



High value care for the hospitalist

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Disclosures

- I have no financial disclosures
- I am jointly employed by the VHA and OHSU Center for Evidence-based Policy
- I serve on the ACP Scientific Medical Policy Committee and the ACP Clinical Guidelines Committee

Obligatory doom and gloom

Obligatory doom and gloom

Figure 2

Assets in the Medicare Hospital Insurance (Part A) Trust Fund are Gradually Being Depleted

Amounts in billions

	Beginning of year HI trust fund balance	HI spending	HI revenues	End of year HI trust fund balance
2021	\$134.2	\$328.9	\$337.4	\$142.7
2022	\$142.7	\$356.2	\$386.0	\$172.4
2023	\$172.4	\$415.6	\$412.6	\$169.4
2024	\$169.4	\$444.6	\$430.2	\$155.1
2025	\$155.1	\$476.7	\$450.5	\$128.9
2026	\$128.9	\$510.7	\$475.1	\$93.3
2027	\$93.3	\$545.4	\$500.4	\$48.3
2028	\$48.3	\$580.6	\$523.7	-\$8.6
2029	-\$8.6	\$616.6	\$547.9	-\$77.3
2030	-\$77.3	\$650.5	\$570.4	-\$157.4
2031	-\$157.4	\$683.7	\$593.7	-\$247.4

NOTE: HI is Hospital Insurance.

SOURCE: KFF analysis of data from the 2022 Annual Report of the Boards of Trustees, Federal Hospital Insurance and Federal Supplementary Medical Trust Funds, June 2022. • PNG

KFF

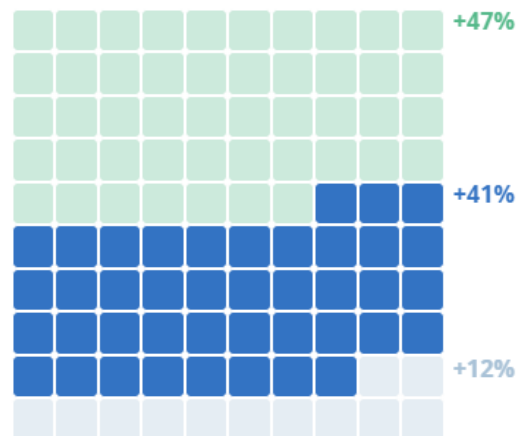


Obligatory doom and gloom

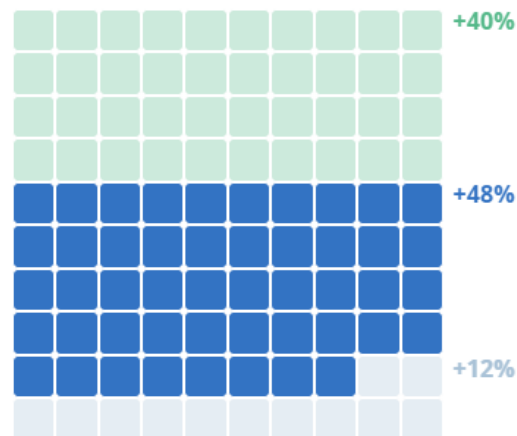
Spending on Physician Services and Other Part B Services Accounts for the Largest Share of Medicare Benefit Spending

Share of Medicare Benefit Spending for **Part A**, **Part B**, and **Part D**

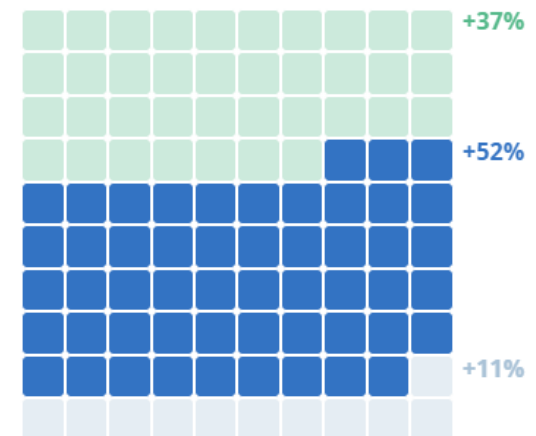
2011 (\$540B)



2021 (\$887B)



2031 (\$1.84T)



