Slow Medicine

Measured Respectful Equitable

CHOOSING WISELY ITALY

Doing more does not mean doing better

SOCIETA' SCIENTIFICA DI MEDICINA INTERNA FADOI FEDERAZIONE DELLE ASSOCIAZIONI DEI DIRIGENTI OSPEDALIERI INTERNISTI

Tests, treatments and procedures at risk of inappropriateness in Italy

that Physicians and Patients should talk about.

Five Recommendations from the Italian Federation of Associations of Hospital Internal Medicine (FADOI) - 1st List

1	**Don't prescribe acid suppressant therapy in order to prevent stress ulcers in hospitalized patients, unless there is a high risk of bleeding.**
	According to the international guidelines, the pharmacological prophylaxis of the peptic stress ulcers with antagonists of the H2 receptors or proton pump inhibitors (PPI), is not indicated outside the intensive care setting. Even the term "gastric protection" should be avoided in this context, because it emphasizes the beneficial (obviously desirable) action, while masking the adverse effects and the possible harms. In particular, the PPI, largely used for prevention purposes in Italy, enhance the susceptibility to community pneumonias and to Chlostridium difficile infections. Even if thought for a limited period of time during an hospital stay, their prescription tends to persist indefinitely outside the hospital, with a relevant impact in terms of pharmacy expenditures.
2	**Don't treat a bacteriuria with antibiotics in elderly patients without urinary symptoms.**
	An asymptomatic bacteriuria should be managed conservatively. In elderly people, a bacteriuria is not necessarily harmful, while antibiotics are not obviously beneficial: often, they bring about undesirable effects, such as specific adverse reactions and undue selective pression over the colonizing bacteria (mainy enteric), wiih the development of resistant species. Screening and subsequent treatment of asymptomatic bacteriuria is justified only before urological procedures with anticipated mucosal bleeding. In 30% of asymptomatic subjects, a bacteriuria is not confirmed by a second examination.
3	**Don't recommend percutaneous feeding tubes in advanced dementia; prefer oral assisted feeding instead.**
	In advanced dementia, the use of percutaneous feeding tubes does not increase survival, does not lower the risk of aspiration pneumonias, does not improve the healing of existing pressure ulcers (instead, it increases their risk); it augments physcological stress, the need for physical containment and sedation, the risk of water overcharge, diarrhea, abdominal pain, local complications. The oral assisted feeding improves the nutritional status. However, in the end of life stage, nutrition should be focused on comfort and human relationship rather than on nutritional objectives.
4	**Don't repeat chemistry testing in the face of clinical and laboratory stability**
	In the general wards, the patients are often submitted to ripetitive draws of blood in the short terms, for redundant chemistry testing. Altered laboratory results often require controls, even though the original request was futile, and this amplifies the phenomenon. The anemia induced during hospitalization as a consequence of frequent draws tends to be underestimated, and this may become a problem in specific clinical settings. Attempts to introduce back-control in laboratory orders, based on "reflex" systems, incompatibility with previous results and authomathc temporal filters are under way. However, it is part of the responsibility of the orderer to discern what is aimlessly repetitive, also through a better collaboration with the laboratory. Obviously, futile examinations produce wasting.
5	**Don't transfuse red blood cells for arbitrary Hb levels, without symptoms of active coronary artery disease, heart failure, stroke.**
	In chronic anemia states, a sparing transfusion policy is recommended, even in hospitalized patients. In general, a decision to transfuse should be considered starting from Hb levels of 6 g/dl in young patients with acute anemia, 7 in the great majority of patients, 8 in patients with previous cardiovascular diseases, 9 in critical patients. However, a decision should be based also on many factors that condition the clinical state of a patient, and the necessity to oxygenate underperfused organs. More liberal indications should be adopted in patients with symptoms of active coronary artery disease, heart failure, stroke. However, also in this kind of patients the benefit of Hb above 10 is uncertain. Unnecessary transfusions expose a patient to undue risk of adverse events not counterbalanced by benefits, and determine wasting.

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.

released: 1 February 2015

How this list was created

After its adhesion to the Slow Medicine® program, the FADOI was asked to contribute with a list of ten recommendations. In early 2014, the National FADOI Council committed 2 of its component to elaborate a questionnaire containing a selection of the recommendations already published by Choosing Wisely® (270 from 56 north-american scientific societies, by February 2014), to be submitted to a critical number of FADOI members, in order to designate the "top ten" list. In march 2014, a list of 32 recommendations (those most relevant for the hospital practice) was sent to 1175 members (those affiliated to Piemonte, Veneto, Trentino AA, Friuli VG, Lazio, Campania), along with an explanatory letter, following the order of publication by Choosing Wisely®. Each member was asked to indicate the most relevant 5. The response rate was 18.1% (213, for a total number of 1037 indications) by the term of april 2014. This method was chosen in order to favor disclosure and sharing. The final "top ten" reflects the qualified opinion of a large number of FADOI members.

