Top Articles of 2016
Turning Evidence into Practice

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Roadmap

- Case based interactive format
- Multiple articles per case
- Quick hitters and Short takes
- Summary of suggested practice changes

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Learning Objectives

1. *Describe* the primary conclusions
2. *Identify* changes to your practice
3. *Implement* these practice changes

Journals Reviewed...

- Jan 2016 – Dec 2016
  - N Engl J Med
  - JAMA; JAMA Intern Med
  - J Gen Intern Med
  - J Hospit Med
  - Lancet; Stroke; Ann Emerg Med; PLOS Med
  - Am J Med; Am Heart J; Am J Cardiol
  - Ann Intern Med + ACP J Club
  - Crit Care Med; Am J Respir Crit Care Med
  - Circulation, J Am Coll Cardiol, JACC HF
  - BMJ, Chest, Clin J Am Soc Nephrol
  - ACP Plus, BMJ Online update, J Watch

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Disclosures

- None relevant

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  UCSF School of Medicine

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Notables in 2016

The NEW ENGLAND JOURNAL of MEDICINE

Perspective

SEPTEMBER 15, 2016

Zero to 50,000 — The 20th Anniversary of the Hospitalist

Robert M. Wachter, M.D., and Lee Goldman, M.D., M.P.H.

Sounding Board

The Emerging Role of "Hospitalists" in the American Health Care System

THE explosive growth of managed care has led to an increased role for general internists and other primary care physicians in the American health care system. This change is welcome in many respects, since generalists have perennially been undervalued by health care institutions, payers, and even patients.[1-3] The greater prominence of generalism has led to an increase in the number of medical students who choose careers in primary care,[4] expanded job opportunities for generalists,[5] and a modest increase in the incomes of primary care physicians.[6]

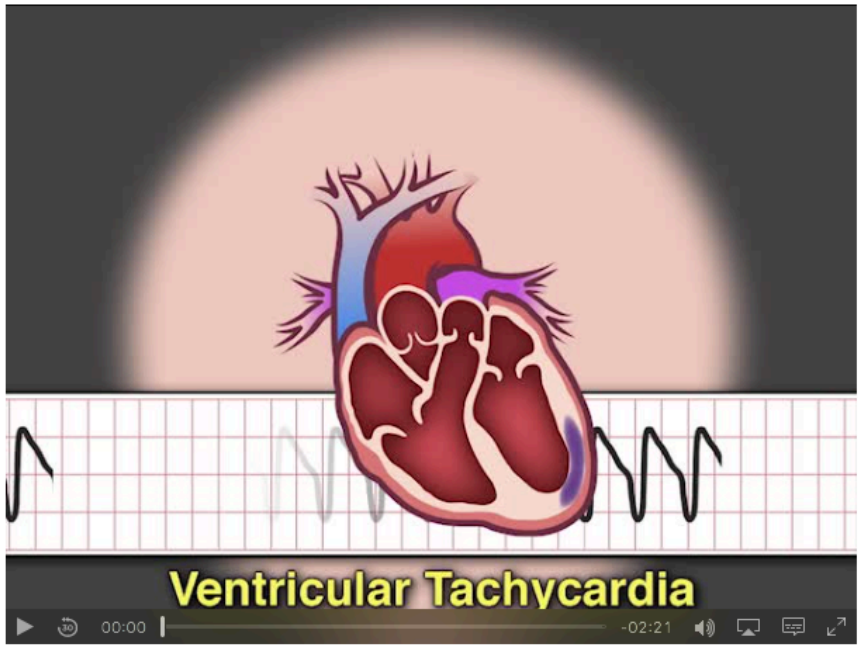
N Engl J Med 1996;335:514-517.

The NEW ENGLAND JOURNAL of MEDICINE

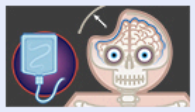
QUICK TAKE VIDEO SUMMARY

Drugs or Ablation in Ventricular Tachycardia

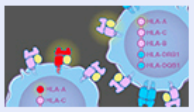
Recurrent ventricular tachycardia is associated with high mortality and morbidity. An ICD can be effective, but the shocks are painful and upsetting. Antiarrhythmic drugs and catheter ablation can suppress tachycardia; which strategy is better? New research findings are summarized in a short video.



MORE QUICK TAKE VIDEOS


Decompressive Craniectomy and TBI


The ZOE-70 Trial


Cord-Blood Transplant


ART to Prevent HIV Transmission

Showing 1-4 of 83 Quick Take Videos | See All Quick Take Videos › ‹ Previous | Next ›

Annals of Internal Medicine

EDITORIAL

Introducing *Annals* for Hospitalists: New Knowledge, Novel Formats, and Unique Perspectives

If you practice hospital medicine, where do you go to find the latest evidence relevant to your practice? Odds are, you spend time wading through several journals, Web sites, or other publications looking for information pertinent to hospitalists—and feel guilty when you don't have time to do this. With the introduction of *Annals* for Hospitalists, we hope to simplify your search for information that matters most to you.

This new feature is a collaboration between the University of Michigan Hospitalist Program and *Annals of Internal Medicine*. The feature editors (D.H.W. and V.C.) will comb through all *Annals of Internal Medicine* articles and ACP Journal Club summaries of articles in the broader literature to identify those most applicable to the practice of hospital medicine. They also will highlight important takeaway points and collate all this information in a monthly alert, which you can have delivered to your e-mail account by signing up at www.annals.org. These alerts also will be archived in a new section called *Annals* for Hospitalists (http://go.annals.org/hospitalist). Because we know you may want even more information, *Annals* for Hospitalists also will link to other hospital medicine content from ACP, including the most-read ACP JournalWise alerts and *ACP Hospitalist*.

In addition, *Annals* for Hospitalists will include a special monthly commentary titled Inpatient Notes. Written by thought leaders in various fields, these articles will provide unique perspectives on contemporary or controversial topics in hospital medicine. We consider Inpatient Notes to be the crown jewel of *Annals* for Hospitalists and are delighted that Dr. Robert (Bob) Wachter, one of the founders of hospital medicine, has written the first commentary. In his inaugural commentary, Dr. Wachter discusses the proliferation, promise, and peril epitomized by health care's digitalization. Focusing on the shortfalls of electronic health systems, as well as lessons learned from other fields, he explains why hospitalists will be crucial in bringing about the unrealized potential of this technology.

We believe that *Annals* for Hospitalists will provide a compelling new way for hospitalists to stay abreast of salient information from *Annals of Internal Medicine* and the ACP, and to keep pace with emerging ideas in the field. We hope you enjoy this debut edition, and we look forward to having you return each month.

David H. Wesorick, MD
Vineet Chopra, MD, MSc
University of Michigan
Ann Arbor, Michigan

Christine Laine, MD, MPH
Editor in Chief

Disclosures: Disclosures can be viewed at www.acponline.org/authors/icmje/ConflictOfInterestForms.do?msNum=M16-1400.

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Current author addresses are available at www.annals.org.

Ann Intern Med. 2016;165:151. doi:10.7326/M16-1400

http://annals.org/SS/hospitalist.aspx

Antithrombotic Therapy for VTE Disease

CHEST Guideline and Expert Panel Report

Clive Kearon, MD, PhD; Elie A. Akl, MD, MPH, PhD; Joseph Ornelas, PhD; Allen Blaivas, DO, FCCP; David Jimenez, MD, PhD, FCCP; Henri Bounameaux, MD; Menno Huisman, MD, PhD; Christopher S. King, MD, FCCP; Timothy A. Morris, MD, FCCP; Namita Sood, MD, FCCP; Scott M. Stevens, MD; Janine R. E. Vintch, MD, FCCP; Philip Wells, MD; Scott C. Woller, MD; and COL Lisa Moores, MD, FCCP

Chest 2016;149:315-352.

JAMA Internal Medicine | Special Communication

Sugar Industry and Coronary Heart Disease Research
A Historical Analysis of Internal Industry Documents

Cristin E. Kearns, DDS, MBA; Laura A. Schmidt, PhD, MSW, MPH; Stanton A. Glantz, PhD

Early warning signals of the coronary heart disease (CHD) risk of sugar (sucrose) emerged in the 1950s. We examined Sugar Research Foundation (SRF) internal documents, historical reports, and statements relevant to early debates about the dietary causes of CHD and assembled findings chronologically into a narrative case study. The SRF sponsored its first CHD research project in 1965, a literature review published in the *New England Journal of Medicine*, which singled out fat and cholesterol as the dietary causes of CHD and downplayed evidence that sucrose consumption was also a risk factor. The SRF set the review's objective, contributed articles for inclusion, and received drafts. The SRF's funding and role was not disclosed. Together with other recent analyses of sugar industry documents, our findings suggest the industry sponsored a research program in the 1960s and 1970s that successfully cast doubt about the hazards of sucrose while promoting fat as the dietary culprit in CHD. Policymaking committees should consider giving less weight to food industry–funded studies and include mechanistic and animal studies as well as studies appraising the effect of added sugars on multiple CHD biomarkers and disease development.

JAMA Intern Med. doi:10.1001/jamainternmed.2016.5394
Published online September 12, 2016. Corrected on October 3, 2016.

Invited Commentary
Author Audio Interview
Supplemental content

Author Affiliations: Author affiliations are listed at the end of this article.

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JAMA Intern Med 2016;online pub Sept 12th.

