast imaging

13. Performing dual-energy x-ray absorptiometry screening for osteoporosis in women younger than 65 y in the absence of risk factors

14. Screening low-risk individuals for hepatitis B virus infection

15. Screening for cervical cancer in low-risk women aged 65 y or older and in women who have had a total hysterectomy (uterus and cervix) for benign disease

16. Screening for colorectal cancer in adults older than 75 y or in adults with a life expectancy of less than 10 y

17. Repeating colonoscopy within 5 y of an index colonoscopy in asymptomatic patients found to have low-risk adenomas

18. Screening for prostate cancer in men older than 75 y or with a life expectancy of less than 10 y

19. Using CA-125 antigen levels to screen women for ovarian cancer in the absence of increased risk

20. Performing imaging studies in patients with nonspecific low back pain

21. Performing preoperative chest radiography in the absence of a clinical suspicion for intrathoracic pathology

22. Ordering routine preoperative laboratory tests, including complete blood count, liver chemistry tests, and metabolic profiles, in otherwise healthy patients undergoing elective surgery

23. Performing preoperative coagulation studies in patients without risk factors or predisposing conditions for bleeding and with a negative history of abnormal bleeding

24. Performing serologic testing for suspected early Lyme disease

25. Performing serologic testing for Lyme disease in patients with chronic nonspecific symptoms and no clinical evidence of disseminated Lyme disease

26. Performing sinus imaging studies for patients with acute rhinosinusitis in the absence of predisposing factors for atypical microbial causes

27. Performing imaging studies in patients with recurrent, classic migraine headache and normal findings on neurologic examination

28. Performing brain imaging studies (CT or MRI) to evaluate simple syncope in patients with normal findings on neurologic examination

29. Routinely performing echocardiography in the evaluation of syncope, unless the history, physical examination, and electrocardiogram do not provide a diagnosis or underlying heart disease is suspected

30. Performing predischarge chest radiography for hospitalized patients with community-acquired pneumonia who are making a satisfactory clinical recovery

31. Obtaining CT scans in a patient with pneumonia that is confirmed by chest radiography in the absence of complicating clinical or radiographic features

32. Performing imaging studies, rather than a high-sensitivity D-dimer measurement, as the initial diagnostic test in patients with low pretest probability of venous thromboembolism

33. Measuring D-dimer rather than performing appropriate diagnostic imaging (extremity ultrasonography, CT angiography, or ventilation–perfusion scintigraphy), in patients with intermediate or high probability of venous thromboembolism

34. Performing follow-up imaging studies for incidentally discovered pulmonary nodules □4 mm in low-risk individuals

35. Monitoring patients with asthma or chronic obstructive pulmonary disease by using full pulmonary function testing that includes lung volumes and diffusing capacity, rather than

spirometry alone (or peak expiratory flow rate monitoring in asthma)

36. Performing an antinuclear antibody test in patients with nonspecific symptoms, such as fatigue and myalgia, or in patients with fibromyalgia

37. Screening for chronic obstructive pulmonary disease with spirometry in individuals without respiratory symptoms

Appropriate Use of Screening and Diagnostic Tests to Foster High-Value, Cost-Conscious Care, Annals of Internal Medicine, January 17, 2012 vol. 156 no. 2 147-149