

Five Things Physicians and Patients Should Question

1

Don't recommend daily home finger glucose testing in patients with Type 2 diabetes mellitus not using insulin.

Self-monitoring of blood glucose (SMBG) is an integral part of patient self-management in maintaining safe and target-driven glucose control in type 1 diabetes. However, there is no benefit to daily finger glucose testing in patients with type 2 diabetes mellitus who are not on insulin or medications associated with hypoglycemia, and there is negative economic impact and potential negative clinical impact of daily glucose testing. SMBG should be reserved for patients during the titration of their medication doses or during periods of changes in patients' diet and exercise routines.

2

Don't perform routine general health checks for asymptomatic adults.

Routine general health checks are office visits between a health professional and a patient exclusively for preventive counseling and screening tests. In contrast to office visits for acute illness, specific evidence-based preventive strategies, or chronic care management such as treatment of high blood pressure, regularly scheduled general health checks without a specific cause including the "health maintenance" annual visit, have not shown to be effective in reducing morbidity, mortality or hospitalization, while creating a potential for harm from unnecessary testing.

3

Don't perform routine pre-operative testing before low-risk surgical procedures.

Pre-operative assessment is expected before all surgical procedures. This assessment includes an appropriately directed and sufficiently comprehensive history and physical examination, and, in some cases, properly includes laboratory and other testing to help direct management and assess surgical risk. However, pre-operative testing for low-risk surgical procedures (such as cataract extraction) results in unnecessary delays and adds to significant avoidable costs and should be eliminated.

4

Don't recommend cancer screening in adults with life expectancy of less than 10 years.

Screening for cancer can be lifesaving in otherwise healthy at-risk patients. While screening tests lead to a mortality benefit, which emerges years after the test is performed, they expose patients to immediate potential harms. Patients with life expectancies of less than 10 years are unlikely to live long enough to derive the distant benefit from screening. However, these patients are in fact more likely to experience the harms since patients with limited life expectancy are more likely to be frail and more susceptible to complications of testing and treatments. Therefore the balance of potential benefits and harms does not favor recommending cancer screening in patients with life expectancies of less than 10 years.

5

Don't place, or leave in place, peripherally inserted central catheters for patient or provider convenience.

Peripherally inserted central catheters (or "PICCs") are commonly used devices in contemporary medical practice that are associated with two costly and potentially lethal health care-acquired complications: central-line associated bloodstream infection (CLABSI) and venous thromboembolism (VTE). Given the clinical and economic consequences of these complications, placement of PICCs should be limited to acceptable indications (long-term intravenous antibiotics, total parenteral nutrition, chemotherapy and frequent blood draws). PICCs should be promptly removed when acceptable indications for their use ends.

How This List Was Created

An ad hoc committee of the Society of General Internal Medicine (SGIM) was impaneled, taking advantage of the clinical expertise of members from the existing Clinical Practice and the Evidence-Based Medicine Committees within the Society. Members of the ad hoc committee were then solicited to determine possible topics for consideration. The topics chosen were selected to meet the goals of the *Choosing Wisely*[®] campaign, utilizing the unique clinical perspective of members of the Society in ambulatory General Medicine as well as hospital-based practice. The final topics were selected by a vote of committee members based on the strength of the existing evidence, the unique standing members of the Society have in addressing the clinical topics selected, as well as contributions the recommendations would make in terms of patient safety, quality and economic impact. The final recommendations were approved by the governing Council of SGIM.

For SGIM's disclosure and conflict of interest policy, please visit www.sgim.org.

Sources

- American Diabetes Association. Standards of medical care in diabetes. *Diabetes Care*. 2013;36 Suppl1:S11-66.

Karter AJ, Parker MM, Moffet HH, Spence MM, Chan J, Ettner SL, Selby JV. Longitudinal study of new and prevalent use of self-monitoring of blood glucose. *Diabetes Care*. 2006;29:1757-63.

Harris MI. Frequency of blood glucose monitoring in relation to glycemic control in patients with type 2 diabetes. *Diabetes Care*. 2001;24:979-82.

Malanda UL, Welschen LMC, Riphagen II, Dekker JM, Nijpels G, Bot SDM. Self-monitoring of blood glucose in patients with type 2 diabetes mellitus who are not using insulin. *Cochrane Database of Systematic Reviews* 2012;1:1-88.

O'Kane MJ, Bunting B, Copeland M, Coates VE; ESMON study group. Efficacy of self-monitoring of blood glucose in patients with newly diagnosed type 2 diabetes (ESMON study): randomised controlled trial. *BMJ*. 2008;336:1174-7.

Peel E, Douglas M, Lawton J. Self-monitoring of blood glucose in type2 diabetes: longitudinal qualitative study of patients' perspectives. *BMJ*. 2007;335:493-8.

Cameron C, Coyle D, Ur E, Klarenback S. Cost-effectiveness of self-monitoring of blood glucose in patients with type 2 diabetes mellitus managed without insulin. *CMAJ*. 2010;182(1):28-34.
- Krogstoll LT, Jorgensen KJ, Gronhoj Larsen C, Gotzsche PC. General health checks in adults for reducing morbidity and mortality from disease: Cochrane systematic review and meta-analysis. *BMJ*. 2012;345:e7191.

Boulware LE, Marinopoulos S, Phillips KA, Hwang CW, Maynor K, Merenstein D, Wilson RF, Barnes GJ, Bass EB, Powe NR, Daumit GL. Systematic review: the value of the periodic health evaluation. *Ann Intern Med*. 2007 Feb 20;146(4):289-300.

United States Preventive Services Task Force. Guide to clinical preventative services: an assessment of the effectiveness of 169 interventions. Baltimore: Williams & Wilkins, 1989.