ACC/AHA Task Force Statement

Further Evolution of the ACC/AHA Clinical Practice Guideline Recommendation Classification System

A Report of the American College of Cardiology/American Heart Association Task Force on Clinical Practice Guidelines

ACC/AHA TASK FORCE MEMBERS
Jonathan L. Halperin, MD, FACC, FAHA, Chair; Glenn N. Levine, MD, FACC, FAHA, Chair-Elect;
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José Joglar, MD, FACC, FAHA; Susan J. Pressler, PHD, RN, FAHA;
Duminda N. Wijeysundera, MD, PHD

Circulation 2016;133:1426-1428.

Table 1. ACC/AHA Recommendation System: Applying Class of Recommendation and Level of Evidence to Clinical Strategies, Interventions, Treatments, or Diagnostic Testing in Patient Care* (Updated August 2015)

CLASS (STRENGTH) OF RECOMMENDATION

CLASS I (STRONG) — Benefit >>> Risk

Suggested phrases for writing recommendations:
- Is recommended
- Is indicated/useful/effective/beneficial
- Should be performed/administered/other
- Comparative-Effectiveness Phrases†:
  - Treatment/strategy A is recommended/indicated in preference to treatment B
  - Treatment A should be chosen over treatment B

CLASS IIa (MODERATE) — Benefit >> Risk

Suggested phrases for writing recommendations:
- Is reasonable
- Can be useful/effective/beneficial
- Comparative-Effectiveness Phrases†:
  - Treatment/strategy A is probably recommended/indicated in preference to treatment B
  - It is reasonable to choose treatment A over treatment B

CLASS IIb (WEAK) — Benefit ≥ Risk

Suggested phrases for writing recommendations:
- May/might be reasonable
- May/might be considered
- Usefulness/effectiveness is unknown/unclear/uncertain or not well established

CLASS III: No Benefit (MODERATE) — Benefit = Risk

(Generally, LOE A or B use only)

Suggested phrases for writing recommendations:
- Is not recommended
- Is not indicated/useful/effective/beneficial
- Should not be performed/administered/other

CLASS III: Harm (STRONG) — Risk > Benefit

Suggested phrases for writing recommendations:
- Potentially harmful
- Causes harm
- Associated with excess morbidity/mortality
- Should not be performed/administered/other

LEVEL (QUALITY) OF EVIDENCE‡

LEVEL A

- High-quality evidence‡ from more than 1 RCT
- Meta-analyses of high-quality RCTs
- One or more RCTs corroborated by high-quality registry studies

LEVEL B-R (Randomized)

- Moderate-quality evidence‡ from 1 or more RCTs
- Meta-analyses of moderate-quality RCTs

LEVEL B-NR (Nonrandomized)

- Moderate-quality evidence‡ from 1 or more well-designed, well-executed nonrandomized studies, observational studies, or registry studies
- Meta-analyses of such studies

LEVEL C-LD (Limited Data)

- Randomized or nonrandomized observational or registry studies with limitations of design or execution
- Meta-analyses of such studies
- Physiological or mechanistic studies in human subjects

LEVEL C-EO (Expert Opinion)

Consensus of expert opinion based on clinical experience

COR and LOE are determined independently (any COR may be paired with any LOE).

A recommendation with LOE C does not imply that the recommendation is weak. Many important clinical questions addressed in guidelines do not lend themselves to clinical trials. Although RCTs are unavailable, there may be a very clear clinical consensus that a particular test or therapy is useful or effective.

* The outcome or result of the intervention should be specified (an improved clinical outcome or increased diagnostic accuracy or incremental prognostic information).

† For comparative-effectiveness recommendations (COR I and IIa; LOE A and B only), studies that support the use of comparator verbs should involve direct comparisons of the treatments or strategies being evaluated.

‡ The method of assessing quality is evolving, including the application of standardized, widely used, and preferably validated evidence grading tools; and for systematic reviews, the incorporation of an Evidence Review Committee.

COR indicates Class of Recommendation; EO, expert opinion; LD, limited data; LOE, Level of Evidence; NR, nonrandomized; R, randomized; and RCT, randomized controlled trial.

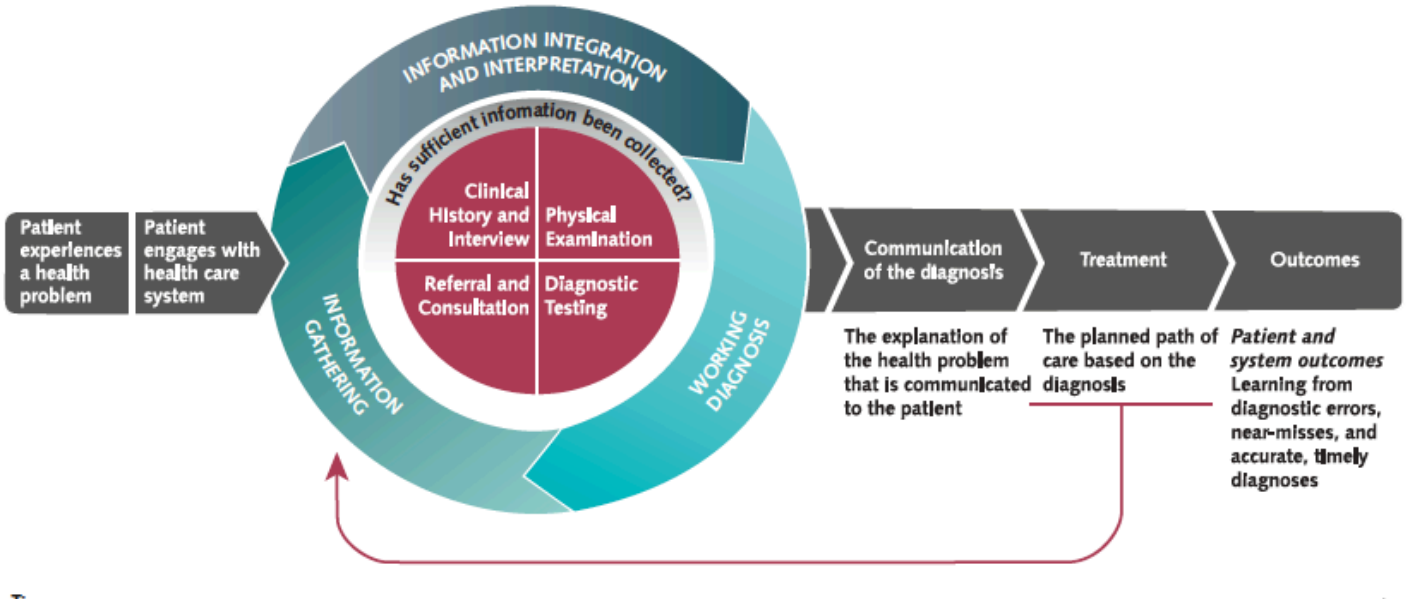
Annals of Internal Medicine

IDEAS AND OPINIONS

Improving Diagnosis in Health Care: Highlights of a Report From the National Academies of Sciences, Engineering, and Medicine

John R. Ball, MD, JD, and Erin Balogh, MPH

Figure. The committee's visualization of the diagnostic process illustrates its complexity and the need for collaboration among clinicians, patients, and their families to achieve accurate, timely diagnosis.



Ann Intern Med 2016;164:59-61.

Clinical Review & Education

Special Communication

CDC Guideline for Prescribing Opioids for Chronic Pain—United States, 2016

Deborah Dowell, MD, MPH; Tamara M. Haegerich, PhD; Roger Chou, MD

JAMA 2016;315:1624-1645.

Case 1

A 67 y/o man presents with three days of productive cough, fevers, fatigue, and chest pain.

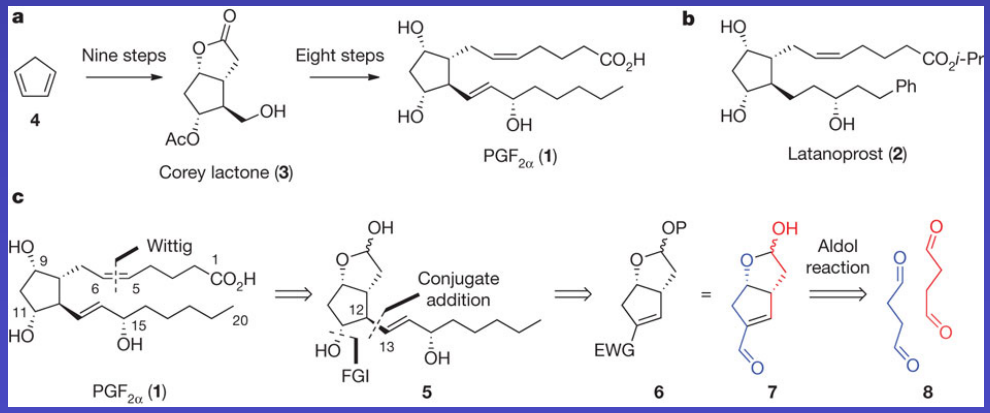
BP 96/64, HR 102, Temp 101.1, RR 24, SaO2 92% on RA. Ill appearing, rales R base

CXR no infiltrate, UA neg, blood cx drawn, WBC 15K, creat 1.5

ER begins empiric ceftriaxone + azithromycin and calls you re: pt with “septicemia.”

Inner monologue w/ ER...

