Choosing Wisely (Outpatient Edition)

Michael Johansen, MD, MS
Assistant Professor - Clinical
Department of Family Medicine
The Ohio State University Wexner Medical Center

Prostate Cancer Screening (and more general)

- Don’t routinely screen for prostate cancer using a prostate-specific antigen (PSA) test or digital rectal exam. (American Academy of Family Physicians)
- Offer PSA screening for detecting prostate cancer only after engaging in shared decision making. (American Urological Association)
- Don’t routinely perform PSA-based screening for prostate cancer. (American College of Preventive Medicine)

Prostate Cancer Screening

- Don’t perform PSA testing for prostate cancer screening in men with no symptoms of the disease when they are expected to live less than 10 years. (American Society of Clinical Oncology)
- Don’t recommend screening for breast, colorectal or prostate cancer if life expectancy is estimated to be less than 10 years. (AMDA – The Society for Post-Acute and Long-Term Care Medicine)
- Don’t screen women younger than 30 years of age for cervical cancer with HPV testing, alone or in combination with cytology. (AAFP)

Pap Smears

- Don’t perform Pap smears on women younger than 21 or who have had a hysterectomy for non-cancer disease. (American Academy of Family Physicians)
- Don’t perform screening for cervical cancer in low-risk women aged 65 years or older and in women who have had a total hysterectomy for benign disease. (American College of Preventive Medicine)
- Don’t screen women younger than 30 years of age for cervical cancer with HPV testing, alone or in combination with cytology. (AAFP)
Pap Smears

- Don't screen women older than 65 years of age for cervical cancer who have had adequate prior screening and are not otherwise at high risk for cervical cancer. (AAFP)
- Don't perform Pap tests for surveillance of women with a history of endometrial cancer. (Society of Gynecologic Oncology)

Upper Respiratory Tract Infections/Sinusitis

- Avoid prescribing antibiotics for upper respiratory infections. (Infectious Diseases Society of America)
- Avoid prescribing antibiotics in the emergency department for uncomplicated sinusitis. (American College of Emergency Physicians)
- Don't routinely prescribe antibiotics for acute mild-to-moderate sinusitis unless symptoms last for seven or more days, or symptoms worsen after initial clinical improvement. (AAFP)
- Don't order sinus computed tomography (CT) or indiscriminately prescribe antibiotics for uncomplicated acute rhinosinusitis. (American Academy of Allergy, Asthma & Immunology)

Thyroid Disease

- Don't order multiple tests in the initial evaluation of a patient with suspected thyroid disease. Order thyroid-stimulating hormone (TSH), and if abnormal, follow up with additional evaluation or treatment depending on the findings. (American Society for Clinical Pathology)
- Don't order a total or free T3 level when assessing levothyroxine (T4) dose in hypothyroid patients. (Endocrine Society)
- Don't routinely order a thyroid ultrasound in patients with abnormal thyroid function tests if there is no palpable abnormality of the thyroid gland. (Endocrine Society)
- Don't use nuclear medicine thyroid scans to evaluate thyroid nodules in patients with normal thyroid gland function. (Society of Nuclear Medicine and Molecular Imaging)

Testosterone

- Don't prescribe testosterone therapy unless there is laboratory evidence of testosterone deficiency. (American Society for Clinical Pathology)
- Don't prescribe testosterone therapy unless there is biochemical evidence of testosterone deficiency. (Endocrine Society)
- Don't prescribe testosterone or testosterone products to men contemplating/attempting to initiate pregnancy. (American Society for Reproductive Medicine)
- Don't prescribe testosterone to men with erectile dysfunction who have normal testosterone levels. (American Urological Association)
**Carotid Stenosis**

- Avoid use of ultrasound for routine surveillance of carotid arteries in the asymptomatic healthy population at any time. (Society for Vascular Surgery)
- Don't screen for carotid artery stenosis (CAS) in asymptomatic adult patients. (AAFP)
- Don't recommend CEA for asymptomatic carotid stenosis unless the complication rate is low (<3%). (American Academy of Neurology)
- Don't perform imaging of the carotid arteries for simple syncope without other neurologic symptoms. (American Academy of Neurology)

