

PRIMARY CARE NEWSFLASH

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February 2017

MOC question

- A 74 year old man presents to your office to establish primary care. He is interested getting up to date for preventative care, and is interested in colon cancer screening. He hasn't seen a doctor in over 20 years and has never had a colonoscopy. He doesn't have any significant past medical history and takes no medications. His vitals and physical exam are unremarkable. He is a little uneasy about doing a colonoscopy because his friend had a perforation during his procedure and was hospitalized.
- Which of the following is true?:
 - (A): Colonoscopy is the only option for colon cancer screening according to USPTF.
 - (B): CT colonography is not a recommended method of screening according to USPTF.
 - (C): This patient is too old for preventative colon cancer screening and does not need to do it.
 - (D): All of the above are true.
 - (E): All of the above are false.

MOC question-answer

- Which of the following is true?:
 - (A): Colonoscopy is the only option for colon cancer screening according to USPTF.
 - (B): CT colonography is not a recommended method of screening according to USPTF.
 - (C): This patient is too old for preventative colon cancer screening and does not need to do this.
 - (D): All of the above are true.
 - (E): All of the above are false.
- A is not true because the USPTF 2016 update for colon cancer screening has testing options including annual gFOBT (guaiac based fecal occult blood testing), annual FIT (fecal immunochemical test), annual FIT-DNA (multi targeted stool DNA test), colonoscopy q 10 years, CT colonography q 5 years, Flexible sigmoidoscopy q 5 years, or flex sig q 10 years with annual FIT testing.
- B is not true because CT colonography is considered a reasonable screening method, albeit with some drawbacks.
- C is not true because USPTF gives an "A" recommendation (meaning that the service has high certainty for substantial benefit) for adults 50-75 years of age for colon cancer screening, and this man falls into this age group. USPTF gives a "C" recommendation for adults 76-85 years, meaning that the service should be selectively offered to individual patients based on professional judgement and patient preferences.
- D is false
- E is true and is the correct answer.
- Source: USPTF website.

Overview:

- This talk will focus on practice changing guidelines and articles for outpatient general internal medicine from 2016.
- There were a significant number of practice changing guideline recommendations from the CDC, USPTF, and articles.
- I will try to give a “take away” for each section.

CDC Guidelines for prescribing opioids for chronic pain, 2016

- Problems:
- 11% of adult population may have some form of chronic pain, but:
- In Utah, from 1997-2007 accidental OD/death from opioids increased 500%.
- From 1997-2007 opioid rx in Utah increased 6 fold.
- From 1990-2002, number of people using opioids for non-medical purposes annually (in U.S. as a whole) went from 600K to 2M (diversion).
- Opioid problems are both local and national.

Source: Utah Dept. of Health

CDC Guidelines for prescribing opioids for chronic pain, 2016

- CDC recommendations:
- For acute pain use lowest dose/shortest duration possible (as long term use often begins in such settings).
- For chronic pain nonopioid and nonpharmacologic treatment is preferred. If opioid therapy is begun it should be in combination with these treatments.
- Realistic treatment goals should be reviewed with the patients, and periodic reassessments for evidence of benefit should be performed, and plan for “exit strategy” should be in place (not easy to do in real life).
- Immediate release medications are preferred over extended release medications.

CDC Guidelines for prescribing opioids for chronic pain, 2016

- Avoid using >90 MME/day as risk of death increases substantially with higher doses. Take extra precautions with >50 MME/day. (30mg MSO4=30mg hydrocodone=20mg oxycodone.)
- Avoid benzodiazepines and opioids in combination. OD risk goes up substantially with this.
- Use state controlled substances monitoring program (DOPL) periodically.
- Use periodic urine drug screens.
- Offer or arrange treatment for “opioid use disorder”.

CDC Guidelines for prescribing opioids for chronic pain, 2016

- This narrative by the CDC I think has really helped doctors and the public understand better the risks of opioid therapy, and proper prescribing practices. I think it is a very important step in addressing the opioid epidemic. Seems to be a bit of a sea change.
- However, level of evidence for most sections is poor and it does not give much help on how to carry out recommendations.
- Even when one wants to treat pain, the evidence for opioid treatment in chronic noncancer pain is poor. Often, it does not work very well in my experience.

CDC Guidelines for prescribing opioids for chronic pain, 2016

- Consider naloxone coprescription (Annals 8/16/16) randomized controlled study-rx reduced opioid related ED visits 63% after one year. Certainly consider in patients taking higher morphine equivalent dosages (>50 MME).
- Source: CDC.gov.

USPTF colorectal cancer screening update 2016

- Problems: A significant number of patients do not want to screen for colon cancer with colonoscopy. Often cited concerns are unpleasant prep, logistics (e.g. “I have no friends nor family to take me home”), disgust with idea, etc.
- Should the healthy elderly (and unhealthy as well) be screened?

