Medical Literature 2017

Turning Evidence into Practice

Mel L. Anderson, MD, FACP
VA Eastern Colorado Healthcare System
Associate Professor of Medicine
University of Colorado School of Medicine
Disclosures:

- None
Roadmap

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

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

- Jan 2017 – Dec 2017
  - 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
  - Am J Respir Crit Care Med
  - Circulation, J Am Coll Cardiol, JACC HF
  - ACP Plus, BMJ Online update, J Watch
Disclosures

- None relevant
Acknowledgements

- Jeffrey J. Glasheen, MD
  University of Colorado School of Medicine
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  University of Colorado School of Medicine
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  Harvard Medical School
- Anneliese Schleyer, MD
  University of Washington
- Brad Sharpe, MD
  UCSF School of Medicine
Topics

- COPD
- Syncope
- Pneumonia
- Nutritional Medicine
- Lots of other things!
Notables in 2017
AHA SCIENTIFIC STATEMENT

Management of Patients on Non–Vitamin K Antagonist Oral Anticoagulants in the Acute Care and Periprocedural Setting
A Scientific Statement From the American Heart Association

FYI, I think it’s now **NOAC** meaning Non-Vitamin K-OAC...

Table 6. Categories of BP in Adults*

<table>
<thead>
<tr>
<th>BP Category</th>
<th>SBP</th>
<th>DBP</th>
</tr>
</thead>
<tbody>
<tr>
<td>Normal</td>
<td>&lt;120 mm Hg</td>
<td>and &lt;80 mm Hg</td>
</tr>
<tr>
<td>Elevated</td>
<td>120–129 mm Hg</td>
<td>and &lt;80 mm Hg</td>
</tr>
<tr>
<td>Hypertension</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Stage 1</td>
<td>130–139 mm Hg</td>
<td>or 80–89 mm Hg</td>
</tr>
<tr>
<td>Stage 2</td>
<td>≥140 mm Hg</td>
<td>or ≥90 mm Hg</td>
</tr>
</tbody>
</table>

*Individuals with SBP and DBP in 2 categories should be designated to the higher BP category.
BP indicates blood pressure (based on an average of ≥2 careful readings obtained on ≥2 occasions, as detailed in Section 4); DBP, diastolic blood pressure; and SBP systolic blood pressure.
Changes in:
Diagnosis
Thresholds for therapy initiation
Ongoing management

JAMA Clinical Guidelines Synopsis
Prevention, Detection, Evaluation, and Management of High Blood Pressure in Adults

Adam S. Cifu, MD; Andrew M. Davis, MD, MPH

JAMA 2017;318:2132-2134.
Core Competencies in Hospital Medicine 2017 Revision
Table of Contents

SECTION 1: CLINICAL CONDITIONS

SECTION 2: PROCEDURES

SECTION 3: HEALTHCARE SYSTEMS

2017 ACC/AHA/HFSA Focused Update of the 2013 ACCF/AHA Guideline for the Management of Heart Failure

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

Sacubitril / valsartan

Clinicopathological Evaluation of Chronic Traumatic Encephalopathy in Players of American Football

Jesse Mez, MD, MS; Daniel H. Daneshvar, MD, PhD; Patrick T. Kiernan, BA; Bobak Abdolmohammadi, BA; Victor E. Alvarez, MD; Bertrand R. Huber, MD, PhD; Michael L. Alosco, PhD; Todd M. Solomon, PhD; Christopher J. Nowinski, PhD; Lisa McHale, EdS; Kerry A. Cormier, BA; Caroline A. Kubilus; Brett M. Martin, MS; Lauren Murphy, MBA; Christine M. Baugh, MPH; Phillip H. Montenigro, BA; Christine E. Chaisson, MPH; Yorghos Tripodis, PhD; Neil W. Kowall, MD; Jennifer Weuve, MPH, ScD; Michael D. McClean, ScD; Robert C. Cantu, MD; Lee E. Goldstein, MD, PhD; Douglas I. Katz, MD; Robert A. Stern, PhD; Thor D. Stein, MD, PhD; Ann C. McKee, MD

Across all 202 = 87%
NFL = 99% (110/111)

Comparison of Hospital Mortality and Readmission Rates for Medicare Patients Treated by Male vs Female Physicians

Women in Medicine and Patient Outcomes: Equal Rights for Better Work?