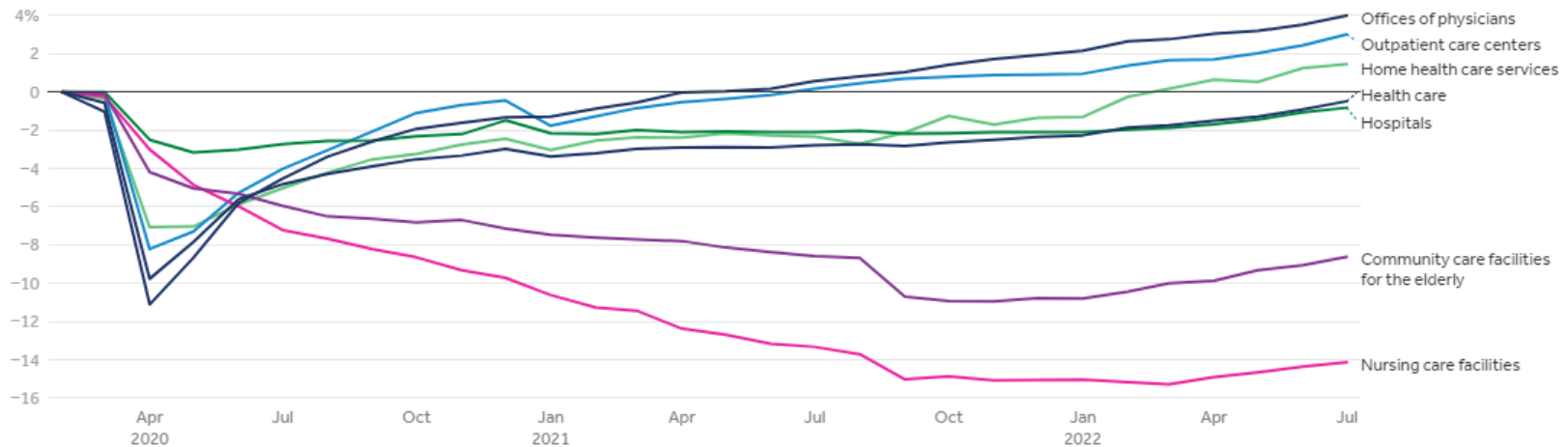
Source: KFF analysis of data from 2022 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds, Table IV.A3—Aggregate Part A Reimbursement Amounts on an Incurred Basis, Table IV.B6—Aggregate Part B Reimbursement Amounts on an Incurred Basis, and Table IV.B10—Aggregate Part D Reimbursement Amounts on an Incurred Basis.

KFF

Obligatory doom and gloom

Nursing home and elderly care employment remain below February 2020 levels

Cumulative % change in health sector employment by setting, February 2020 - July 2022



Note: All data is seasonally adjusted. Data for June and July 2022 are preliminary.

Source: [Bureau of Labor Statistics Current Employment Survey \(CES\)](#) • [Get the data](#) • [PNG](#)

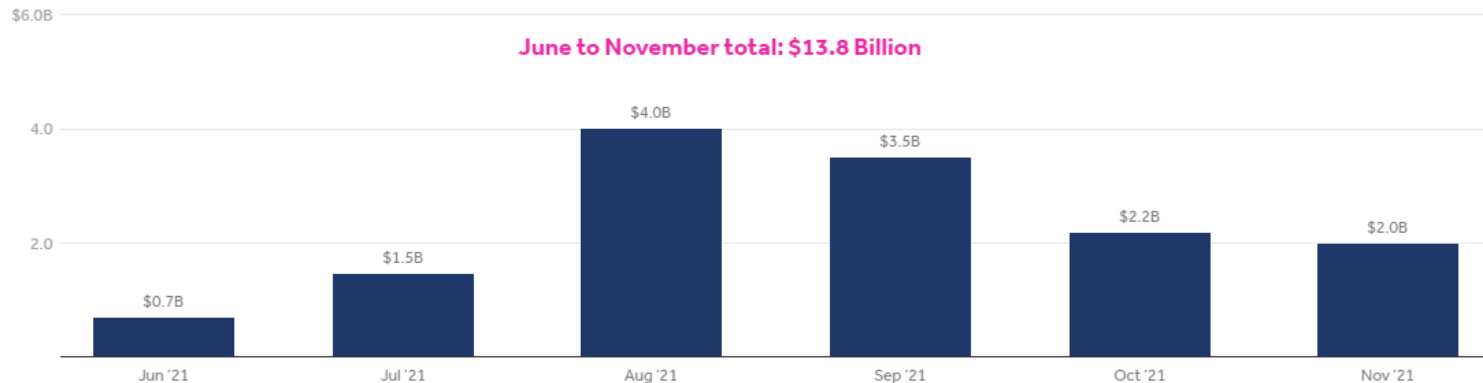
Peterson-KFF
Health System Tracker



Obligatory doom and gloom

From June through November 2021,
preventable COVID-19 hospitalizations
among unvaccinated adults cost over \$13
Billion

Estimated cost of preventable COVID-19 hospitalizations among unvaccinated adults in the U.S., June-November 2021



Note: See brief for stepwise calculations. Numbers may not sum due to rounding.