**Low Back Pain (Imaging)**

- Don't do imaging for low back pain within the first six weeks, unless red flags are present. (AAFP)
- Don't obtain imaging studies in patients with non-specific low back pain. (ACP)
- Avoid imaging studies (MRI, CT or X-rays) for acute low back pain without specific indications. (American Society of Anesthesiologists – Pain Medicine)
- Don't initially obtain X-rays for injured workers with acute non-specific low back pain. (American College of Occupational and Environmental Medicine)

**Low Back Pain (Other)**

- Don't obtain imaging (plain radiographs, magnetic resonance imaging, computed tomography [CT], or other advanced imaging) of the spine in patients with non-specific acute low back pain and without red flags. (American Association of Neurological Surgeons and Congress of Neurological Surgeons)
- Don't prescribe opiates in acute disabling low back pain before evaluation and a trial of other alternatives is considered. (American Academy of Physical Medicine and Rehabilitation)
- Don't order an EMG for low back pain unless there is leg pain or sciatica. (American Academy of Physical Medicine and Rehabilitation)
**Diabetes**

- Don't recommend daily home finger glucose testing in patients with Type 2 diabetes mellitus not using insulin. (SGIM)

**HME / Preoperative Testing**

- Don’t perform routine general health checks for asymptomatic adults. (SGIM)
- Don’t perform routine pre-operative testing before low-risk surgical procedures. (SGIM)
- Don’t perform preoperative medical tests for eye surgery unless there are specific medical indications. (American Academy of Ophthalmology)

**Antipsychotics**

- Don’t prescribe antipsychotic medications to patients for any indication without appropriate initial evaluation and appropriate ongoing monitoring. (APA)
- Don’t routinely prescribe antipsychotic medications as a first-line intervention for insomnia in adults. (APA)
- Don’t routinely use antipsychotics as first choice to treat behavioral and psychological symptoms of dementia. (APA)
- Don’t use antipsychotics as the first choice to treat behavioral and psychological symptoms of dementia. (American Geriatrics Society)

**Antipsychotics**

- Don’t prescribe antipsychotic medications for behavioral and psychological symptoms of dementia (BPSD) in individuals with dementia without an assessment for an underlying cause of the behavior. (AMDA – The Society for Post-Acute and Long-Term Care Medicine)
- Don’t routinely prescribe two or more antipsychotic medications concurrently. (APA)
### Choosing Wisely (Inpatient Edition)

**Jennifer Allen, MD**  
Assistant Professor - Clinical  
Department of Internal Medicine  
Division of Hospital Medicine  
The Ohio State University Wexner Medical Center

#### Does my patient need a foley?

- Don’t place, or leave in place, urinary catheters for incontinence or convenience of monitoring of output for non-critically ill patients. (Society of Hospital Medicine)
  - Acceptable indications: critical illness, obstruction, hospice, perioperatively for <2 days for urologic procedures; use weights instead to monitor diuresis.
- Don’t place or maintain a urinary catheter in a patient unless there is a specific indication to do so. (American Academy of Nursing)
- Avoid invasive devices (including urinary catheters) and if required, use no longer than necessary. They pose a major risk factor for infection. (Society for Healthcare Epidemiology of America)

#### Should I prescribe a PPI?

- Don’t prescribe medications for stress ulcer prophylaxis to medical inpatients unless at high risk for GI complications. (Society of Hospital Medicine)
- For pharmacologic treatment of patients with GERD, long-term acid suppression therapy (PPI or H2 blockers) should be titrated to lowest effective dose needed to achieve therapeutic goals. (American Gastroenterology Association)

#### Should I order a blood transfusion?

- Avoid transfusions of red blood cells for arbitrary hemoglobin or hematocrit thresholds and in the absence of symptoms of active coronary disease, heart failure or stroke. (SHM)
- Don’t transfuse more units of blood than absolutely necessary. (American Association of Blood Banks)
- Don’t transfuse more than the minimum number of RBC units necessary to relieve symptoms of anemia or to return a patient to a safe hemoglobin range (7-8g/dL in stable, non-cardiac patients). (American Society of Hematology)
Does my patient need to be on telemetry?