USPTF colorectal cancer screening update 2016

- USPTF recommends screening starting at age 50 until age 75 (“A” recommendation).
- Screening between age 76-85 should be an individual one (“C” recommendation).
- Acceptable screening methods include annual guaiac based FOBT, annual fecal immunochemical testing (FIT), FIT-DNA every 1-3 years, colonoscopy q10 years, CT colonography q5 years, flexible sigmoidoscopy q5 years, or combination annual FIT plus flexible sigmoidoscopy q 10 years.
- FIT-DNA, gFOBT, sigmoidoscopy are thought to be not as efficient screening methods but are acceptable.

USPTF colorectal cancer screening

- Update from 2008 adds screening options and deemphasizes specific screening approaches.
- Takeaway: I generally order colonoscopies q 10 years, but in some patients they do not want to proceed. In such cases I discuss the various options, primarily FIT. USPTF seems to be saying as an editorialist notes, that screening in any form is better than no screening at all. Many patients who will not do endoscopy are amenable to FIT.
- In patients who are >75 the guideline helps me discuss options for patients including not screening. If the patient I believe is in generally good health and has many years ahead of them, screening seems reasonable.

Statins for primary prevention, USPTF 2016

- Question: Can we identify high risk patients who will benefit from statins?
- Update from 2008 now give recs for statin rx:
- They recommend low to moderate dose statins for adults aged 40-75 w/o hx CVD with one or more risk factor (DM, HTN, HLD, smoking), and a 10 year CVD risk of 10% (using the 2013 ACC/AHA pooled cohort equation) or greater (evidence level B).
- They recommend low to moderate dose statin use selectively for those in those with risk between 7.5-10% (C recommendation).
- Insufficient evidence for recommendations for adults 21-39 and >75 years of age.

Statins for primary prevention, USPTF 2016

- Changes from 2008 are significant because the 2013 ACC/AHA guidelines greatly altered the clinical question from “which population should be screened for HLD” to “which populations should be prescribed statin therapy”?
- Takeaways:
- Definite push in last several years to treat patients for primary prevention by the guidelines they recommend for the four “statin benefit groups” (ASCVD, DM, LDL >190, high risk by calculation (>7.5%).
- I discuss uncertainties with patients older than 75 (of whom there are many in my practice) and frequently but not always will treat them based on individual discussion. USPTF recs correspond well with 2013 ACC/AHA guidelines.

SPRINT subgroup analysis JAMA 6/28/16

- Q: Should we treat the old old aggressively for HTN?
- SPRINT results posted in late 2015.
- This subgroup article focused on results of adults >75 years of age.
- At three years, they found a significantly lower rate of primary outcome (ASCVD events, death) in aggressive treatment group (SBP <120).
- Serious adverse events were higher in aggressive treatment group, but not statistically significant. Likewise also more adverse events in very frail subjects, but not statistically significant.
- Importantly for clinical use, this study excluded nursing home residents, DMII, heart failure, prior stroke.

SPRINT >75 y.o subgroup analysis

- Takeaway: More aggressive treatment of hypertension in the elderly seems to have significant benefit in reducing risk of death or ASCVD events. I do try to get BPs lower clinically, in discussion with patients when I think it appropriate.
- Clinical judgment must be used case to case in all patients but particularly patients who are very frail, with polypharmacy, and patients in the excluded groups (nursing home residents, CHF, DM, hx CVA), etc. There are lots of patients in real world composing the excluded groups. This makes generalizing findings difficult.

Breast cancer screening, USPTF 2016.

- Updates 2009 recommendations.
- Continues recommendation that women of 50-74 years of age should be screened biennially.
- Clarifies that the “C” recommendation for women aged 40-49 years (where there was the big controversy a few years ago) is not recommendation against mammography. C rec. signifies “moderate certainty of a net benefit for screening that is small in magnitude”). Decision should be an individual one and risk factors (e.g. first degree relative) should be considered.
- No change in recommendation of medium of screening, (e.g. film vs digital mammography, MRI, etc.)

Breast cancer screening, USPTF 2016.

- Continued conclusion that screening in women 75 years and older is insufficient.
- Takeaway-No major changes in recommendations. I discuss pro/con with women age 40-49 and also after 75. I think annual vs. biennial screening is acceptable in women age 50-74, but most do it annually as is the recommendation of the breast radiologists here at the University. I believe the breast CA specialists here feel that beginning screening at 40 is often best.

Change in BMD is an indicator of treatment related antifracture effect in clinical practice. Annals 10/4/16

- 6600 women >40 years old initiating osteoporosis tx with two DEXA scans in follow up with a mean interval of 4.5 years between scans.
- Women with a detectable decrease (as opposed to stable or increased BMD) in total hip BMD had an absolute increase of 2.9% and 5.5% for incidence of fracture at any site at 5 and 10 years.
- Women with detectable increase in hip BMD had a fracture risk decrease of 1.3% and 2.6% lower at 5 and 10 years.

Change in BMD is an indicator of treatment related antifracture effect in clinical practice. *Annals* 10/4/16

- Clinical takeaway: This provides a more definitive rationale to me for followup DEXA scan for reassessment of bone density. I think if the patient has continued statistically significant lower bone density on usual tx (bisphosphonates), I would consider alternative tx, e.g. teriparatide, etc.

Thanks!