A. *Not sure what 'septicemia is,' this is 'Severe Sepsis'*
B. *Should I ask what the qSOFA score is??*
C. *Yes. I dread learning why SIRS is so wrong*
D. *Hmm. It's all about the prostaglandins...*



Clinical Review & Education

Special Communication | CARING FOR THE CRITICALLY ILL PATIENT

The Third International Consensus Definitions for Sepsis and Septic Shock (Sepsis-3)

Mervyn Singer, MD, FRCP; Clifford S. Deutschman, MD, MS; Christopher Warren Seymour, MD, MSc; Manu Shankar-Hari, MSc, MD, FFICM; Djillali Annane, MD, PhD; Michael Bauer, MD; Rinaldo Bellomo, MD; Gordon R. Bernard, MD; Jean-Daniel Chiche, MD, PhD; Craig M. Coopersmith, MD; Richard S. Hotchkiss, MD; Mitchell M. Levy, MD; John C. Marshall, MD; Greg S. Martin, MD, MSc; Steven M. Opal, MD; Gordon D. Rubenfeld, MD, MS; Tom van der Poll, MD, PhD; Jean-Louis Vincent, MD, PhD; Derek C. Angus, MD, MPH

JAMA 2016;315:801-810.

Sepsis-3 Definitions

Objective:	Evaluate and update definitions for sepsis
Design:	Task force—meetings, Delphi, voting
Participants:	19 international experts
Goals:	Limitations, definitions; clarity

JAMA 2016;315:801-810.

Sepsis-3: Limitations

Previous models focus too much on inflammation

JAMA 2016;315:801-810.

Sepsis-3: Limitations

Previous models focus too much on inflammation

Misleading that sepsis proceeds through continuum

JAMA 2016;315:801-810.

Sepsis-3: Limitations

Previous models focus too much on inflammation

Misleading that sepsis proceeds through continuum

The term “severe sepsis” is redundant…

JAMA 2016;315:801-810.

Sepsis-3: Definitions

“Life-threatening organ dysfunction caused by a dysregulated host response to infection…”

JAMA 2016;315:801-810.

Sepsis-3: Definitions

"Life-threatening organ dysfunction caused by a dysregulated host response to infection…"

Sequential Organ Failure Assessment (SOFA) score of 2 or more:

Mortality > 10%

JAMA 2016;315:801-810.

Sepsis-3: Definitions

Quick SOFA (qSOFA)
RR ≥ 22 / min, GCS < 13, SBP ≤ 100 mm Hg
qSOFA ≥ 2 = Mortality RR 3-14

JAMA 2016;315:801-810.

Research

Original Investigation | CARING FOR THE CRITICALLY ILL PATIENT

Assessment of Clinical Criteria for Sepsis
For the Third International Consensus Definitions for Sepsis and Septic Shock (Sepsis-3)

Christopher W. Seymour, MD, MSc; Vincent X. Liu, MD, MSc; Theodore J. Iwashyna, MD, PhD; Frank M. Brunkhorst, MD; Thomas D. Rea, MD, MPH; André Scherag, PhD; Gordon Rubenfeld, MD, MSc; Jeremy M. Kahn, MD, MSc; Manu Shankar-Hari, MD, MSc; Mervyn Singer, MD, FRCP; Clifford S. Deutschman, MD, MS; Gabriel J. Escobar, MD; Derek C. Angus, MD, MPH

JAMA 2016;315:762-774.

Sepsis-3 Clinical Criteria

Question:	Evaluate validity of clinical criteria of sepsis
Design:	Retrospective cohort
Participants:	148,907 encounters suspected infection
1° outcome:	Area under receiver operating curves of SIRS, SOFA, qSOFA, and LODS, i.e. accuracy

JAMA 2016;315:762-774.

SIRS

Chest 1992;101:1644-1655.

Sepsis-Related Organ Failure Assessment (SOFA)

1. Partial pressure of oxygen
2. FiO2
3. Plt count
4. Glasgow coma scale
5. Bilirubin
6. Level of hypotension
7. Creatinine

Intensive Care Med 1996;22:707-710; MD Calc

Sequential Organ Failure Assessment (SOFA)

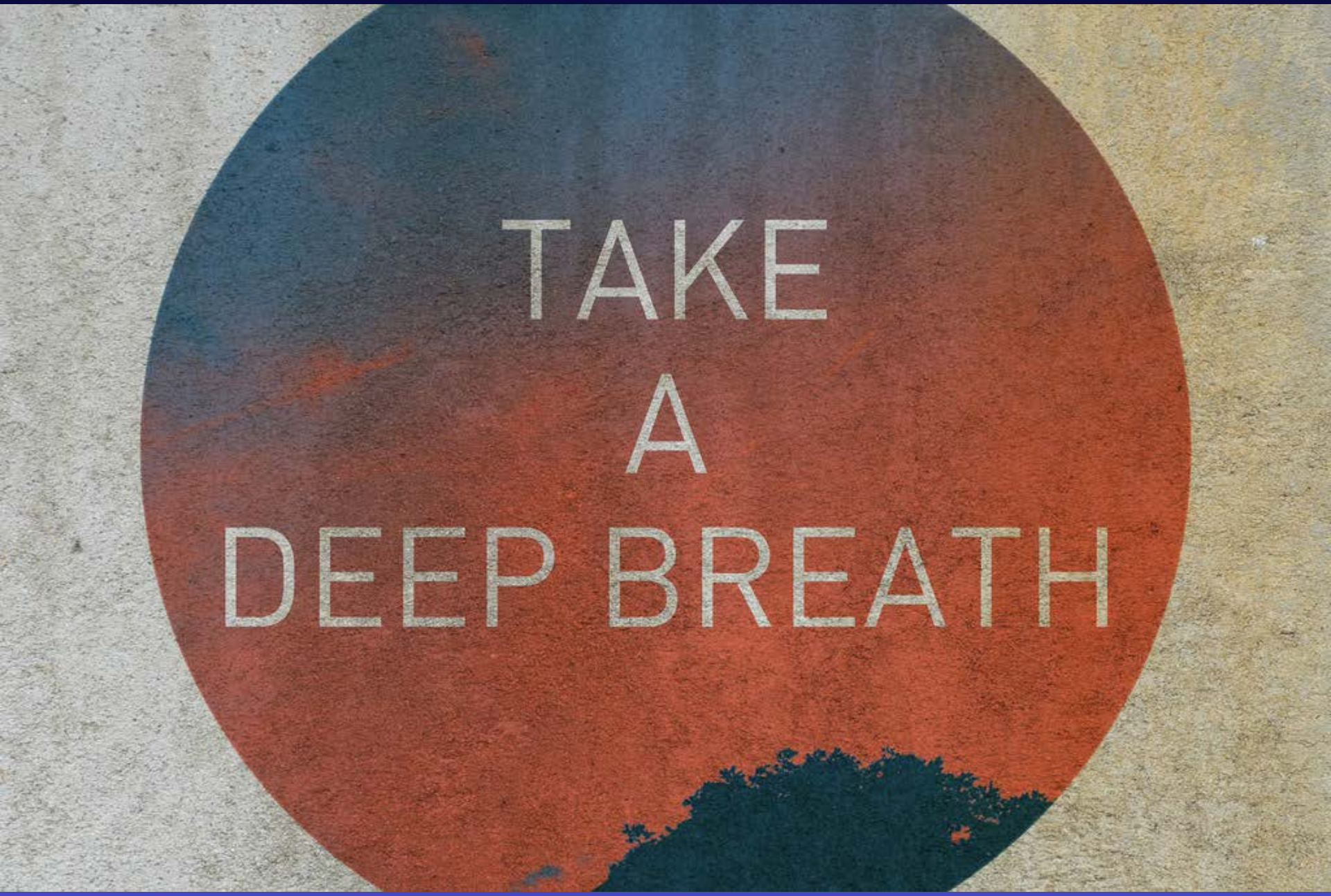
1. Partial pressure of oxygen
2. FiO2
3. Plt count
4. Glasgow coma scale
5. Bilirubin
6. Level of hypotension
7. Creatinine