Don’t order continuous telemetry monitoring outside of the ICU without using a protocol that governs continuation. (SHM)

Are daily labs better?

• Don’t perform repetitive CBC and chemistry testing in the face of clinical and lab stability. (SHM)
• Don’t perform serial blood counts on clinically stable patients. (AABB)

Does my patient with syncope need imaging?

• In the evaluation of simple syncope and a normal neurologic examination, don’t obtain brain imaging studies (CT or MRI). (American College of Physicians)
• Don’t perform imaging of the carotid arteries for simple syncope without other neurologic complaints. (American Academy of Neurology)

Should I order a CT angiogram?

• In patients with low pretest probability of venous thromboembolism (VTE), obtain a high-sensitivity D-dimer measurement as the initial diagnostic test; don’t obtain imaging studies as the initial diagnostic test. (ACP)
• Don’t perform CT angiography to evaluate for possible PE in patients with a low clinical probability and negative results of a highly sensitive D-dimer assay. (ACCP/ATS)
• Don’t image for suspected PE without moderate or high pretest probability of PE. (American College of Radiology)
<table>
<thead>
<tr>
<th>Does my patient need an IVC filter?</th>
<th>Should I order FFP for INR reversal?</th>
</tr>
</thead>
</table>
| • Don’t use inferior vena cava (IVC) filters routinely in patients with acute VTE. (ASH) | • Don’t administer plasma for non-emergent reversal of vitamin K antagonists (outside setting of major bleeding, intracranial hemorrhage or anticipated major surgery). (ASH)  
• Don’t routinely use blood products to reverse warfarin. (AABB) |

<table>
<thead>
<tr>
<th>Does my patient have HIT?</th>
<th>When does my patient with SCD need a blood transfusion?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Don’t test or treat for suspected heparin-induced-thrombocytopenia (HIT) in patients with a low pre-test probability of HIT. (ASH)</td>
<td>Don’t routinely transfuse patients with sickle cell disease (SCD) for chronic anemia or uncomplicated pain crises without an appropriate clinical indication. (ASH)</td>
</tr>
</tbody>
</table>
### Does my patient need antibiotics for a possible UTI?

- Don’t prescribe antimicrobials to patients using indwelling or intermittent catheterization of the bladder unless there are signs and symptoms of urinary tract infection. (American Urological Association)
- Don’t treat asymptomatic bacteriuria with antibiotics. (Infectious Diseases Society of America)

### C. difficile: Do’s and Don’ts

- Avoid testing for a *C. difficile* infection in the absence of diarrhea. (IDSA)
- Don’t perform *C. difficile* testing unless patients have signs or symptoms of infection. Tests can be falsely positive leading to over diagnosis and treatment. (SHEA)
- Don’t use antibiotics in patients with recent *C. difficile* without convincing evidence of need. Antibiotics pose a high risk of *C. difficile* recurrence. (SHEA)
- Don’t continue antibiotics beyond 72 hours in hospitalized patients unless patient has clear evidence of infection. (SHEA)

### Should I order an abdominal CT?

For a patient with functional abdominal pain syndrome (as per ROME III criteria) CT scans should not be repeated unless there is major change in clinical findings or symptoms. (AGA)

### Reminders for the older adult

- Don’t use physical restraints to manage behavioral symptoms of hospitalized older adults with delirium. (American Geriatrics Society)
- Don’t use physical restraints with an older hospitalized patient. (American Academy of Nursing)
- Don’t prescribe a medication without conducting a drug regimen review. (American Geriatrics Society)
<table>
<thead>
<tr>
<th><strong>Should my patient with CKD get a PICC line?</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Don't place PICC lines in stage III-V CKD patients without consulting nephrology. (American Society of Nephrology)</td>
</tr>
</tbody>
</table>