Canadian Task Force on the Periodic Health Examination. The periodic health examination. *CMAJ*. 1979;121(9):1193-254.
- Keay L, Lindsley K, Tielsch J, Katz J, Schein O. Routine preoperative medical testing for cataract surgery. *Cochrane Database Syst Rev*. 2012 Mar 14;3:CD007293.

Czosi-Murray C, Jones ML, McCabe C, Claxton K, Oluboyede Y, Roberts J, Nicholl JP, Rees A, Reilly CS, Young D, Fleming T. What is the value of routinely testing full blood count, electrolytes and urea, and pulmonary function tests before elective surgery in patients with no apparent clinical indication and in subgroups of patients with common comorbidities: a systematic review of the clinical and cost-effective literature. *Health Technol Assess*. 2012 Dec;16(50):1-159.

Fritsch G, Flamm M, Hepner DL, Panisch S, Seer J, Soennichsen A. Abnormal pre-operative tests, pathologic findings of medical history, and their predictive value for perioperative complications. *Acta Anaesthesiol Scand*. 2012;56(3):339-50.

Benarroch-Gampel J, Sheffield KM, Duncan CB, Brown KM, Han Y, Townsend CM Jr, Riall TS. Preoperative laboratory testing in patients undergoing elective, low-risk ambulatory surgery. *Ann Surg*. 2012 Sep;256(3):518-28.

Van Veen JJ, Spahn DR, Makris M. Routine preoperative coagulation tests: an outdated practice? *Br J Anaesth*. 2011;106:1-3.

Chung F, Yuan H, Yin L, Vairavanathan S, Wong DT. Elimination of preoperative testing in ambulatory surgery. *Anesth Analg*. 2009 Feb;108(2):467-75.

Apfelbaum JL, Connis RT and the Committee on Standards and Practice Parameters. Practice advisory for preanesthesia evaluation: an updated report by the American Society of Anesthesiologists Task Force on Preanesthesia Evaluation. *Anesthesiology*. 2012 Mar;116:522-38.
- Lee SJ, Boscardin WJ, Stijacic-Cenzer I, Conell-Price J, O'Brien S, Walter LC. Time lag to benefit after screening for breast and colorectal cancer: meta-analysis of survival data from the United States, Sweden, United Kingdom, and Denmark. *BMJ*. 2012 Jan 8;345:e8441.

Moyer VA, U.S. Preventive Services Task Force. Screening for prostate cancer: U.S. Preventive Services Task Force Recommendation Statement. *Ann Intern Med*. 2012 Jul 17;157(2):120-34.

Schröder FS, Hugosson J, Roobol, MJ, Tammela TL, Ciatto S, Nelen V, Kwiatkowski M, Lujan M, Lilja H, Zappa M, Denis LJ, Recker F, Páez A, Mänttinen L, Bangma CH, Aus G, Carlsson S, Villers A, Rebillard X, van der Kwast T, Kujala PM, Blijenberg BG, Stenman UH, Huber A, Taari K, Hakama M, Moss SM, de Koning HJ, Auvinen A; ERSPC Investigators. Prostate-cancer mortality at 11 years of follow-up. *N Eng J Med*. 2012 Mar 15;366(11):981-90.

Whitlock EP, Lin JS, Liles E, Beil TL, Fu R. Screening for colon cancer: a targeted updated systematic review for the U.S. Preventive Services Task Force. *Ann Intern Med*. 2008 Nov 4;149(9):638-58.

Walter LC and Covinsky KE. Cancer screening in elderly patients: a framework for individualized decision making. *JAMA*. 2001 Jun 6;285(21):2750-6.
- Chopra V, Anand S, Krein SL, Chenoweth C, Saint S. Bloodstream infection, venous thrombosis, and peripherally inserted central catheters: reappraising the evidence. *Am J Med*. 2012;125(8):733-74.

Chopra V, Anand S, Hickner A, Buist M, Rogers MA, Saint S, Flanders SA. Risk of venous thromboembolism associated with peripherally inserted central catheters: a systematic review and meta-analysis. *Lancet*. 2013 May 17; pii: S0140-6736(13)60592-9. ePub ahead of print.

Safdar N, Maki DG. Risk of catheter-related bloodstream infection with peripherally inserted central venous catheters used in hospitalized patients. *Chest*. 2005;128(2):489-95.

Tejedor SC, Tong D, Stein J, Payne C, Dressler D, Xue W, Steinberg JP. Temporary central venous catheter utilization patterns in a large tertiary care center: tracking the "Idle central venous catheter". *Infect Control Hosp Epidemiol*. 2012 Jan;33(1):50-57.

About the ABIM Foundation

The mission of the ABIM Foundation is to advance medical professionalism to improve the health care system. We achieve this by collaborating with physicians and physician leaders, medical trainees, health care delivery systems, payers, policymakers, consumer organizations and patients to foster a shared understanding of professionalism and how they can adopt the tenets of professionalism in practice.



To learn more about the ABIM Foundation, visit www.abimfoundation.org.

About the Society of General Internal Medicine

The membership of the Society of General Internal Medicine (SGIM) consists of academic general internal medicine faculty practicing, teaching and conducting research in outpatient settings as well as in our nation's teaching hospitals. As leading teachers of the next generation of physicians, we are committed to moving the practice of medicine to a more evidence-based approach. We are deeply committed to using science to improve our knowledge-base so that our patients can receive the best treatments, the optimal prevention care and the highest quality of life. We believe that the *Choosing Wisely* campaign mirrors these same commitments to the evidence-based practice of medicine for the benefit of our patients.



To learn more about the SGIM, visit www.sgim.org.

For more information or to see other lists of Five Things Physicians and Patients Should Question, visit www.choosingwisely.org.