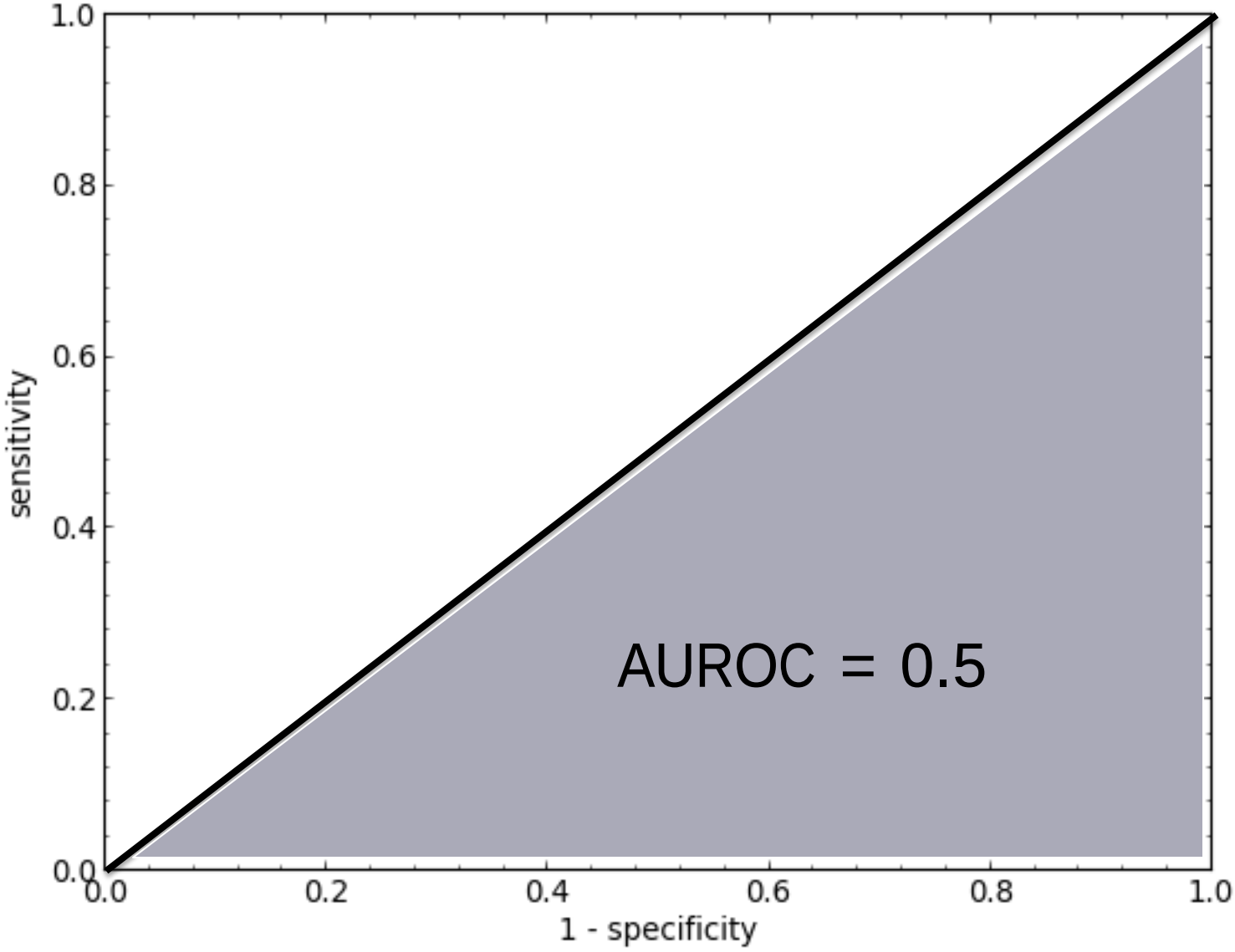
Intensive Care Med 1996;22:707-710; MD Calc

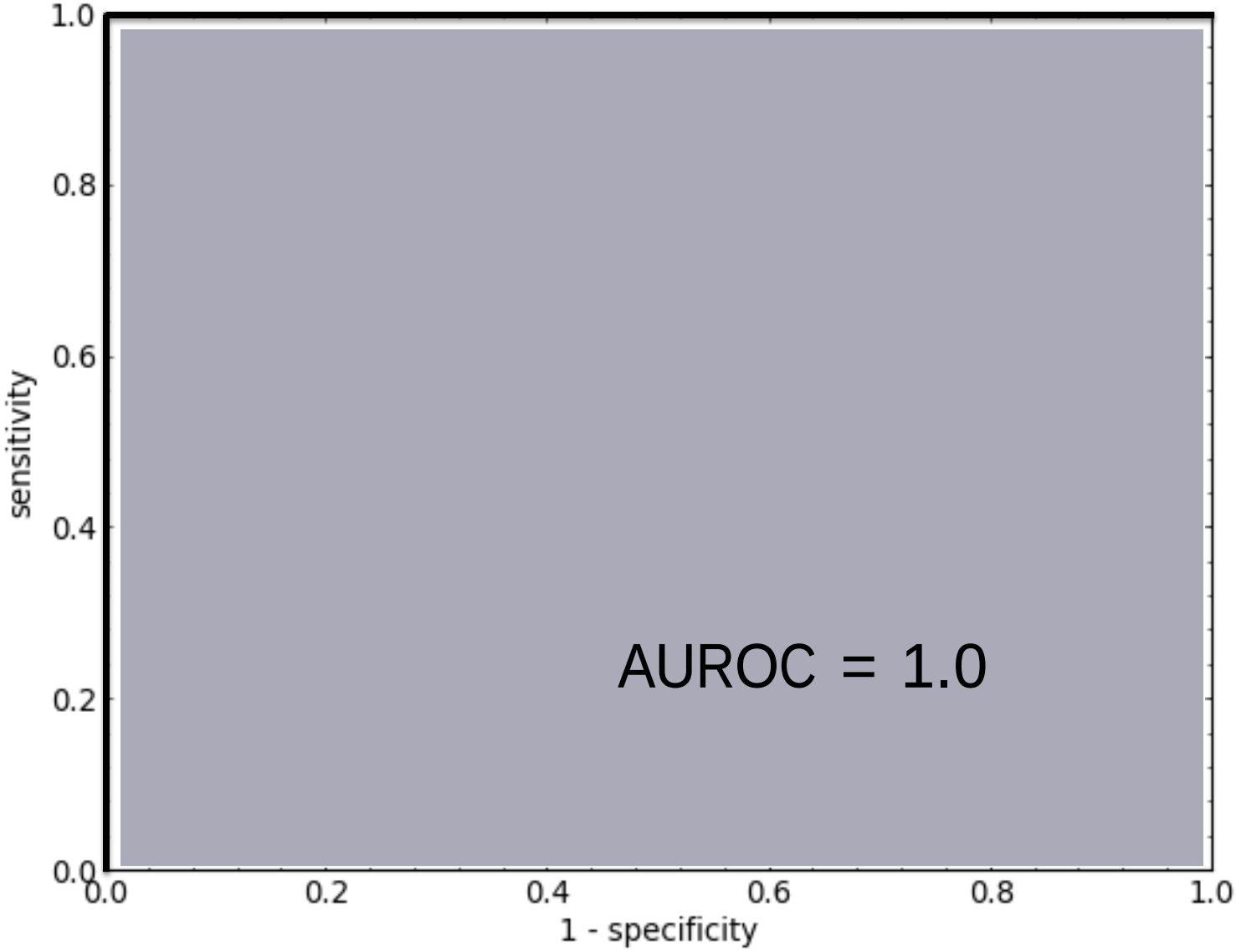
Logistic Organ Dysfunction System (LODS)

1. Partial pressure of oxygen
2. HR and BP
3. Plt count, WBC
4. Glasgow coma scale
5. Bilirubin
6. PT
7. BUN
8. Creatinine
9. Urine output

JAMA 1996;276:802-810.


TAKE
A
DEEP BREATH


1.0
0.8
0.6
0.4
0.2
0.0
sensitivity
0.0
0.2
0.4
0.6
0.8
1.0
1 - specificity
AUROC = 0.5


1.0
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sensitivity
0.0
0.2
0.4
0.6
0.8
1.0
1 - specificity
AUROC = 1.0