Source: KFF analysis of CDC, CMS, and HHS Protect data • [Get the data](#) • [PNG](#)

Peterson-KFF
Health System Tracker



Obligatory doom and gloom

Table 3. Cost of Low-Value Health Services Delivered by Veterans Health Administration (VA) Facilities and in VA Community Care Programs in Fiscal Year 2018

Low-value health services by domain	Cost ^a	
	Millions of dollars	Proportion of overall cost, %
Cancer screening		
PSA testing for men aged ≥75 y	7.9	3.8
Colorectal cancer screening for adults aged ≥75 y	4.3	2.1
Cervical cancer screening for women aged ≥65 y	0.3	0.1
Cancer screening for patients with CKD receiving dialysis	0.6	0.3
Total	13.0	6.3
Imaging		
Imaging for patients with nonspecific low back pain	25.4	12.3
Screening for carotid artery disease in asymptomatic adults	19.6	9.5
Head imaging for uncomplicated headache	12.7	6.2
Head imaging for syncope	3.1	1.5
CT of the sinuses for uncomplicated acute rhinosinusitis	1.5	0.7
Screening for carotid artery disease for syncope	1.4	0.7
Imaging for diagnosis of plantar fasciitis	0.4	0.2
EEG for headaches	0.6	0.3
Total	64.7	31.4
Preoperative testing		
Chest radiography	8.7	4.2
Echocardiography	7.9	3.8
Stress test	7.5	3.7
Pulmonary function test	1.0	0.5
Total	25.1	12.2

Table 3. Cost of Low-Value Health Services Delivered by Veterans Health Administration (VA) Facilities and in VA Community Care Programs in Fiscal Year 2018

Low-value health services by domain	Cost ^a	
	Millions of dollars	Proportion of overall cost, %
Diagnostic and preventive testing		
PTH measurement for patients with stage 1-3 CKD	4.5	2.2
1,25-Dihydroxyvitamin D testing in the absence of hypercalcemia or decreased kidney function	1.4	0.7
Total or free T3 level testing for patients with hypothyroidism	0.5	0.3
Homocysteine testing for cardiovascular disease	0.1	0.1
BMD testing at frequent intervals	0.4	0.2
Hypercoagulability testing for patients with deep vein thrombosis	0.1	<0.001
Total	7.0	3.4
Other procedures		
Spinal injection for low back pain	43.9	21.4
Arthroscopic surgery for knee osteoarthritis	3.0	1.4
Total	46.9	22.8
Cardiovascular testing and procedures		
Stress testing for stable coronary disease	4.0	2.0
PCI with balloon angioplasty or stent placement for stable coronary disease	36.8	17.9
IVC filters to prevent pulmonary embolism	6.4	3.1
Renal artery angioplasty or stenting	1.8	0.9
Carotid endarterectomy in asymptomatic patients	<0.001	<0.001
Total	49.0	23.8
Grand total	205.8	100

Radomski TR, Zhao X, Lovelace EZ, Sileanu FE, Rose L, Schwartz AL, Schleiden LJ, Oakes AH, Pickering AN, Yang D, Hale JA, Gellad WF, Fine MJ, Thorpe CT. Use and Cost of Low-Value Health Services Delivered or Paid for by the Veterans Health Administration. JAMA Intern Med. 2022 Aug 1;182(8):832-839.

Cases

Case 1

63 y/o man admitted with inferior MI who is recovering uneventfully after DES to the RCA

He is started on a usual package of medications for secondary prevention of coronary heart disease

As you are readying his discharge, you come to the diet section of the discharge instructions but aren't quite sure what to select

Case 1

Which of the following diets has been shown to reduce major cardiovascular events in patients with coronary heart disease:

- A. Atkins diet
- B. Keto diet
- C. Mediterranean diet
- D. Werewolf diet
- E. Cotton ball diet