Anna L. Parks, MD; Rita F. Redberg, MD, MSc
750K total evaluated between two prospective cohorts…inverse relationship between coffee consumption and mortality!
Only a 16 second difference in ETT time
6 week max med run-in: some angina free
Bottom Line: Still a role for PCI; look further...
Case 1

A 67 y/o woman Gold III COPD presents with three days of dyspnea, fatigue, and chest pain.

BP 96/64, HR 102, Temp 98.2, RR 24, SaO2 92% on RA. Fatigued, bilat wheezing.

CXR hyperexpanded, UA neg, blood cx drawn, WBC 9K, creat 1.5.

ER begins bronchodilators, oxygen, steroids for COPD exacerbation.
Prevalence and Localization of Pulmonary Embolism in Unexplained Acute Exacerbations of COPD

A Systematic Review and Meta-analysis

Floor E. Aleva, MD; Lucas W. L. M. Voets, BSc; Sami O. Simons, MD, PhD; Quirijn de Mast, MD, PhD; André J. A. M. van der Ven, MD, PhD; and Yvonne F. Heijdra, MD, PhD

Chest 2017;151:544-554.
Objective: Determine impact of PE in unexplained AE-COPD

Design: Systematic review and meta-analysis

Studies: 7 international studies, 880 patients

Outcomes: Prevalence, embolus location and significance, clinical markers

*Chest* 2017;151:544-554.
PE in “idiopathic” AE-COPD

Prevalence 16.1% (8.3% -- 25.8%)

Or

About one in six patients
PE in “idiopathic” AE-COPD

<table>
<thead>
<tr>
<th>Location</th>
<th>Prevalence</th>
</tr>
</thead>
<tbody>
<tr>
<td>Main pulmonary art.</td>
<td>35.8%</td>
</tr>
<tr>
<td>Lobar / Interlobar</td>
<td>31.7%</td>
</tr>
<tr>
<td>Sub-segmental</td>
<td>32.5%</td>
</tr>
</tbody>
</table>

‘Treatment prevalence’ = 11%
PE in “idiopathic” AE-COPD

Objective: Determine impact of PE in unexplained AE-COPD

Design: Systematic review and meta-analysis

Studies: 7 international studies, 880 patients

Outcomes: Prevalence, embolus location and significance, clinical markers

Conclusions: Proximal PE is present in about one in nine patients with idiopathic AE-COPD – look for it

Chest 2017;151:544-554.
Quick hitter: “Bendopnea”

Bendopnea and risk of adverse clinical outcomes in ambulatory patients with systolic heart failure

Jennifer T. Thibodeau, MD, MSc, Benjamin E. Jenny, MD, Jeomi O. Maduka, MD, Punag H. Divanji, MD, Colby R. Ayers, MS, Faris Araj, MD, Alpesh A. Amin, MD, Robert M. Morlend, MD, Pradeep P. A. Mammen, MD, and Mark H. Drazner, MD, MSc Dallas, TX

1. Bend at the waist
2. “Tell me if you get short of breath”
3. < 30 sec = positive

*Am Heart J 2017;183:102-7.*
Quick hitter: “Bendopnea”

- 179 patients in CHF clinic
- 18% “bendopneic”, mean onset 13 sec
- Compared to non-bendopneic pts:
  - Higher NYHA Class and diuretics
  - Pro-NT-BNP the same
  - About 3 times as likely to be admitted in the next 3 months (p<0.004)
Letter to the Editor

Bendopnea: The next prognostic marker of advanced heart failure?