Sepsis-3 Results ICU

	AUROC	95% C.I.	p
SIRS			

Sepsis-3 Results ICU

	AUROC	95% C.I.	p
SIRS	0.64	0.62-0.66	

Sepsis-3 Results ICU

	AUROC	95% C.I.	p
SIRS	0.64	0.62-0.66	
qSOFA	0.66	0.64-0.68	

Sepsis-3 Results ICU

	AUROC	95% C.I.	p
SIRS	0.64	0.62-0.66	
qSOFA	0.66	0.64-0.68	
SOFA	0.74	0.73-0.76	< 0.001

Sepsis-3 Results ICU

	AUROC	95% C.I.	p
SIRS	0.64	0.62-0.66	
qSOFA	0.66	0.64-0.68	
SOFA	0.74	0.73-0.76	< 0.001
LODS	0.75	0.73-0.76	< 0.001

Sepsis-3 Results non-ICU

	AUROC	95% C.I.	p
SIRS			

Sepsis-3 Results non-ICU

	AUROC	95% C.I.	p
SIRS	0.76	0.75-0.77	

Sepsis-3 Results non-ICU

	AUROC	95% C.I.	p
SIRS	0.76	0.75-0.77	
SOFA	0.79	0.78-0.80	< 0.001

Sepsis-3 Results non-ICU

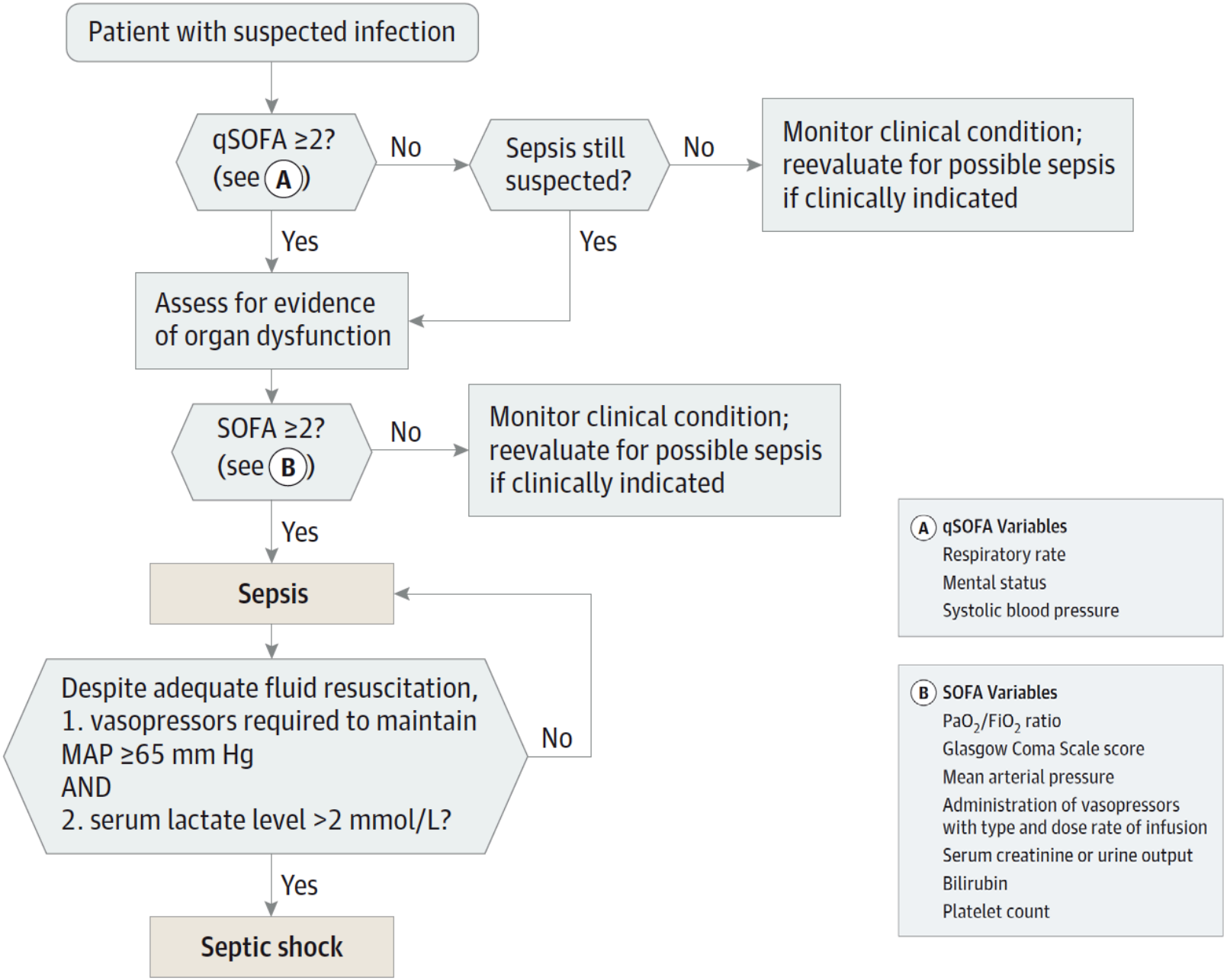
	AUROC	95% C.I.	p
SIRS	0.76	0.75-0.77	
SOFA	0.79	0.78-0.80	< 0.001
qSOFA	0.81	0.80-0.82	< 0.001

Sepsis-3 Clinical Criteria

Question:	Evaluate validity of clinical criteria of sepsis
Design:	Retrospective cohort
Participants:	148,907 encounters suspected infection
1° outcome:	Area under receiver operating curves of SIRS, SOFA, qSOFA, and LODS
Conclusions:	In the ICU, SOFA and LODS better than SIRS and qSOFA; outside the ICU, qSOFA better than SOFA and SIRS

JAMA 2016;315:762-774.

Figure. Operationalization of Clinical Criteria Identifying Patients With Sepsis and Septic Shock



New Sepsis Criteria
A Change We Should Not Make

Steven Q. Simpson, MD, FCCP
Kansas City, KS

PODCAST

Chest 2016;149:1117-1118.

New Sepsis Criteria
A Change We Should Not Make

Steven Q. Simpson, MD, FCCP
Kansas City, KS

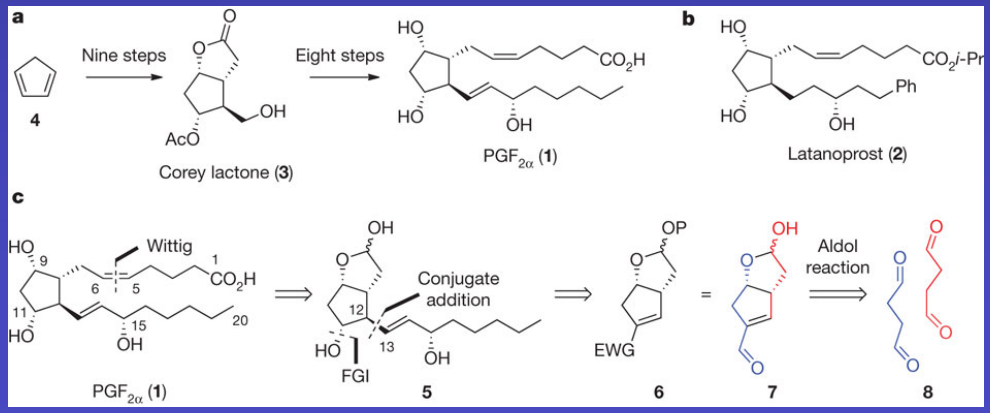
PODCAST

1. SIRS wasn't meant to define sepsis
2. Who uses SOFA?
3. "Surviving Sepsis" Campaign – do we start all over again?
4. Caution please

Chest 2016;149:1117-1118.

Inner monologue w/ ER...

A. *Not sure what 'septicemia is,' this is 'Severe Sepsis'*
B. *Should I ask what the qSOFA score is??*
C. *Yes. I dread learning why SIRS is so wrong*
D. *Hmm. It's all about the prostaglandins...*



PNA & Sepsis Short Takes

CT chest showed an infiltrate in 33% of pts with suspected PNA and clear CXR. *Am J Respir Crit Care Med* 2016;192:974-982.

Continuous infusion B-lactams better than intermittent dosing in severe sepsis. *Am J Respir Crit Care Med* 2016;194:681-691.

Sniffing out significant "Pee values": genome wide association study of asparagus anosmia

Sarah C Markt,[1] Elizabeth Nuttall,[1] Constance Turman,[4] Jennifer Sinnott,[1,5] Eric B Rimm,[1,2,6] Ethan Ecsedy,[7] Robert H Unger,[1] Katja Fall,[1,8,9] Stephen Finn,[10] Majken K Jensen,[2,6] Jennifer R Rider,[1,11] Peter Kraft,[1,3,4] Lorelei A Mucci[1,6,9]

CONCLUSION

A large proportion of people have asparagus anosmia. Genetic variation near multiple olfactory receptor genes is associated with the ability of an individual to smell the metabolites of asparagus in urine. Future replication studies are necessary before considering targeted therapies to help anosmic people discover what they are missing.

BMJ 2016;355:i6071.

Case 2

82 y/o woman on an inpatient palliative care service is seen in consultation for distressing hallucinations.

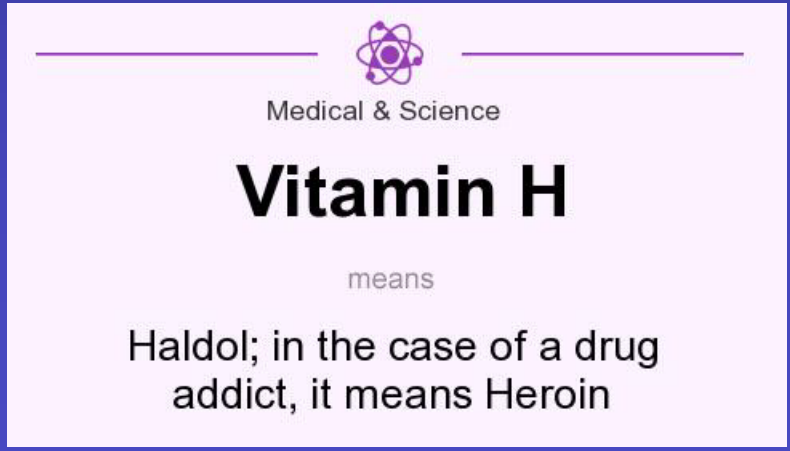
Physical examination and thorough review of medications do not identify a culprit etiology.

U/A negative, TSH and Chem normal.

The primary team is asking about pharmacologic options for treatment...

Which of the following are true?

A. Risperidone increases extrapyramidal sx
B. Risperidone decreases delirium severity
C. Degree of QTc prolongation predicts excess CV risk with antipsychotics.
D. All of the above are true.
E. Hello *Vitamin H.*



JAMA Internal Medicine | Original Investigation

Efficacy of Oral Risperidone, Haloperidol, or Placebo for Symptoms of Delirium Among Patients in Palliative Care

A Randomized Clinical Trial

Meera R. Agar, PhD; Peter G. Lawlor, MB; Stephen Quinn, PhD; Brian Draper, MD; Gideon A. Caplan, MBBS; Debra Rowett, BPharm; Christine Sanderson, MPH; Janet Hardy, MD; Brian Le, MBBS; Simon Eckermann, PhD; Nicola McCaffrey, PhD; Linda Devilee, MBus; Belinda Fazekas, BN; Mark Hill, PhD; David C Currow, PhD

JAMA Intern Med 2017;177:34-42.