Case 1: Secondary prevention with Med diet

- CARDIOPREV RCT compared Mediterranean diet with a low fat diet in adults with coronary heart disease
- N=1,002 adults aged 20-74 (83% men)
- Conducted in Cordoba, Spain
- Intensive diet education in both groups
 - Med diet group received 1 L/week of olive oil
 - Low fat group received healthy complex carb rich food packs of equivalent value

Delgado-Lista J, Alcala-Diaz JF, Torres-Peña JD, et al. Long-term secondary prevention of cardiovascular disease with a Mediterranean diet and a low-fat diet (CORDIOPREV): a randomised controlled trial. *Lancet*. 2022;399:1876-85. b/w/o ACP JC doi:10.7326/J22-0061



Case 1: Secondary prevention with Med diet

Results: Mediterranean diet vs. low-fat diet in adults with CHD (intention-to-treat analysis)

Outcome	Events/1000 person-y		At a median 7 y	
	Mediterranean diet	Low-fat diet	RRR (95% CI)†	NNT (CI)†
Major CV events‡	28	38	23% (1 to 41)	20 (12 to 366)

CHD = coronary heart disease; CV = cardiovascular; other abbreviations defined in Glossary. Primary outcome indicated by boldface.

†RRR, NNT, and CI calculated using low-fat diet event rate and unadjusted hazard ratio in article.

‡Nonfatal myocardial infarction (5.7 vs. 7.5 events/1000 person-y), revascularization (20 vs. 26 events/1000 person-y), ischemic stroke (2.4 vs. 4.7 events/1000 person-y), peripheral arterial disease (3.3 vs. 5.3 events/1000 person-y), and CV death (3.3 vs. 6.1 events/1000 person-y); all $P \geq 0.12$.

Bottom line:
In patients with CHD, a Mediterranean diet reduced major CV events at a median 7 years compared with a low-fat diet.

Delgado-Lista J, Alcala-Diaz JF, Torres-Peña JD, et al. Long-term secondary prevention of cardiovascular disease with a Mediterranean diet and a low-fat diet (CORDIOPREV): a randomised controlled trial. *Lancet*. 2022;399:1876-85. b/w/o ACP JC doi:10.7326/J22-0061



Case 1: Secondary prevention with Med diet

- Intensity of the dietary counseling could be difficult to replicate
- Generalizability outside the Mediterranean
- Event rates were lower than expected in both groups
- Adds to the small number of solidly evidence-based diet recommendations

Delgado-Lista J, Alcala-Diaz JF, Torres-Peña JD, et al. Long-term secondary prevention of cardiovascular disease with a Mediterranean diet and a low-fat diet (CORDIOPREV): a randomised controlled trial. *Lancet*. 2022;399:1876-85. b/w/o ACP JC doi:10.7326/J22-0061

Case 2

A 75 y/o woman with HFpEF is admitted to your service with dyspnea, orthopnea, weight gain, peripheral edema, and a BNP of 6,000.

As part of your heart failure history, you ask whether she has been eating more sodium lately. She responds that she doesn't really keep track of how much sodium she eats, but she did have one slice of deli turkey yesterday and a can of tomato soup three days ago.

As you're wrapping up the H&P, she asks you whether you think the soup could really be to blame for her fluid retention.

Case 2

How would you respond to the patient's question?

- A. The big soup industry is a menace to public health and must be stopped!
- B. That depends on how many oyster crackers you added.
- C. You should carefully limit your dietary sodium intake to <1,500 mg per day.
- D. We're still uncertain whether dietary sodium restriction makes much difference in heart failure.
- E. Salt is good for you—eat as much as you want!

Case 2: Sodium restriction in HF

- RCT of low sodium diet recommendation (<1,500 mg/d) vs “usual care”
- N=841, median age 67 years, 66% men
- Intervention pts were prescribed a specific low sodium diet supported by behavioral counseling and sample menus
- Control pts received general advice to restrict sodium
- 26 hospitals in 6 countries
- Stopped early for futility

Ezekowitz JA, Colin-Ramirez E, Ross H, et al. Reduction of dietary sodium to less than 100 mmol in heart failure (SODIUM-HF): an international, open-label, randomised, controlled trial. *Lancet*. 2022;399:1391-400. b/w/o ACP JC doi:10.7326/J22-0058



Case 2: Sodium restriction in HF

Results: Reduced dietary sodium vs. usual care in patients with heart failure (intention-to-treat analysis)

Outcomes	Events/100 patient-y		At 12 mo
	Reduced sodium†	Usual care†	RRR (95% CI)‡
Primary composite§	17.2	19.2	1% (-41 to 32)
CV hospitalization	11.4	13.8	6% (-48 to 40)
			RRI (CI)‡
CV emergency department visit	4.7	3.9	6% (-51 to 125)
All-cause mortality	6.0	4.3	34% (-36 to 171)

The reduced sodium group was more likely to improve by 1 New York Heart Association functional class ($P = 0.0061$) and had larger improvements on the Kansas City Cardiomyopathy Questionnaire overall summary score, clinical summary score, and physical limitation score than did the usual care group ($P \leq 0.017$ for all). Groups did not differ for 6-min walk distance.

