

Tests, treatments and procedures at risk of inappropriateness in Italy  
that Physicians and Patients should talk about.

**Five Recommendations from Cochrane Neurological Sciences Field (CNF) – 1st List**

<b>1</b>	<p><b>Don't recommend Enteral Artificial Nutrition through Percutaneous Endoscopic Gastrostomy (PEG) or nasogastric tube in patients with advanced dementia; instead, offer oral assisted feeding.</b></p> <p>In severe stage dementia clinical trials have demonstrated PEG and naso-gastric tube feeding to be associated with pressure sores, physical restraints or sedative use, patient distress caused by the tube, ascites, diarrhea, pain and local infections, reduced interpersonal relationship opportunities and possible increase of aspiration pneumonia.</p> <p>Functional decline and intercurrent diseases can indicate that significant or long-term favorable benefits from artificial nutrition are unlikely.</p> <p>In providing nutrition manual help in physiological eating is as efficacious as tube feeding.</p> <p>In advanced dementia manual feeding aims are the patient's comfort and interpersonal relationships more than food intake.</p> <p><b>Adapted from American Academy of Hospice and Palliative Medicine, American Geriatrics Society and AMDA – Dedicated to Long Term Care Medicine™.</b></p>
<b>2</b>	<p><b>Don't use antipsychotics as a first choice to treat behavioral symptoms of dementia. Identifying and addressing causes of behavior change can make treatment unnecessary.</b></p> <p>Behavioral and psychological symptoms of dementia (BPSD) include agitation, aggression, anxiety, irritability, depression, apathy and psychosis. In such instances the use of antipsychotics are often prescribed with limited benefit, and the possibility of severe side effects such as higher risk of stroke and vascular death, parkinsonian or other extrapyramidal symptoms, sedation, confusion, cognitive functions impairment and weight increase, may outweigh potential benefits.</p> <p>The objective in using antipsychotics is not to calm generic agitation but to help patients at risk of harming themselves or others or in extreme conditions of distress. Assessing and identifying the cause of a behavioral disorder (including pain, constipation, environmental factors such as noise or temperature), ensuring safety, reducing distress and supporting everyday life functions can make antipsychotic treatment unnecessary. If these measures prove ineffective, antipsychotics can be used considering the balance between risks and benefits.</p> <p><b>Adapted from American Geriatrics Society, AMDA – Dedicated to Long Term Care Medicine™, American Psychiatric Association</b></p>
<b>3</b>	<p><b>Don't use benzodiazepines or other sedative-hypnotics in older adults as first choice for insomnia.</b></p> <p>Large population studies of the elderly have demonstrated that the use of benzodiazepines or other hypnotics is associated to a more than doubled risk in motor vehicle accidents, falls and hip fractures leading to hospitalization and death. Elderly patients, their families and their care-givers should be aware of this risk while treating insomnia, behavioral disturbances or delirium. Benzodiazepines should be reserved to treatment of delirium tremens or severe generalized anxiety disorder unresponsive to other treatments.</p> <p><b>Adapted from American Geriatrics Society</b></p>
<b>4</b>	<p><b>In documented clinical and radiological evidence of dementia, don't ask for brain SPECT (single-photon emission computed tomography) or 18-FDG PET (fluorodeoxyglucose positron emission tomography) or PET (positron emission tomography) with amyloid markers.</b></p> <p>Brain SPECT investigates brain blood perfusion, the 18-FDG PET investigates the hypometabolism of the cerebral gray matter, the amyloid PET marks amyloid deposits in the brain.</p> <p>In the presence of a documented clinical and radiologic diagnosis of dementia and its nature, potential benefits of the use of these diagnostics are unlikely due to the low possibility of obtaining further data to strengthen evidence.</p> <p>Otherwise these exams can help in the diagnostic process if no structural dementia changes in the brain MR are reported and/or in atypical clinical presentation (age of onset or evolution), with other diagnostics.</p>
<b>5</b>	<p><b>In subjects asymptomatic for cognitive impairment, even in familial recurrence, or in patients with memory complaints without any neuropsychological evidence, don't ask for brain PET (positron emission tomography) with amyloid markers.</b></p> <p>The fear of onset of dementia induces healthy people to ask for inappropriate consultations and diagnostics. Brain amyloid PET identifies cerebral amyloidosis that is not diagnostic of Alzheimer disease but common to other dementia subtypes and reported in healthy subjects. Furthermore, increased patient age reduces method accuracy; cognitive impairment can't be identified nor monitored with this exam, standardized neuropsychological evaluation carries out a fundamental role. In family recurrence, brain amyloid PET can't be used in place of genetics.</p>

Please note that these items are provided only for information and are not intended as a substitute for consultation with a clinician. Patients with any specific questions about the items on this list or their individual situation should consult their clinician.

