Medical Literature 2018
Turning Evidence into Practice

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Disclosurers:

- None
Roadmap

- Case based interactive format
- Multiple articles per case
- Quick hitters and Short takes
- ** Lightning Reviews **
- 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 2018 – Dec 2018
  - N Engl J Med
  - JAMA; JAMA Intern Med
  - J Gen Intern Med
  - J Hospit Med
  - Ann Intern Med + ACP J Club
  - ACP Plus, BMJ Online update, J Watch
Disclosures

- None relevant
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Topics

- Syncope and PE – something new...
- Pneumonia
- A fib and Heart Failure
- Sepsis, Stroke
- Opiate use disorder
- Acute cholecystitis
Notables in 2018
1. ORAL VANCO or FIDAX instead of METRO, non severe
2. If severe, high dose enteral vanco + IV metro
JAMA 2018;320(23):2471-2473.
Changes in:
Diagnosis
Thresholds for therapy initiation
Ongoing management

*JAMA* 2017;318:2132-2134.
Cluster randomized trial of 319 black men
Pharmacist-led intervention in the shop
SBP reduction at 6 months 21.6 mm Hg more
compared to control

Case 1

67 y/o woman presents with syncope while seated at dinner. Had been feeling more dyspneic that afternoon while mowing the lawn.

BPPV, HTN, OA, GERD, OSA

146/74, 102, 18, Afeb. Clear lungs, trace edema

Neuro exam including gait/cerebellar nl.

EKG NSR with sinus tach

CXR clear
Case 1, cont.

D-dimer 1.05
CT-PE is performed and...
PE in Syncope

PE in Syncope
PE in Syncope

Case 1a: PE

There are bilateral segmental pulmonary emboli without evidence of cardiac dilation.

You begin anticoagulation and ask a pharmacy colleague about DOAC’s they might recommend.

But as a great internist, you can’t help but ask the larger question of why...
Case 1a: Do I Look for Ca?

A. H&P and age appropriate screening
B. Above, plus IV/po contrast CT abd/pelvis
Idiopathic VTE Cancer Screening

Idiopathic VTE Cancer Screening

Idiopathic VTE Cancer Screening

Quick Hitter

Case 1b: no PE

The CT scan shows evidence of prior granulomatous disease but no pulmonary emboli with good timing of contrast bolus.

As you consider your next move, you are called for rapid atrial fibrillation to 160s with hypotension – she is close to passing out again.

Hurray! An answer!
Case 1b: no PE

Now you DO get an ECHO and LVEF 35%
More detailed history shows Class II-III DOE over six months
And more ETOH intake than first described
Her stroke risk score is high...
Please see slide at Presentation
CASTLE-AF Study

CASTLE-AF Study Results
CASTLE-AF Study

JAMA 2018;319:2227-2228.
Lightning Review: Acute Stroke
NNT 3, p < 0.001
NNT 9, p = 0.02
NNT 8, p = 0.04
Case 2

56 y/o man presents with one week of worsening pleuritic chest pain with productive cough, fevers, and chills.
Tobacco, HTN, MDD, obesity
EKG NSR with sinus tach
CXR clear
CAP on CT: Reality Check

Chest 2018;153:601-610.
EPIC CT-CAP Initial Clinical
EPIC CT-CAP Initial Clinical
CAP on CT: Reality Check

*Chest* 2018;153:601-610.
SALT-ED – Non-ICU

SALT-ED: Results
SALT-ED – Non-ICU

SMART – ICU

SMART: Results
SMART – ICU

Please see slide at presentation
Steroids in CAP

*Clinical Infectious Disease* 2018;66:346-54.
Steroids in CAP: Results
Steroids in CAP: Harms
Steroids in CAP

Clinical Infectious Disease 2018;66:346-54.
CID paper 6 studies; Cochrane 17 (Children = 4)
CID authors couldn’t get IPD from 3 studies
CID paper exploration age, COPD, blood cultures, Strep pneumoniae, duration of steroids
Bottom line: do it to speed time to recovery, recognize the risks
Case 2, cont.

CT scan shows lingular infiltrate w/ air bronchograms, no effusion.
Start CTX, azithro, and empiric COPD rx.
HD #2, confused, agitated, tremulous...
Lightning Review:
Opioid Use Disorder
Lightning Review: Opioid Use Disorder
JAMA 2018;320:984-994.
Miscellaneous Short Takes

Practice Summary

Things to Do:

1. Check out 2017 ACC-AHA HTN Guidelines
2. Look for PE in syncope, although it’s probably less common than previously thought
3. Idiopathic VTE: screen for ca with H&P and age appropriate screening
4. CT scan or US to dx PNA if CXR neg / mgnt Δ
5. Advocate for Procalcitonin algorithms
Practice Summary

Things to Do:
6. Select balanced crystalloids as a saline alternative, especially in the ICU / sepsis
7. Connect opiate use disorder patients with medical therapy options
8. Prescribe meropenem over pip/tazo in E coli or Klebsiella bacteremia if CTX resistant
9. Prescribe oral vanco or fidax for non-fulminant C diff instead of metro
Practice Summary

Things to Do:

10. Advocate for lap chole vs. perc tube in high risk patients w/ acute cholecystitis
Practice Summary

Things to Consider:

1. Refer AF – CHF patients to EP for ablation
2. Naltrexone for ETOH use disorder
3. Edoxaban for Ca-VTE instead of LMWH, maybe not if upper GI malignancy
4. Apixaban as DOAC-max in AF
5. Steroids in CAP to hasten recovery
6. Zolendronate for osteopenia in women 65+
Practice Summary

Things not to Do:
1. Refer for cath if not yet up-titrated on antianginals
2. Aspirin for primary prevention in adults 70 or older, even if diabetic...
Thank you!

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