CV = cardiovascular; other abbreviations defined in Glossary. Primary outcome indicated by boldface.

†The reduced sodium group consumed 415 mg less sodium per day than did the usual care group at 12 mo ($P < 0.0001$).

‡RRR, RRI, and CI calculated from usual care event rates and adjusted hazard ratios in article.

§CV hospitalization, CV emergency department visit, or all-cause mortality.

||992 patients were needed to provide 80% power to detect a 30% relative risk reduction in the primary composite outcome, assuming a 25% event rate in the usual care group (2-sided $\alpha = 0.05$).

Bottom line:

In patients with chronic heart failure, reduced dietary sodium did not reduce risk for a composite of CV hospitalization, CV emergency department visit, or all-cause mortality.

Ezekowitz JA, Colin-Ramirez E, Ross H, et al. Reduction of dietary sodium to less than 100 mmol in heart failure (SODIUM-HF): an international, open-label, randomised, controlled trial. *Lancet*. 2022;399:1391-400. b/w/o ACP JC doi:10.7326/J22-0058



Case 2: Sodium restriction in HF

- There is still no strong evidence that specific sodium restriction targets and associated dietary/behavioral interventions improve objective outcomes in heart failure
- In this study, a dietary intervention that resulted in an observed reduction of about 500 mg of daily sodium intake did not reduce CV admissions or mortality in patients with HF
- Adds to a growing body of literature that interventions to encourage sodium restriction remain unproven

Ezekowitz JA, Colin-Ramirez E, Ross H, et al. Reduction of dietary sodium to less than 100 mmol in heart failure (SODIUM-HF): an international, open-label, randomised, controlled trial. *Lancet*. 2022;399:1391-400. b/w/o ACP JC doi:10.7326/J22-0058

Burgermaster M, Rudel R, Seres D. Dietary Sodium Restriction for Heart Failure: A Systematic Review of Intervention Outcomes and Behavioral Determinants. *Am J Med*. 2020 Dec;133(12):1391-1402



Case 3

You are preparing to discharge an 82 y/o man after an admission for heart failure

He is moderately frail and typically has 1-2 admissions per year for various reasons

PT assessed that was at his functional baseline and did not have skilled rehab needs

Case 3

Which of the following have been shown to decrease readmissions in older adults:

- A. Home exercise program
- B. Vitamin D
- C. Home vital sign monitoring
- D. None of the above

Case 3: Preventing readmissions

- Systematic review of 10 RCTs of home exercise programs for older adults after discharge
- K=10 RCTs; N=1,322; mean age ~75-85
- Home exercise interventions delivered by PT compared with usual care or facility-based PT
- Began 1-4 weeks after discharge and continued for 1-6 months
- Generally low risk of bias in the included studies

Lin I, Glinsky J, Dean C, et al. Effectiveness of home-based exercise for improving physical activity, quality of life and function in older adults after hospitalisation: a systematic review and meta-analysis. Clin Rehabil. 2022;36:1170-85. b/w/o ACP JC doi:10.7326/J22-0070



Case 3: Preventing readmissions

Results: Home-based exercise programs vs. control in older adults recently discharged from the hospital

Outcomes	Control	Number of trials (n)	Weighted event rates*	RRR (CI)*	NNT (CI)*
Rehospitalization	No intervention	3 (325)	32% vs. 45%	29% (1 to 54)	8 (5 to 402)
Standardized mean difference† (95% CI)					
Mobility	No intervention	2 (143)		0.17 (-0.16 to 0.50)	
	Usual care	2 (301)		0.23 (0.00 to 0.45)	
	Center-based exercise	2 (146)		-0.36 (-0.78 to 0.07)	
Activities of daily living	No intervention	2 (154)		0.60 (0.03 to 1.17)	
Quality of life	Usual care	3 (552)		0.30 (0.11 to 0.49)	

Abbreviations defined in Glossary.

*Weighted event rate, RRR, NNT, and CI calculated from control group event rate and odds ratio in article.