To the Editor,

We have read with great interest the article by Thibodeau et al. \(^1\) Bendopnea is the last symptom of heart failure reported in the literature that still shows many unanswered questions. After confirming its relationship with advanced functional New York Heart Association class and other symptoms of advanced heart failure, the most repeated question might be the relationship between this new symptom and its prognosis (readmissions and mortality of heart failure), especially in the short term. This topic has generated a great excitement in our group. We conducted a prospective study in patients with decompensated heart failure admitted to our internal medicine indicating a group of patients with worse prognosis. It has been confirmed that patients with bendopnea have more adverse hemodynamic parameters, which would support its worst prognosis. \(^2\)–\(^4\) The maneuver to confirm the presence of bendopnea can be done during standard physical examination, which takes less than a minute and does not require technology, so it would be very interesting that other groups confirm our findings to include the analysis of this new symptom in our usual practice.

Am Heart J 2017;e1. 0002-8703 http://dx.doi.org/10.1016/j.ahj.2017.01.002

Ramón Baeza-Trinidad, MD
Internal Medicine Department
Hospital San Pedro
Logroño, Spain
Next diagnostic step?

A. Viral panel
B. D-dimer
C. Highly sensitive troponin
D. Determine presence of “bendopnea”
E. Consult Watson...
It’s in the chest: CAP Abx duration

Duration of Antibiotic Treatment in Community-Acquired Pneumonia
A Multicenter Randomized Clinical Trial

Ane Uranga, MD; Pedro P. España, MD; Amaia Bilbao, MSc, PhD; Jose María Quintana, MD, PhD; Ignacio Arriaga, MD; Maider Intxausti, MD; Jose Luis Lobo, MD, PhD; Laura Tomás, MD; Jesus Camino, MD; Juan Nuñez, MD; Alberto Capelastegui, MD, PhD

JAMA 2016;176:1257-1265.
Objective: Determine optimal CAP abx duration
Design: Randomized noninferiority trial intervention versus control
Patients: 4 hospitals in Spain, 312 patients
Outcomes: Symptoms at 5 and 10 days, ‘clinical success score’ at 10 and 30 days
Duration of antibiotics

*JAMA* 2016;176:1257-1265.
CAP Abx duration

Intervention Group – all 3
1. At least 5 days of abx
2. Temp < 37.8 °C x 48 hours
3. No more than 1 CAP-instability sign:
   - SBP<90mm Hg
   - HR>100/min
   - RR>24/min
   - PaO2<60mm Hg

*JAMA* 2016;176:1257-1265.
## CAP Abx duration Outcomes

<table>
<thead>
<tr>
<th></th>
<th>Interv.</th>
<th>Control</th>
<th>p</th>
</tr>
</thead>
<tbody>
<tr>
<td>OK @ Day 10</td>
<td>56.3%</td>
<td>48.6%</td>
<td>0.18</td>
</tr>
<tr>
<td>Per protocol</td>
<td>59.7%</td>
<td>50.45</td>
<td>0.12</td>
</tr>
<tr>
<td>OK @ Day 30</td>
<td>91.9%</td>
<td>88.6%</td>
<td>0.33</td>
</tr>
<tr>
<td>Per protocol</td>
<td>94.4%</td>
<td>92.7%</td>
<td>0.54</td>
</tr>
</tbody>
</table>
# CAP Abx duration Outcomes

<table>
<thead>
<tr>
<th></th>
<th>Interv.</th>
<th>Control</th>
<th>p</th>
</tr>
</thead>
<tbody>
<tr>
<td>Days abx</td>
<td>5</td>
<td>10</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>Rec’d just 5d?</td>
<td>70.1%</td>
<td>2.9%</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>Readmit 30d</td>
<td>1.4%</td>
<td>6.6%</td>
<td>0.02</td>
</tr>
</tbody>
</table>
CAUTION

Community dwelling
Non-ICU
HIV negative
Not on steroids
No recent abx
High FQ use