Sources

1

1. American Society of Health System Pharmacists. *ASHP therapeutic guidelines on stress ulcer prophylaxis.* Am J Health Syst Pharm 1999;56:347-379.
2. Bez C, Perrottet N, Zingg T, Leung Ki EL, Demartines N. Pannatier A. *Stress ulcer prophylaxis in non-critically ill patients: a prospective evaluation of current practice in a general surgery department.* Journal of Evaluation in Clinical Practice 2013;19:374–378. doi: 10.1111/j.1365-2753.2012.01838.x
3. Gullottha R, Ferraris L, Corlezzi C, Minoli G, Prada A, Comin U, Rocca F, Ferrara A, Curzio M. *Are we correctly using the inhibitors of gastric acid secretion and cytoprotective drug? Results of a multicentre study.* Ital J Gastroenterol Hepatol 1997;29(4):325-9.
4. Parente F, Cicino C, Gallus S, Bagiggia S, Greco S, Pastore L, Bianchi Porro G. *Hospital use of acid-suppressive medications and its fall-out on prescribing in general practice: a 1-month survey.* Aliment Pharmacol Ther 2003;17(12):1503-6.
5. Herzig SJ, Howell MD, Ngo LH, Marcantonio ER. *Acid-suppressive medication use and the risk for hospital-acquired pneumonia.* JAMA 2009;301(20):2120-8. doi: 10.1001/jama.2009.722.
6. Cunningham R, Dale B, Undy B, Gaunt N. *Proton pump inhibitors as a risk factor for Clostridium difficile diarrhoea.* J Hosp Infect 2003;54(3):243-5.

2

1. Infectious Disease Society of America Guidelines for the diagnosis and teatment of asymptomatic bacteriuria in adults. Clin Infect Dis 2005;40:643-665.
2. Société de Pathologie Infectieuse de Langue Française (SPILF) et Association française d'urologie (AFU). *Infections urinaire nosocomiales de l'adulte.* Médecine et Maladies Infectieuses 2003;33:193s-215s.
3. Bulfoni A, Concia E, Costantino S, Giusti M, Iori I, Mazzei T, Nardi R, Salsi A, Schito G. *Orientamenti terapeutici per il trattamento delle infezioni batteriche nel paziente anziano in Medicina Interna.* Italian J Med 2007;(1)2 Suppl: III-IV,156s-61s.

3

1. Sampson EL, Candy B, Jones L. Enteral tube feeding for older people with advanced dementia. Cochrane Syst Rev 2009 Apr15; (2): CD007209
2. Palecek EJ, Teno JM, Casarett DJ, Hanson Lc et al. Comfort feeding only: a proposal to bring clarity to decision making regarding difficulty with eating for person with advanced dementia. J Am Geriatr Soc. 2010; 59(3): 580-584.
3. Hanson LC, Carey TS, Caprio AJ, LeeTJ et al Improving decision-making for feeding options in advanced dementia: a randomized controlled trial. J Am Geriatr Soc 2011 Nov 59(11):2009-2016
4. Teno JM, Gozalo, PL, Mitchell SL, Does feeding tube insertion and its timimg improve survival? J Am Geriatr Soc 2012 Oct, 60(10): 1918-21
5. Van der Steen JT, Radbruch L, MPM Hertogh C, de Boer ME, Hughes JC, Larkin P, *et al. White paper defining optimal palliative care in older people with dementia: A Delphi study and recommendations from the European Association for Palliative Care.* Palliative Care 2013;0:1-13, DOI: 10.1177/0269216313493685

4

1. Salisbury AC, Reid KR, Alexander KP. Et al. *Diagnostic blood loss from phlebotomy and hospital acquired anemia during acute myocardial infarction.* Arch Intern Med 2011;171:1646-53
2. Janssens PM. *Managing the demand for laboratory testing: options and opportunities.* Clin Chim Acta 2010;411:1596-602, doi: 10.1016/j.cca.2010.07.022. Epub 2010 Jul 24.
3. http://www.roche.it/fmfiles/re7143001/ESADIA42.pdf

5

1. Jeffrey L. Carson, MD; Brenda J. Grossman, MD, MPH et al, for the Clinical Transfusion Medicine Committee of the AABB. *Red blood cell transfusion: a critical practice guideline from tha AABB.* Ann Intern Med 2012;157(1):49-58. doi:10.7326/0003-4819-157-1-201206190-00429.
2. Carson JL, Carless PA, Hebert P.*Transfusion thresholds and other strategies for guiding allogenic red blood cell transfusion.* Cochrane Library, DOI:10.1002/14651858.CD002042.pub3
3. Retter A, Wynol D, Pearse R, et al; British Committee for Standards ih Haematology. *Guidelines on the management of anaemia and red cell transfusion in adult critically ill patients.* Br J Haematol 2013 Feb;160(4):445-64. doi: 10.1111/bjh.12143. Epub 2012 Dec 27.
4. Società Italiana di Medicina Trasfusionale e Immunoematologia (SIMTI). *Raccomandazioni SIMTI sul corretto utilizzo degli emocomponenti e dei plasmaderivati.* 1^Edizione, settembre 2008. Edizioni SIMTI, Italia

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; www.slowmedicine.it

FADOI (Federazione delle Associazioni Dirigenti Ospedalieri Internisti) is a scientific society aimed at promoting Internal Medicine and its role inside the hospitals, augmenting the medical knowledge and improving its good practice among practicioners, and developing the "disease management" culture. It also promotes sharing of the different experiences in health organization among different regions of Italy, exchanging clinical experiences across the different departments within an hospital, and encourages continuity in medical assistance of the patients after discharge from the hospital.

FADOI has established "ten points" for a sustainable and wise health care approach.
http://www.fadoi.org/