†0.2 = small effect, 0.5 = moderate effect, 0.8 = large effect. Positive difference favors home-based exercise.

Bottom line:
In older adults recently discharged from hospital, home-based exercise programs reduce risk for rehospitalization and improve some outcomes compared with control.

Lin I, Glinsky J, Dean C, et al. Effectiveness of home-based exercise for improving physical activity, quality of life and function in older adults after hospitalisation: a systematic review and meta-analysis. Clin Rehabil. 2022;36:1170-85. b/w/o ACP JC doi:10.7326/J22-0070

Case 3: Preventing readmissions

- Some heterogeneity in the interventions and outcome measurement/timing
- Effect size for other outcomes was generally small
- Emphasizes the importance of PT and HEP when ordering home health services
- Along with hospital-at-home programs, this is one of the few demonstrably effective programs to reduce readmissions

Lin I, Glinsky J, Dean C, et al. Effectiveness of home-based exercise for improving physical activity, quality of life and function in older adults after hospitalisation: a systematic review and meta-analysis. Clin Rehabil. 2022;36:1170-85. b/w/o ACP JC doi:10.7326/J22-0070

Case 4

75 y/o man presenting for pre-op evaluation for elective R TKA

Inquires about the plan for pain control after surgery

You note that the order set calls for perioperative initiation of gabapentin as part of multimodal pain control

Case 4

True or false: Routine perioperative use of gabapentin may increase the risk of adverse events after surgery.

Case 4: Perioperative gabapentin

- Large propensity matched retrospective cohort study of the adverse effects of perioperative gabapentin
- Compared 118,000 perioperative patients exposed to gabapentin to 118,000 matched controls
 - Matching was based on demographics, insurance type, surgery type and urgency, comorbidities, other analgesic drugs, other psychoactive drugs, and hospital characteristics
 - Removed patients with other apparent indications for gabapentin other than multimodal pain control

Park CM, Inouye SK, Marcantonio ER, et al. Perioperative Gabapentin Use and In-Hospital Adverse Clinical Events Among Older Adults After Major Surgery. *JAMA Intern Med*. Published online September 19, 2022. doi:10.1001/jamainternmed.2022.3680



Case 4: Perioperative gabapentin

Table 2. Association Between Perioperative Gabapentin Use and In-Hospital Adverse Clinical Events After Major Surgery Before and After Propensity Score Matching

Outcome	Before propensity score matching				After propensity score matching ^a			
	Gabapentin use, No. (%) (n = 119 087)	No gabapentin use, No. (%) (n = 848 460)	RR (95% CI)	RD, per 100 persons (95% CI)	Gabapentin use, No. (%) (n = 118 936)	No gabapentin use, No. (%) (n = 118 936)	RR (95% CI)	RD, per 100 persons (95% CI)
Delirium diagnosis	4051 (3.4)	34 342 (4.0)	0.84 (0.81 to 0.87)	-0.6 (-0.8 to -0.5)	4040 (3.4)	3148 (2.6)	1.28 (1.23 to 1.34)	0.75 (0.61 to 0.89)
New antipsychotic use	945 (0.8)	9877 (1.2)	0.68 (0.64 to 0.73)	-0.4 (-0.4 to -0.3)	944 (0.8)	805 (0.7)	1.17 (1.07 to 1.29)	0.12 (0.05 to 0.19)
Pneumonia	1522 (1.3)	19 902 (2.3)	0.54 (0.52 to 0.57)	-1.1 (-1.1 to -1.0)	1521 (1.3)	1368 (1.2)	1.11 (1.03 to 1.20)	0.13 (0.04 to 0.22)
In-hospital death	363 (0.3)	6360 (0.7)	0.41 (0.37 to 0.45)	-0.4 (-0.5 to -0.4)	362 (0.3)	354 (0.2)	1.02 (0.88 to 1.18)	0.00 (-0.04 to 0.05)

Abbreviations: RD, risk difference; RR, risk ratio.

^a The propensity score model included demographic information, insurance type, admission characteristics, surgery type, combined comorbidity score,

comorbidities, inpatient medication use and procedures before or on postoperative day 2, hospital-level characteristics, geographic region, and calendar year.