*JAMA* 2016;176:1257-1265.
**Objective:** Determine optimal CAP abx duration

**Design:** Randomized noninferiority trial intervention versus control

**Patients:** 4 hospitals in Spain, 312 patients

**Outcomes:** Symptoms at 5 and 10 days, ‘clinical success score’ at 10 and 30 days

**Conclusion:** Shorter duration abx safe, supports IDSA / ATS Guidelines

*JAMA* 2016;176:1257-1265.
The New Antibiotic Mantra—“Shorter Is Better”

Brad Spellberg, MD
20% of patients experience an adverse event
Of these, one in five abx prescriptions NOT INDICATED
GI, Renal, Hematologic – Choose Wisely

Addition of NIPPV to home O2 lowers readmission and death in COPD with PCO2 > 53 mm Hg / pH < 7.3 at 2-4 weeks after discharge. Plan accordingly. *JAMA*. 2017;317: 2177-2186.

The “DUMAS” behavioral intervention improved appropriate abx prescribing from 64% to 77% at 12 months and counting. *JAMA Intern Med.* 2017;177:1130-1138.
AMPLE trial: in malignant pleural effusion, indwelling pleural catheter vs. talc pleurodesis → shorter LOS, fewer subsequent taps; symptoms and adverse events no different. It’s an option. *JAMA* 2017;151:374-382.
Case 2: Syncope

67 y/o man presents with syncope following micturition. Arose last night to void, felt immediately unwell on arising. While emptying his bladder developed tunnel vision then LOC with minimal trauma. Spouse observed and confirms.

BPH, HTN, OA, GERD, OSA

146/74, 82, 18, Afeb. Normal exam.

EKG NSR with sinus irregularity
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*

PESIT trial

Question: Prevalence of PE in first syncope
Design: Prospective cohort
Patients: 560 patients across 11 centers in Italy
Intervention: Wells score, D-dimer, further testing for PE
1° Outcome: PE prevalence and extent

560 Patients were included in the study

97 Had pulmonary embolism confirmed
<table>
<thead>
<tr>
<th>Variable</th>
<th>Points</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clinical signs or symptoms of deep-vein thrombosis</td>
<td>3.0</td>
</tr>
<tr>
<td>Alternative diagnosis less likely than pulmonary embolism</td>
<td>3.0</td>
</tr>
<tr>
<td>Heart rate &gt;100 beats/min</td>
<td>1.5</td>
</tr>
<tr>
<td>Immobilization or surgery in the previous 4 wk</td>
<td>1.5</td>
</tr>
<tr>
<td>Previous venous thromboembolism</td>
<td>1.5</td>
</tr>
<tr>
<td>Hemoptysis</td>
<td>1.0</td>
</tr>
<tr>
<td>Active cancer</td>
<td>1.0</td>
</tr>
<tr>
<td>Result</td>
<td>%</td>
</tr>
<tr>
<td>--------------------------------------------------------------</td>
<td>------</td>
</tr>
<tr>
<td>No PE: Neg Wells + Neg D-D</td>
<td>58.9%</td>
</tr>
<tr>
<td>No PE: Neg CT or V/Q</td>
<td>23.8%</td>
</tr>
<tr>
<td><strong>Dx of PE overall</strong></td>
<td>17.3%</td>
</tr>
<tr>
<td>PE if ‘no alternate etiology’</td>
<td>25.4%</td>
</tr>
<tr>
<td>PE in ‘known etiology’</td>
<td>12.7%</td>
</tr>
<tr>
<td>Clot distribution</td>
<td></td>
</tr>
<tr>
<td>---------------------------------------</td>
<td>-------</td>
</tr>
<tr>
<td>Main pulmonary artery</td>
<td>41.7%</td>
</tr>
<tr>
<td>Lobar artery</td>
<td>25.0%</td>
</tr>
<tr>
<td>Segmental artery</td>
<td>26.4%</td>
</tr>
<tr>
<td>Sub-segmental artery</td>
<td>6.9%</td>
</tr>
</tbody>
</table>
PESIT trial