Delirium Treatment

Question:	Efficacy of risperidone and haloperidol in treating distressing delirium in palliative care
Design:	Placebo controlled RCT
Patients:	247 adults with delirium + distress inpatient palliative care services in Australia
1° Outcome:	Improvement in delirium symptom score
2° Outcome:	Delirium severity, midazolam use, EPS, sedation, and survival

JAMA Intern Med 2017;177:34-42.

Delirium Treatment

	Ris	Hal	plac	P
1° Outcome	↑	↑		0.009
Del severity	↑	↑		<0.001

Delirium Treatment

	Ris	Hal	plac	P
1° Outcome	↑	↑		0.009
Del severity	↑	↑		<0.001
Midazolam	↑	↑		0.01

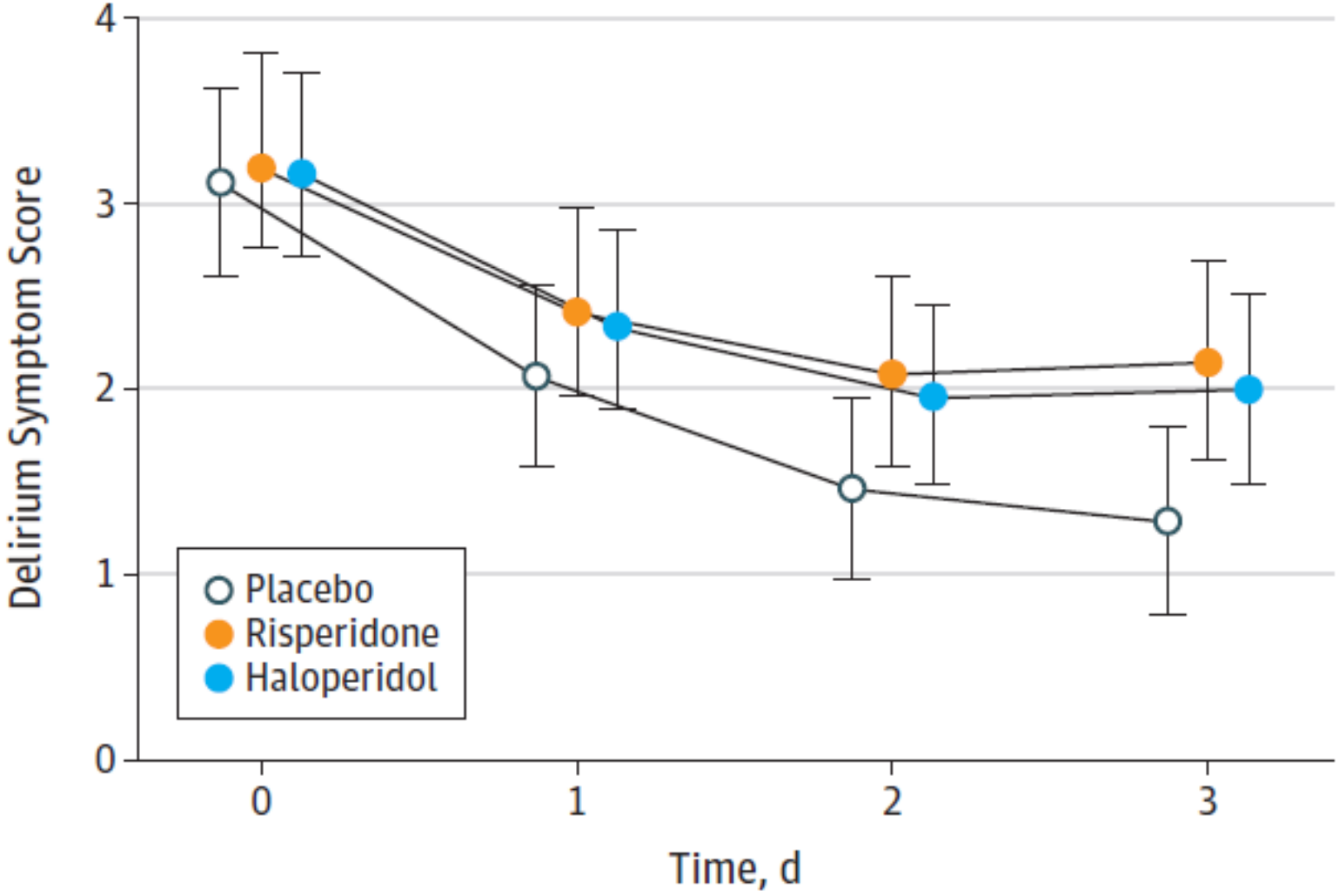
Delirium Treatment

	Ris	Hal	plac	P
1° Outcome	↑	↑		0.009
Del severity	↑	↑		<0.001
Midazolam	↑	↑		0.01
EPS	↑	↑		0.01

Delirium Treatment

	Ris	Hal	plac	P
1° Outcome	↑	↑		0.009
Del severity	↑	↑		<0.001
Midazolam	↑	↑		0.01
EPS	↑	↑		0.01
Survival	17d	16d	26d	0.01

Figure 2. Secondary Multivariable Mixed-Model Analysis of Delirium



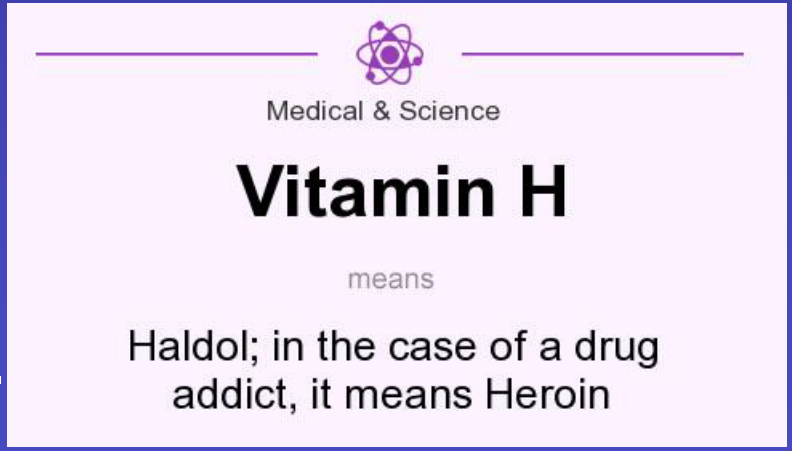
Delirium Treatment

Question:	Efficacy of risperidone and haloperidol in treating distressing delirium in palliative care
Design:	Placebo controlled RCT
Patients:	247 adults with delirium + distress inpatient palliative care services in Australia
1° Outcome:	Improvement in delirium symptom score
2° Outcome:	Delirium severity, midazolam use, EPS, sedation, and survival
Conclusion:	Antipsychotics worsen delirium, increase EPS, and haloperidol increases mortality

JAMA Intern Med 2017;177:34-42.

Which of the following are true?

A. Risperidone increases extrapyramidal sx
B. Risperidone decreases delirium severity
C. Degree of QTc prolongation predicts excess CV risk with antipsychotics.
D. All of the above are true.
E. Hello *Vitamin H.*



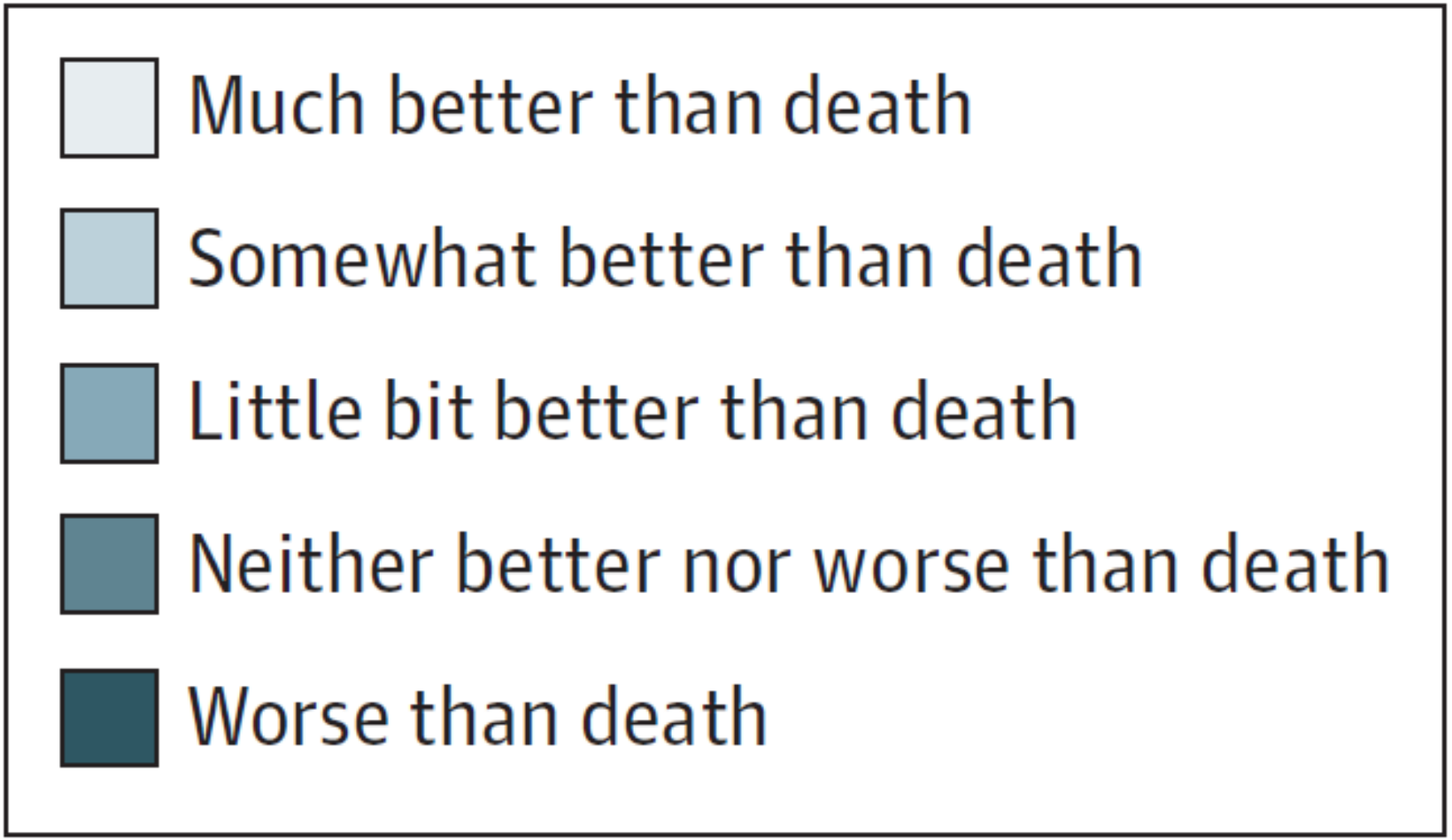
JAMA Intern Med 2017;177:34-42.