Park CM, Inouye SK, Marcantonio ER, et al. Perioperative Gabapentin Use and In-Hospital Adverse Clinical Events Among Older Adults After Major Surgery. *JAMA Intern Med*. Published online September 19, 2022. doi:10.1001/jamainternmed.2022.3680



Case 4: Perioperative gabapentin

- Risk of residual confounding even with well done propensity matching
- Likely under-ascertainment of post-op delirium
- Clear dose-response relationship was observed
- Previous RCTs of post-op gabapentin suggested delirium as a possible adverse effect but were underpowered for that outcome

Park CM, Inouye SK, Marcantonio ER, et al. Perioperative Gabapentin Use and In-Hospital Adverse Clinical Events Among Older Adults After Major Surgery. *JAMA Intern Med.* Published online September 19, 2022. doi:10.1001/jamainternmed.2022.3680



Case 5

Otherwise healthy 52 y/o man presents with 1 day of acute onset of LLQ abdominal pain

CT scan of the abdomen is consistent with acute uncomplicated diverticulitis

VS normal, slightly uncomfortable but non-toxic appearing, WBC 13, CRP 10

He had an unremarkable colonoscopy 2 years ago except for mild diverticulosis

ED requests admission for further management

Case 5

Which of the following would you recommend:

- A. Admit for IV abx and outpatient referral for colonoscopy
- B. Admit for IV abx only
- C. Discharge with oral abx and outpatient referral for colonoscopy
- D. Discharge with oral abx only
- E. Discuss expectant outpatient management without abx with the patient

Case 5: Acute left-sided diverticulitis

- New ACP Clinical Guidelines on the management of acute left-sided diverticulitis and follow-up
- Mainly low to moderate certainty evidence for most interventions and outcomes of interest
- Many otherwise healthy patients with uncomplicated diverticulitis can be managed expectantly as an outpatient and follow-up colonoscopy is typically not needed

Case 5: Acute left-sided diverticulitis



Management of Acute Left-Sided Colonic Diverticulitis

Recommendations

RECOMMENDATION 2

ACP suggests that clinicians manage most patients with acute uncomplicated left-sided colonic diverticulitis in an outpatient setting (conditional recommendation; low-certainty evidence).

RATIONALE: In the absence of evidence suggesting a benefit of routine hospitalization for patients with acute uncomplicated diverticulitis, the initial (default) management of uncomplicated diverticulitis can be as an outpatient. This applies to most immunocompetent patients with acute uncomplicated left-sided diverticulitis who have no evidence of systemic inflammatory response and can continue treatment at home under medical supervision with adequate family and social support and follow-up. Low-certainty evidence showed that there may be no differences in risk for elective surgery or long-term diverticulitis recurrence for outpatient compared with inpatient management.

RECOMMENDATION 3

ACP suggests that clinicians initially manage select patients with acute uncomplicated left-sided colonic diverticulitis without antibiotics (conditional recommendation; low-certainty evidence).

RATIONALE: “Select” patients are defined as immunocompetent patients with uncomplicated left-sided diverticulitis, with no systemic inflammatory response or immunosuppression, who are not medically frail, do not require hospitalization, and can follow up as an outpatient under medical supervision with social and family support. For these patients, low-certainty evidence showed that there may be no differences in diverticulitis-related complications (such as abscess, fistula, stenosis, and obstruction), quality of life, need for surgery, or long-term recurrence between those receiving and those not receiving antibiotics. The use of antibiotics without evidence of important benefit to the patient may incur potential harms and costs, and inappropriate use of antibiotics contributes to antibiotic resistance, a major individual and public health threat.

Clinical Considerations

Uncomplicated diverticulitis refers to localized inflammation, whereas complicated diverticulitis refers to inflammation associated with an abscess, a phlegmon, a fistula, an obstruction, bleeding, or perforation.

Predictors of progression to complicated disease among patients with uncomplicated acute diverticulitis: symptoms >5 days, vomiting, systemic comorbidity, high C-reactive protein levels (>140 mg/L), CT findings of pericolic extraluminal air, fluid collection, or a longer inflamed colon segment (69, 70).

Case 5: Acute left-sided diverticulitis



Colonoscopy for Diagnostic Evaluation After Acute Left-Sided Colonic Diverticulitis

Recommendation

RECOMMENDATION 1

ACP suggests that clinicians refer patients for a colonoscopy after an initial episode of complicated left-sided colonic diverticulitis in patients who have not had recent colonoscopy (conditional recommendation; low-certainty evidence).