## How this list was created

In November 2013 the **Cochrane Neurological Sciences Field (CNF)** searched the list of recommendations published in Choosing Wisely for those of interest from a neurological point of view, dealing with dementia. The first three recommendations of present list are adapted from Choosing Wisely Master List (American Academy of Hospice and Palliative Medicine, American Geriatrics Society, AMDA – Dedicated to Long Term Care Medicine™, American Psychiatric Association) and were found to be adequate for the Italian situation. The fourth recommendation, initially inspired to the corresponding one by the Society of Nuclear Medicine and Molecular Imaging, has been radically amended and updated in January 2015. The last recommendation arises from the need to identify the correct use of diagnostic imaging, recently introduced in cognitive impairment, warning of the risk of over-diagnosis. The last two recommendations will be given particular attention in future updates.

## Sources

<b>1</b>	<ol style="list-style-type: none"> <li>1. Finucane TE, Christmas C, Travis K. Tube feeding in patients with advanced dementia: A review of the evidence. <i>JAMA</i>. 1999;282(14):1365-1370.</li> <li>2. Gillick MR, Volandes AE. The standard of caring: why do we still use feeding tubes in patients with advanced dementia? <i>J Am Med Dir Assoc</i>. 2008 Jun;9(5):364-7.</li> <li>3. Sampson EL, Candy B, Jones L. Enteral tube feeding for older people with advanced dementia. <i>Cochrane Database Syst Rev</i>. 2009 Apr 15;(2):CD007209.</li> <li>4. Palecek EJ, Teno JM, Casarett DJ, Hanson LC, Rhodes RL, Mitchell SL. Comfort feeding only: A proposal to bring clarity to decision-making regarding difficulty with eating for persons with advanced dementia. <i>J Am Geriatr Soc</i>. 2010;58(3):580-584.</li> <li>5. Hanson LC, Ersek M, Gilliam R, Carey TS. Oral feeding options for people with dementia: A systematic review. <i>J Am Geriatr Soc</i>. 2011;59(3):463-472..</li> <li>6. Teno JM, Gozalo PL, Mitchell SL, Kuo S, Rhodes RL, Bynum JP, Mor V. Does feeding tube insertion and its timing improve survival? <i>J Am Geriatr Soc</i>. 2012 Oct;60(10):1918-21.</li> </ol>
<b>2</b>	<ol style="list-style-type: none"> <li>1. Sink KM, Holden KF, Yaffe K. Pharmacological treatment of neuropsychiatric symptoms of dementia: a review of the evidence. <i>JAMA</i>. 2005;293:596–608.</li> <li>2. Schneider LS, Dagerman KS, Insel P. Risk of death with atypical antipsychotic drug treatment for dementia: meta-analysis of randomized placebo-controlled trials. <i>JAMA</i>. 2005;294(15):1934–43.</li> <li>3. Ballard CG, Waite J, Birks J. Atypical antipsychotics for aggression and psychosis in Alzheimer's disease. <i>Cochrane Database Syst Rev</i>. 2006 Jan 25;(1):CD003476.</li> <li>4. Maher A, Maglione M, Bagley S, Suttrop M, Hu JH, Ewing B, Wang Z, Timmer M, Sultzer D, Shekelle PG. Efficacy and comparative effectiveness of atypical antipsychotic medications for off-label uses in adults: A systematic review and meta-analysis. <i>JAMA</i>. 2011 Sep 28;306(12):1359-69.</li> <li>5. The American Geriatrics Society 2012 Beers Criteria Update Expert Panel. American Geriatrics Society Updated Beers Criteria for potentially inappropriate medication use in older adults. <i>J Am Geriatr Soc</i>. 2012 Apr;60(4):616-31.</li> <li>6. Richter T, Meyer G, Möhrer R, Köpke S. Psychosocial interventions for reducing antipsychotic medication in care home residents. <i>Cochrane Database Syst Rev</i>. 2012 Dec 12;12:CD008634.</li> </ol>
<b>3</b>	<ol style="list-style-type: none"> <li>1. Finkle WD, Der JS, Greenland S, Adams JL, Ridgeway G, Blaschke T, Wang Z, Dell RM, VanRiper KB. Risk of fractures requiring hospitalization after an initial prescription of zolpidem, alprazolam, lorazepam or diazepam in older adults. <i>J Am Geriatr Soc</i>. 2011 Oct;59(10):1883–1890.</li> <li>2. Allain H, Bentue-Ferrer D, Polard E, Akwa Y, Patat A. Postural instability and consequent falls and hip fractures associated with use of hypnotics in the elderly: a comparative review. <i>Drugs Aging</i>. 2005;22(9):749–765.</li> <li>3. The American Geriatrics Society 2012 Beers Criteria Update Expert Panel. American Geriatrics Society Updated Beers Criteria for potentially inappropriate medication use in older adults. <i>J Am Geriatr Soc</i>. 2012 Apr;60(4):616-31.</li> </ol>
<b>4</b>	<ol style="list-style-type: none"> <li>1. Guerra UP, Nobili FM, Padovani A, Perani D, Pupi A, Sorbi S, Trabucchi M. Recommendations from the Italian Interdisciplinary Working Group (AIMN, AIP, SINDEM) for the utilization of amyloid imaging in clinical practice. <i>Neurol Sci</i> 10.1007/s10072-015-2079-3 (Published 24 January 2015).</li> </ol>
<b>5</b>	<ol style="list-style-type: none"> <li>1. Zhang S, Smailagic N, Hyde C, Noel-Storr AH, Takwoingi Y, McShane R, Feng J. <sup>11</sup>C-PIB-PET for the early diagnosis of Alzheimer's disease dementia and other dementias in people with mild cognitive impairment (MCI). <i>Cochrane Database of Systematic Reviews</i> 2014 Issue 7 DOI 10.1002/14651858.CD010386.pub2</li> <li>2. Guerra UP, Nobili FM, Padovani A, Perani D, Pupi A, Sorbi S, Trabucchi M. Recommendations from the Italian Interdisciplinary Working Group (AIMN, AIP, SINDEM) for the utilization of amyloid imaging in clinical practice. <i>Neurol Sci</i> 10.1007/s10072-015-2079-3 (Published 24 January 2015).</li> <li>3. Le Couteur DJ, Doust J, Creasey H, Brayne C. Political drive to screen for pre-dementia: not evidence based and ignores the harms of diagnosis <i>BMJ</i> 2013;347:f5125 doi: 10.1136/bmj.f5125 (Published 9 September 2013).</li> </ol>