Quick Hitter

States Worse Than Death Among Hospitalized Patients With Serious Illnesses

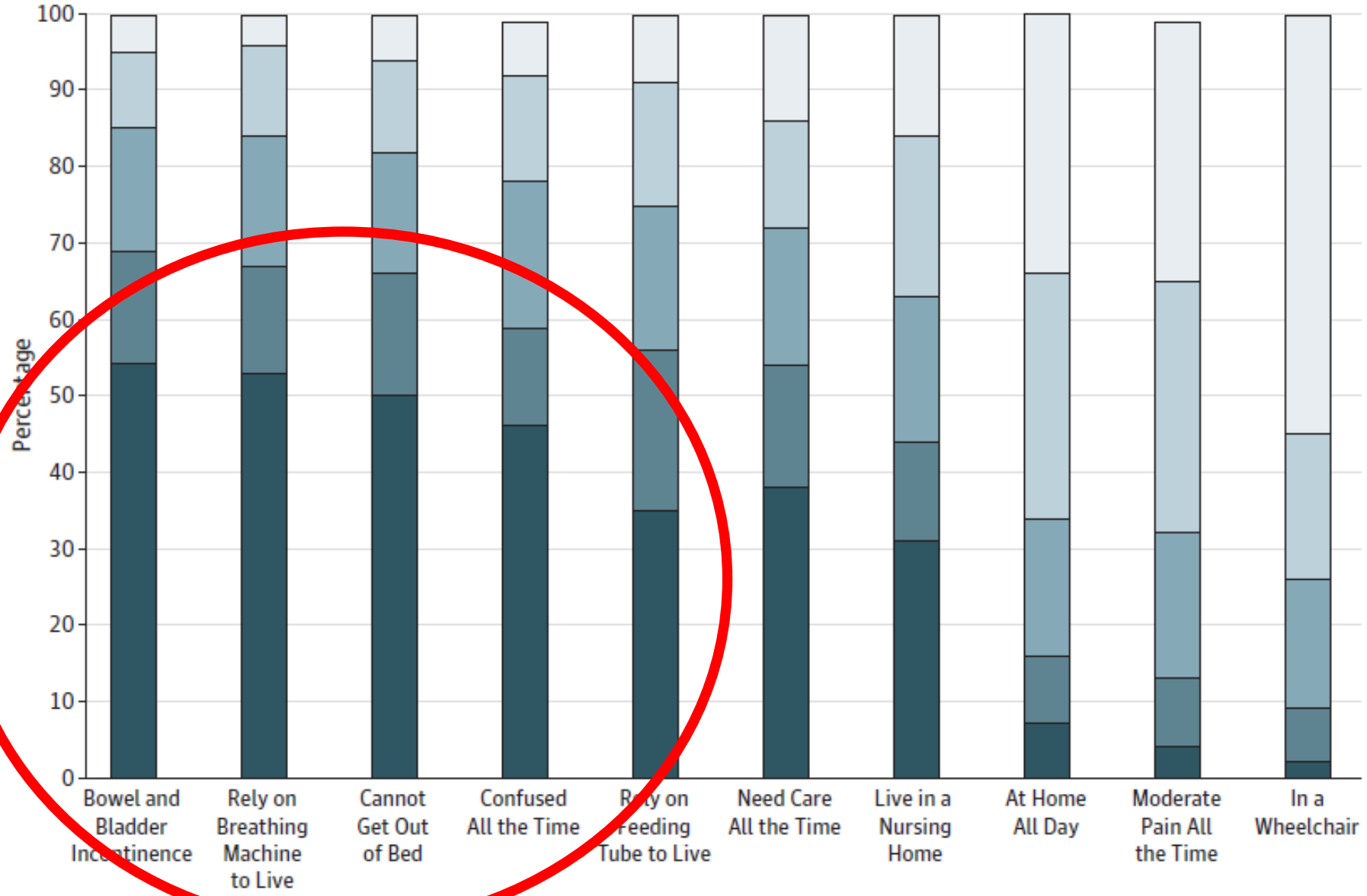
n=180

JAMA Intern Med 2016;176:1557-1559.



JAMA Intern Med 2016;176:1557-1559.

Figure. Ratings of States of Functional Debility Relative to Death by Hospitalized Patients With Serious Illnesses



Choose Wisely

Journal of HOSPITAL MEDICINE
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ORIGINAL RESEARCH

Evaluation of Baseline Corrected QT Interval and Azithromycin Prescriptions in an Academic Medical Center

Rachael A. Lee, MD[1]*, Allison Guyton, PharmD[2], Danielle Kunz, RPh[2], Gary R. Cutter, PhD[3], Craig J. Hoesley, MD[1]

[1]Department of Medicine, Division of Infectious Diseases, University of Alabama at Birmingham, Birmingham, Alabama; [2]Department of Pharmacology, University of Alabama at Birmingham, Birmingham, Alabama; [3]Department of Biostatistics, University of Alabama at Birmingham, Birmingham, Alabama.

35% didn't get a baseline EKG

Of those that did, 60% had QTc prolongation...

J Hospit Med 2016;11:15-20.