Question: Prevalence of PE in first syncope
Design: Prospective cohort
Patients: 560 patients across 11 centers in Italy
Intervention: Wells score, D-dimer, further testing for PE
1° Outcome: PE prevalence and extent
Conclusion: PE present in nearly 1 in 6 syncope admissions, mostly proximal

11,429 patients in ARIC study
Postural BP every 30 s x 5 min after 20 min supine

Ortho hypo at 30 and 60 seconds predict future syncope, fall, fracture, MVA, all-cause death

*JAMA Intern Med* 2017;177(9):1316-1323.
Simplified diagnostic management of suspected pulmonary embolism (the YEARS study): a prospective, multicentre, cohort study

Tom van der Hulle, Whitney Y Cheung, Stephanie Kooij, Ludo F M Beenen, Thomas van Bemmelen, Josien van Es, Laura M Faber, Germa M Hazelaar, Christian Heringhaus, Herman Hofstee, Marcel M C Hovens, Karin A H Kaasjager, Rick C J van Klink, Marieke J H A Kruip, Rinske F Loeffen, Albert T A Mairuhu, Saskia Middeldorp, Mathilde Nijkerk, Liselotte M van der Pol, Suzanne Schol-Gelok, Marije ten Wolde, Frederikus A Klok, Menno V Huisman, for the YEARS study group

YEARS trial

Question: Can differential D-dimer cutoffs safely reduce the use of CT-PE in suspected acute PE?

Design: Prospective multicenter cohort

Patients: 3465 patients across 12 Dutch centers

Intervention: YEARS clinical decision rule

1° Outcome: PE prevalence and outcomes at 3 months

YEARS Decision Rule

Suspected acute pulmonary embolism

Order D-dimer test and score presence of the three YEARS items:
- Clinical signs of deep vein thrombosis
- Haemoptysis
- Pulmonary embolism the most likely diagnosis

Suspected acute pulmonary embolism

Order D-dimer test and score presence of the three YEARS items:
Clinical signs of deep vein thrombosis
Haemoptysis
Pulmonary embolism the most likely diagnosis

0 YEARS items
D-dimer <1000 ng/mL
Pulmonary embolism excluded

0 YEARS items
D-dimer ≥1000 ng/mL
Order CTPA

≥1 YEARS items
D-dimer <500 ng/mL
Pulmonary embolism excluded

≥1 YEARS items
D-dimer ≥500 ng/mL
Order CTPA

YEARS: results

- Mean age 53
- 2996 (86%) outpatient
- 456 Total PE detected (13% overall)
- 2946 not diagnosed w/ PE

YEARS: 3m outcomes n=2946

<table>
<thead>
<tr>
<th>Management</th>
<th>n=</th>
<th>Any VTE</th>
<th>Fatal PE</th>
</tr>
</thead>
<tbody>
<tr>
<td>w/ CT</td>
<td>1317</td>
<td>11 (0.84%)</td>
<td>4 (0.30%)</td>
</tr>
<tr>
<td>w/o CT</td>
<td>1629</td>
<td>7 (0.43%)</td>
<td>2 (0.12%)</td>
</tr>
</tbody>
</table>

14% reduction in CT-PE

YEARS trial

Question: Can differential D-dimer cutoffs safely reduce the use of CT-PE in suspected acute PE?

Design: Prospective multicenter cohort

Patients: 3465 patients across 12 Dutch centers

Intervention: YEARS clinical decision rule

1° Outcome: PE prevalence and outcomes at 3 months

Conclusion: YEARS safely reduces CT-PE by 14%

Delirium Mini-Summit

CLINICAL PRACTICE

Caren G. Solomon, M.D., M.P.H., Editor

Delirium in Hospitalized Older Adults

Edward R. Marcantonio, M.D.