RATIONALE: Although evidence from comparative studies is inconclusive about the incremental benefit of colonoscopy on clinical outcomes after a recent episode of presumed acute left-sided colonic diverticulitis, it is a reasonable option for patients with resolved complicated diverticulitis who have not had a recent colonoscopy, given that CRC may rarely present with signs and symptoms similar to those of acute complicated diverticulitis and may have similar CT findings. The identified CRC cases and high-risk colonic lesions in the included studies occurred mostly in patients with complicated diverticulitis, and patients with complicated diverticulitis had higher prevalence of CRC, advanced colonic neoplasia, and advanced adenomas.

Clinical Considerations

- This recommendation applies to patients with complicated diverticulitis in whom there is diagnostic uncertainty related to ruling out CRC or advanced colonic neoplasia presenting as acute diverticulitis. Clinicians should assess whether patients have had a recent high-quality direct visualization colonoscopy for any reason, such as screening for CRC or iron deficiency anemia or intestinal bleeding.

Case 5: Acute left-sided diverticulitis



Interventions to Prevent Recurrence After Acute Left-Sided Colonic Diverticulitis

Recommendations

RECOMMENDATION 2

ACP recommends against clinicians using mesalamine to prevent recurrent diverticulitis (strong recommendation; high-certainty evidence).

RATIONALE: High-certainty evidence shows that mesalamine (dose range, 1.2 to 4.8 g/d) resulted in no difference in risk for recurrent diverticulitis compared with placebo, and low-certainty evidence showed that mesalamine may not improve symptoms. Evidence showed that mesalamine compared with placebo probably results in no difference in urinary tract infection requiring antibiotics (moderate certainty) or serious adverse events (low certainty), but high-certainty evidence showed higher risk for discontinuation due to adverse events. There are no demonstrated clinical benefits but known harms associated with mesalamine therapy, such as epigastric pain, nausea, diarrhea, dizziness, rash, and renal and hepatic impairment.

RECOMMENDATION 3

ACP suggests that clinicians discuss elective surgery to prevent recurrent diverticulitis after initial treatment in patients who have either uncomplicated diverticulitis that is persistent or recurs frequently or complicated diverticulitis (conditional recommendation; low-certainty evidence). The informed decision whether or not to undergo surgery should be personalized based on a discussion of potential benefits, harms, costs, and patient's preferences.

RATIONALE: High-certainty evidence showed that recurrence rates are lower in patients with complicated or uncomplicated colonic diverticulitis with either smoldering symptoms (persisting >3 months) or frequent recurring symptoms (≥3 episodes within 2 years) who had elective surgery. However, any benefits must be balanced by potential harms of surgery. Low- to moderate-certainty evidence showed that 1.4% to 5.5% of patients experience perioperative surgical complications (such as anastomotic leakage, sepsis, and myocardial infarction).

Clinical Considerations

Elective Surgery

- This recommendation does not apply to patients with uncomplicated diverticulitis that is not persistent or frequently recurring.
- Clinicians should take a team-based approach to shared decision making with patients; discussions should include the primary care physician/internist, the gastroenterologist, and the surgeon.

Quick Hits: New SHM Choosing Wisely Recommendations (May 2022)

Quick hits: New SHM Choosing Wisely Recs

- Avoid using opioids for treatment of mild, acute pain. For moderate to severe acute pain, if opioids are used, it should be in conjunction with non-opioid methods with the lowest effective dose for the shortest required duration.
- Don't maintain a peripheral capillary oxygen saturation (SpO₂) of higher than 96% when using supplemental oxygen, unless for carbon monoxide poisoning, cluster headaches, sickle cell crisis, or pneumothorax.
- Don't wake patients at night for routine care; redesign workflow to promote sleep at night.

Quick hits: New SHM Choosing Wisely Recs

- Don't order creatine kinase (CK) or Creatine Kinase-Myocardial Band (CK-MB) in suspected Acute Coronary Syndrome or Acute Myocardial Infarction.
- Don't order daily chest radiographs in hospitalized patients unless there are specific clinical indications.
- Do not routinely prescribe VTE prophylaxis to all hospitalized patients; use an evidence-based risk stratification system to determine whether a patient needs VTE prophylaxis. If they do warrant prophylaxis, use a bleeding risk assessment to determine if mechanical rather than pharmacologic prophylaxis is more appropriate.

Summary

- Consider recommending the Mediterranean diet for the secondary prevention of CHD
- Question the role of strict sodium restriction in patients with heart failure
- Home exercise programs prevent readmissions
- Question the routine perioperative use of gabapentin
- Uncomplicated acute left-sided diverticulitis can be conservatively managed in otherwise healthy patients
- Risk stratify patients when deciding on VTE prophylaxis



Thank You
Questions and Examples?