Quick Hitter

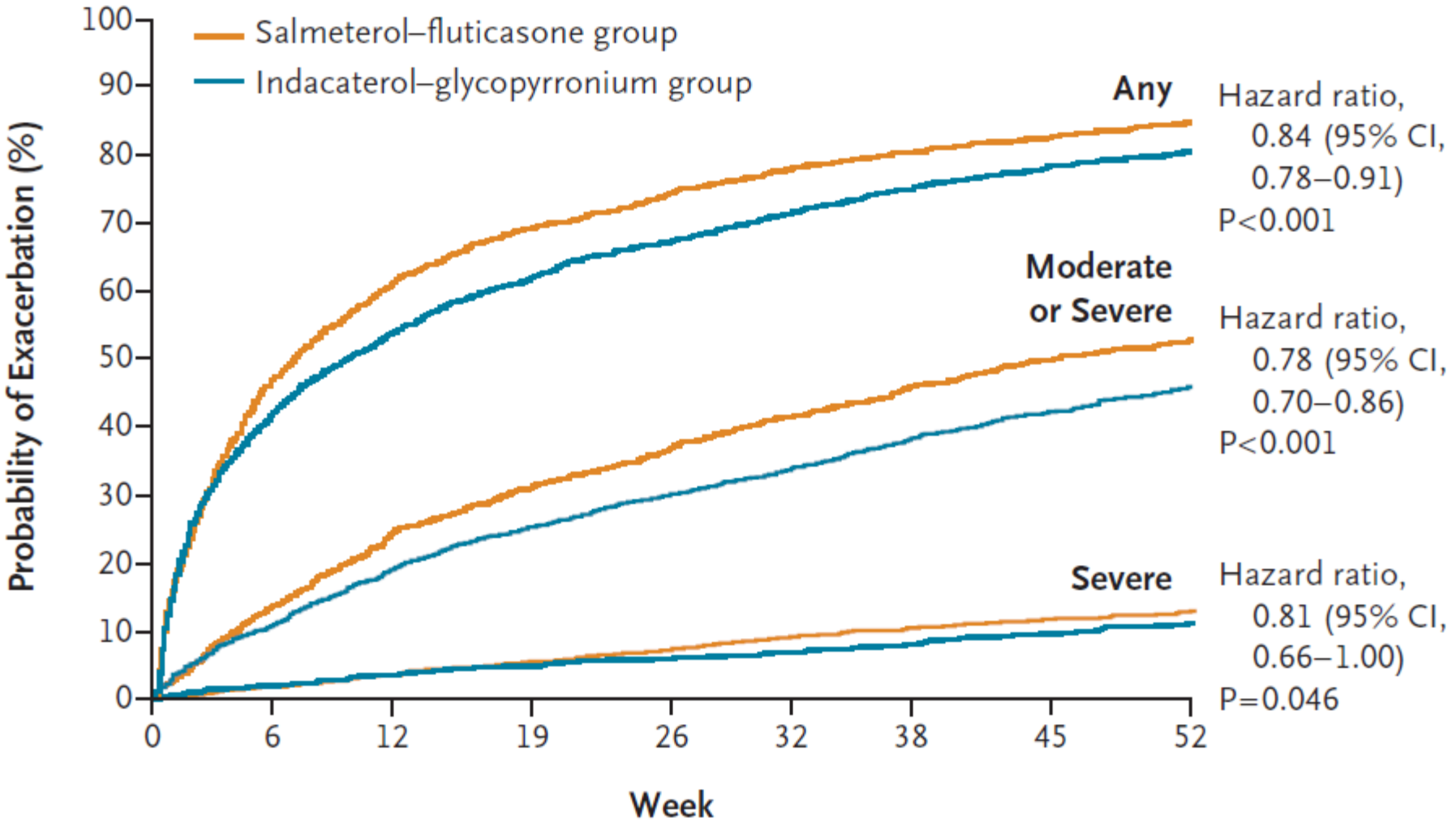
ORIGINAL ARTICLE

Indacaterol–Glycopyrronium versus Salmeterol–Fluticasone for COPD

Jadwiga A. Wedzicha, M.D., Donald Banerji, M.D., Kenneth R. Chapman, M.D., Jørgen Vestbo, M.D., D.M.Sc., Nicolas Roche, M.D., R. Timothy Ayers, M.Sc., Chau Thach, Ph.D., Robert Fogel, M.D., Francesco Patalano, M.D., and Claus F. Vogelmeier, M.D., for the FLAME Investigators*

N Engl J Med 2016;374:2222-34.

Time to First Exacerbation



However, does the FLAME trial provide sufficient data to support the use of a LABA–LAMA regimen over the use of a LABA–inhaled glucocorticoid regimen in patients in GOLD group C or D (i.e., high-risk patients) who have a history of exacerbations? The FLAME trial seems to indicate that the answer is yes.

N Engl J Med 2016;374:2284-86.

Quick Hitter

ORIGINAL ARTICLE

Prevalence of Pulmonary Embolism among Patients Hospitalized for Syncope

Paolo Prandoni, M.D., Ph.D., Anthonie W.A. Lensing, M.D., Ph.D., Martin H. Prins, M.D., Ph.D., Maurizio Ciammaichella, M.D., Marica Perlati, M.D., Nicola Mumoli, M.D., Eugenio Bucherini, M.D., Adriana Visonà, M.D., Carlo Bova, M.D., Davide Imberti, M.D., Stefano Campostrini, Ph.D., and Sofia Barbar, M.D., for the PESIT Investigators*

N Engl J Med 2016;375:1524-31.

Quick Hitter

Idiopathic syncope: 25.4%

Syncope explained....still 12.7%

WE NEED TO TEST: Wells score, D-dimer, CT/V-Q

N Engl J Med 2016;375:1524-31.

Dispelling the nice or naughty myth: retrospective observational study of Santa Claus

John J Park,[1] Ben G T Coumbe,[2] Esther H G Park,[3] George Tse,[4] S V Subramanian,[5] Jarvis T Chen[5]

CONCLUSION

The results of this study dispel the traditional belief that Santa Claus rewards children based on how nice or naughty they have been in the previous year. Santa Claus is less likely to visit children in hospitals in the most deprived areas. Potential solutions include a review of Santa's contract or employment of local Santas in poorly represented regions.

BMJ 2016;355:i6355.

Misc. Short Takes

About face: non-selective BB ok in advanced cirrhosis. *Hepatology* 2016;63:1968-1976.

Lille score at 4 days as good as at 7 days to determine steroid responsiveness in severe alcoholic hepatitis. *Am J Gastroenterol* 2016; online 6 December 2016; doi:10.1038/ajg.2016.539.

Misc. Short Takes

Olanzapine effective for prevention of chemotherapy-induced nausea and vomiting. *N Engl J Med* 2016;375:134-42.

...But is associated with DRESS syndrome. Be careful. [FDA Report] *JAMA* 2016;315:2514.

Avoid cipro for uncomplicated UTI, acute sinusitis, and bronchitis unless other drugs have failed – disabling and potentially permanent tendon, muscle, and CNS. [FDA Report] *JAMA* 2016;315:2513.

Cardiac Short Takes

Invasive strategy for NSTEMI superior to conservative in 80+ y/o pts. *Lancet* 2016;387:1057-65.

In VKA treatment, bleeding risk not higher in 80-89, mildly inc 90+ compared to 70-79. But clot risk increases. Treat on. *JAMA Intern Med* 2016;176:1176-1183.

Practice Summary

Things to Do:

1. Check out Annals for Hospitalists, NEJM Quick Take videos, and “Improving Diagnosis in Healthcare.”
2. Use qSOFA / SOFA but not at the expense of early identification of sepsis.
3. Ask about preferences in serious illness re: ‘what might be worse than death.’
4. Lille score at 4 days for severe ETOH Hep

Practice Summary

Things to Do:

5. Invasive NSTEMI mgnt for patients over 80 – they benefit.
6. Anticoagulate if over 80 and high risk – we overestimate bleeding risk.
7. Obtain baseline 12-lead if rx azithromycin and analyze carefully.
8. Look for PE in syncope – it's common.

Practice Summary

Things to Consider:

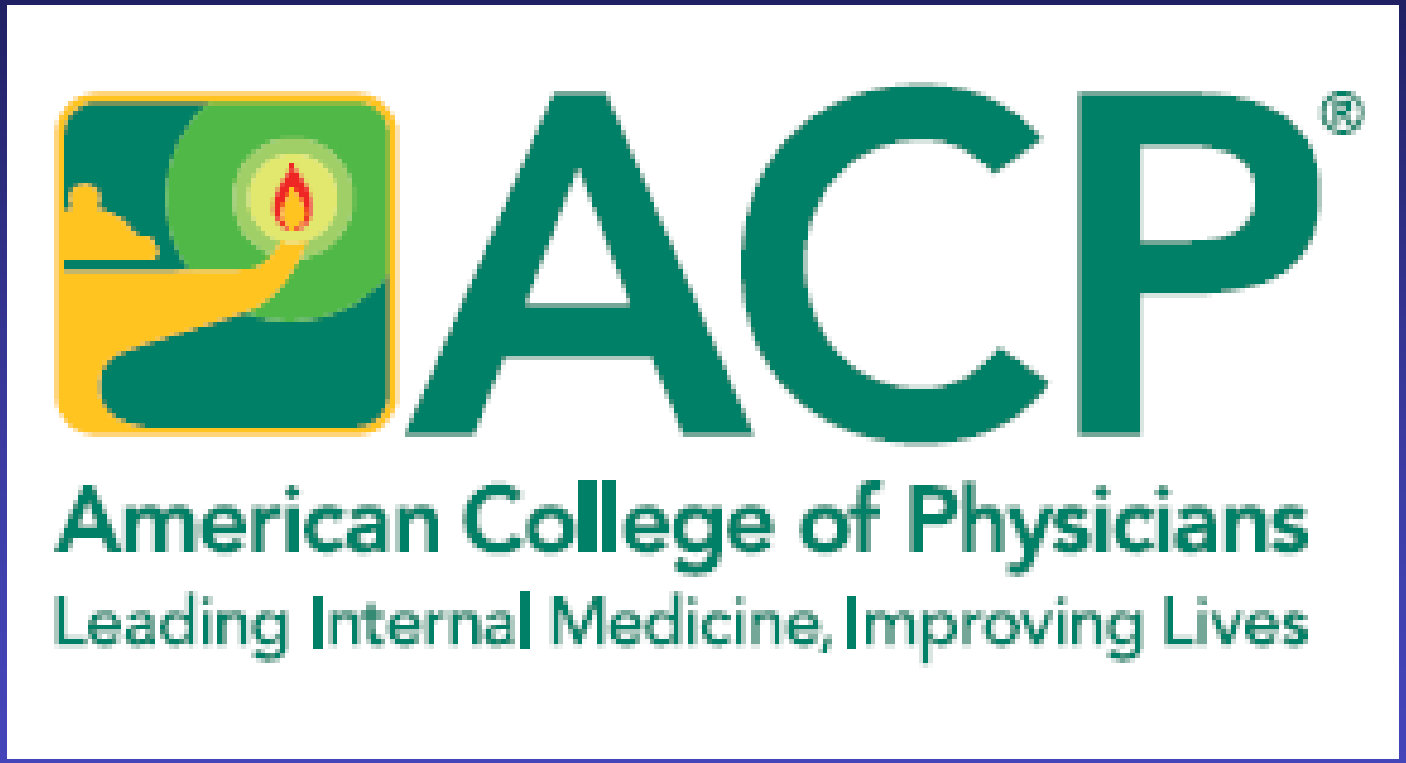
1. CT chest for suspected PNA if CXR neg and if it will impact management.
2. Continuous infusion B-lactam dosing in sepsis
3. Continuing BB in advanced cirrhosis.
4. Olanzapine for chemo-associated N/V
5. LABA+LAMA > LABA+inhaled steroid in COPD

Practice Summary

Things Not to Do:

1. Antipsychotics in palliative care
2. Rx cipro for uncomplicated UTI, bronchitis, sinusitis

Thank you!



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