Delirium in Older Persons
Advances in Diagnosis and Treatment

Esther S. Oh, MD, PhD; Tamara G. Fong, MD, PhD; Tammy T. Hshieh, MD, MPH; Sharon K. Inouye, MD, MPH

Case 3

58 y/o woman admitted for observation after uncomplicated PCI for angina.
CAD, T2DM, HTN, OA, GERD, OSA
DAPT, atorva 80, ACEI, thiazide, amlodipine 10, isosorbide mononitrate 60, metop 25 BID
146/78, 68, 18, Afeb. BMI 37
Pulses equal, radial site no hematoma
EKG NSR with old inferior Q waves
“Aggressive lifestyle modification.”
Our current reality...

A. Outpatient Nutritional Medicine consult
B. “Important to exercise and eat right”
C. We don’t know the nutritional medicine literature
D. We miss opportunities to intervene
FIGHT LIKE YOUR WORLD DEPENDS ON IT

an inconvenient sequel
TRUTH TO POWER
Whole Food Plant Based Diet Pyramid

- **Fats and Oils**
  - Almonds, pecans
  - Walnuts, avocado
  - Olive oil (in moderation)

- **Leafy Greens**
  - Spinach, broccoli
  - Kale, lettuce
  - (2-3 servings daily)

- **Grains**
  - Whole wheat bread
  - Oats, brown rice
  - Pasta, whole wheat tortilla, granola
  - Quinoa, barley
  - (5 servings daily)

- **Fruits**
  - Pineapple, grapes
  - Berries, tomato
  - Banana, apple
  - Pears, oranges
  - Grapefruit
  - (3-4 servings daily)

- **Legumes**
  - Black beans
  - Chickpeas, edamame
  - Flax seeds, chia seeds, sunflower seeds, lentils
  - (2-3 servings daily)

- **Vegetables**
  - Cauliflower, sweet potato, mushrooms
  - Squash, Brussels sprouts, asparagus
  - Cucumbers, corn
  - Carrots, celery
  - Bell peppers
  - (unlimited amount daily)

△ThisIsMyYear
NHANES data 10 dietary factors
Mortality from CVD, stroke, Type II DM
**Good for You:**
- Fruit excluding juice
- Veg. + legumes
- Nuts/seeds
- Whole grains
- PUFAs for Sat fat.
- Seafood omega-3

**Not Good for You:**
- Red meat, unproc.
- Red meat, proc.
- Sugar beverages
- Sodium

*JAMA* 2017;317:912-924.
### Annual Deaths*

<table>
<thead>
<tr>
<th></th>
<th>Annual Deaths*</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Heart disease</td>
<td>223,960</td>
<td>44.3%</td>
</tr>
<tr>
<td>Stroke</td>
<td>66,547</td>
<td>51.9%</td>
</tr>
<tr>
<td>Diabetes</td>
<td>32,732</td>
<td>48.2%</td>
</tr>
<tr>
<td>Total CardMet</td>
<td>318,656</td>
<td>45.4%</td>
</tr>
</tbody>
</table>

*Suboptimal diet accounts for: JAMA 2017;317:912-924.*

*of 702,308 CardMet US deaths
Trending Cardiovascular Nutrition Controversies

Andrew M. Freeman, MD, Pamela B. Morris, MD, Neal Barnard, MD, Caldwell B. Esselstyn, MD, Emilio Ros, MD, PhD, Arthur Agatston, MD, Stephen Devries, MD, James O’Keefe, MD, Michael Miller, MD, Dean Ornish, MD, Kim Williams, MD, Penny Kris-Etherton, PhD
AVOID or LIMIT:
Added fat, fried foods, eggs, organ and processed meats, SSB, cholesterol, palm and coconut oil; antiox suppl.
**FREQUENT**: Anti-oxidant rich fruits and veggies, green leafy veggies, plant protein

**MODERATION**: Canola, sunflower, olive oils
6500 rural Chinese – animal protein 10% of US
Diet 14% fat, 10% protein, 71% carb

Male CHD mortality 4.0/100,000
US Male CHD mortality 66.8/100,000

Female CHD mortality 3.4/100,000
US female CHD mortality 18.9/100,000

Association of Animal and Plant Protein Intake With All-Cause and Cause-Specific Mortality

Mingyang Song, MD, ScD; Teresa T. Fung, ScD; Frank B. Hu, MD, PhD; Walter C. Willett, MD, DrPH; Valter D. Longo, PhD; Andrew T. Chan, MD, MPH; Edward L. Giovannucci, MD, ScD

131,342 US health care professionals...