**Slow Medicine**, an Italian movement of health professionals, patients and citizens promoting a Measured, Respectful and Equitable Medicine, launched the campaign **“Doing more does not mean doing better-Choosing Wisely Italy”** in Italy at the end of 2012, similar to Choosing Wisely in the USA. The campaign aims to help physicians, other health professionals, patients and citizens engage in conversations about tests, treatments and procedures at risk of inappropriateness in Italy, for informed and shared choices. The campaign is part of the Choosing Wisely International movement. Partners of the campaign are the National Federation of Medical Doctors' and Dentists' Orders (FNOMCeO), that of Registered Nurses' Orders (FNOPI), the Academy of Nursing Sciences (ASI), National Union of Radiologists (SNR), Tuscany regional health agency, PartecipaSalute, Altroconsumo, the Federation for Social Services and Healthcare of Aut. Prov. of Bolzano, Zadig. [www.choosingwiselyitaly.org](http://www.choosingwiselyitaly.org). [www.slowmedicine.it](http://www.slowmedicine.it)

**The Cochrane Neurological Sciences Field (CNF)** is an entity of the Cochrane Collaboration; It was formally registered in 2000. Headquarters were in Milan, at the University Department of Neurological Sciences, until 2006, since 2007 it has been based in Perugia at the Region Umbria Health Authority. The main objective of the CNF is to disseminate Cochrane reviews of neurological interest, promoting evidence-based medicine, building links between review authors, clinicians, patients, their families and administrators to contribute to the health information of citizens and provide scientific support to health professionals and decision makers. The team is made up of the director of the field, the coordinator, clinical neurologists, administrative staff, and archive management.

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