Average 14% animal protein energy intake

In those with 1+ unhealthy lifestyle factor, replacing meat with plant protein lowers mortality.

Mortality from different causes associated with meat, heme iron, nitrates, and nitrites in the NIH-AARP Diet and Health Study: population based cohort study

Arash Etemadi, Rashmi Sinha, Mary H Ward, Barry I Graubard, Maki Inoue-Choi, Sanford M Dawsey, Christian C Abnet

536,969 AARP members age 50-71
16 year follow-up...
All cause mortality 26% higher
Across NINE different causes of death
(of TEN studied – Alz. Dz. Neutral)

Red meat: another inconvenient truth

Fiona Godlee editor in chief

The BMJ
RESEARCH LETTER

Updated Cost-effectiveness Analysis of PCSK9 Inhibitors Based on the Results of the FOURIER Trial

With PCSK9 Inhibition in Subjects With Elevated Risk (FOURIER) trial found the PCSK9 inhibitor evolocumab reduced risk of major adverse cardiovascular events (MACE; myocardial infarction, stroke, or cardiovascular death).\(^2\) This study

Effects of Anacetrapib in Patients with Atherosclerotic Vascular Disease

The HPS3/TIMI55–REVEAL Collaborative Group*
Nutrition Counseling in Clinical Practice
How Clinicians Can Do Better

Scott Kahan, MD, MPH
Department of Health Policy and Management, Johns Hopkins Bloomberg School of Public Health, Baltimore, Maryland; and George Washington University School of Medicine, Washington, DC.

JoAnn E. Manson, MD, DrPH
Department of Nutrition, Harvard T.H. Chan School of Public Health, Boston, Massachusetts.

Despite overwhelming evidence that relatively small dietary changes can significantly improve health, clinicians seldom discuss nutrition with their patients. Poor nutritional intake and nutrition-related health conditions, such as cardiovascular disease (CVD), diabetes, obesity, hypertension, and many cancers, are highly prevalent in the United States, yet only 12% of office visits include counseling about diet. Even among high-risk patients with CVD, diabetes, or hyperlipidemia, only 1 in 5 receive nutrition counseling. It is likely that many patients receive most of their nutrition information from other, and often unreliable, sources.
Rx

1. Educate ourselves
2. Reconcile the data with our own lives
3. Start the conversation with our patients
Quick hitter

Screening BMI>30 inpatients with STOP or STOP/BANG → sleep med → in house nox ox → outpt PSM → better outcomes.

Quick hitter

CHOOSING WISELY®: THINGS WE DO FOR NO REASON

Against Medical Advice Discharges

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Document, but otherwise discharge w/ Shared Decision Making – appointments, medications, counseling.

Practice Summary

Things to Do:

1. Check out JAMA Clinical Synopsis Guidelines, Updated SHM Core Competencies
2. Look for PE in idiopathic AE-COPD: common
3. 5 days abx in CAP IF no exclusions
4. Look for PNA infiltrate US or CT if mgnt change
5. Look for PE in syncope: common
Practice Summary

Things to Do:

6. Assess orthostatic hypotension at 1 minute instead of 3 minutes.
7. Post DC ABG and referral for NIPPV in COPD
8. Start the conversation around nutrition with your patients
Things to Consider:

1. Learning from your female colleagues...
2. YEARS evaluation protocol for suspected PE.
3. Screening STOP/STOP BANG if BMI $>$ 30
4. ‘Bendopnea’ check in systolic heart failure
Practice Summary

Things to Consider:
5. IR referral for pleural catheter in malignant pleural effusion

Things not to Do:
1. AMA discharge – approach as shared decision making
Thank you!

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