UFRGS
UNIVERSIDADE FEDERAL DO RIO GRANDE DO SUL

Unidade de Geriatria
HCPA - UFRGS

CHOOSING WISELY BRASIL

II Fórum Fórum de Geriatria do Conselho Federal de Medicina

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Grupo de Trabalho ***Chossing Wisely*** **-** HCPA

ALL-NITE DRIVE-THRU
SCREENING CLINIC
I'm obliged to inform you: You have the right to remain anxious
Anything you say will be used to further test you
If you do not already have a diagnosis one will be provided for you
Statistically-funny.blogspot.com

Choosing Wisely
escolhas sensatas em saúde
MAIS
NEM SEMPRE
É MELHOR.
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CENÁRIOS

1. Diagnóstico de condição sem repercussão clínica ou prognóstica.
2. Não há tratamento que mude o PROGNÓSTICO ou Curso Clínico
3. Tratamento gera risco iatrogênico maior do que benefício clínico
4. Monitoramento rígido leva a potencial dano

Causas

- Hábito médico
- Medicina defensiva
- Demanda do paciente
- Incentivo financeiro
- Disponibilidade – “paciente não paga”
- Sensação de segurança
- Ilusão Terapêutica

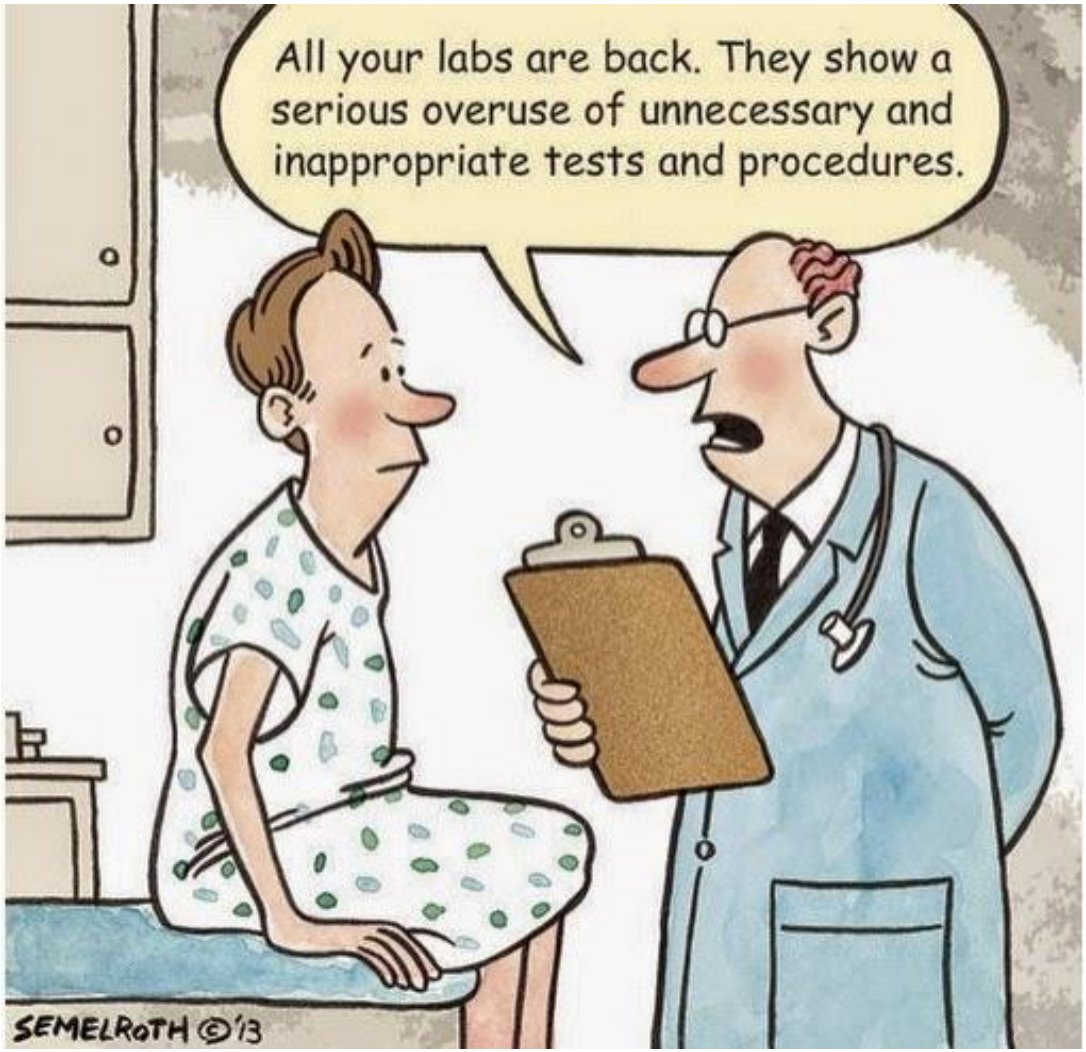
Scott I A, Internal Medicine Journal, 2013

HOSPITAL DE CLÍNICAS PORTO ALEGRE RS

Consequências

- ASSINTOMÁTICOS DOENTES
- Tratamentos nocivos sem mudar prognóstico
- Radiação – 2 TCs abd contraste = Hiroshima
- Erro diagnóstico (perda do foco real)
- Ansiedade – Angústia desnecessária
- DANO indireto
- DANO DIRETO

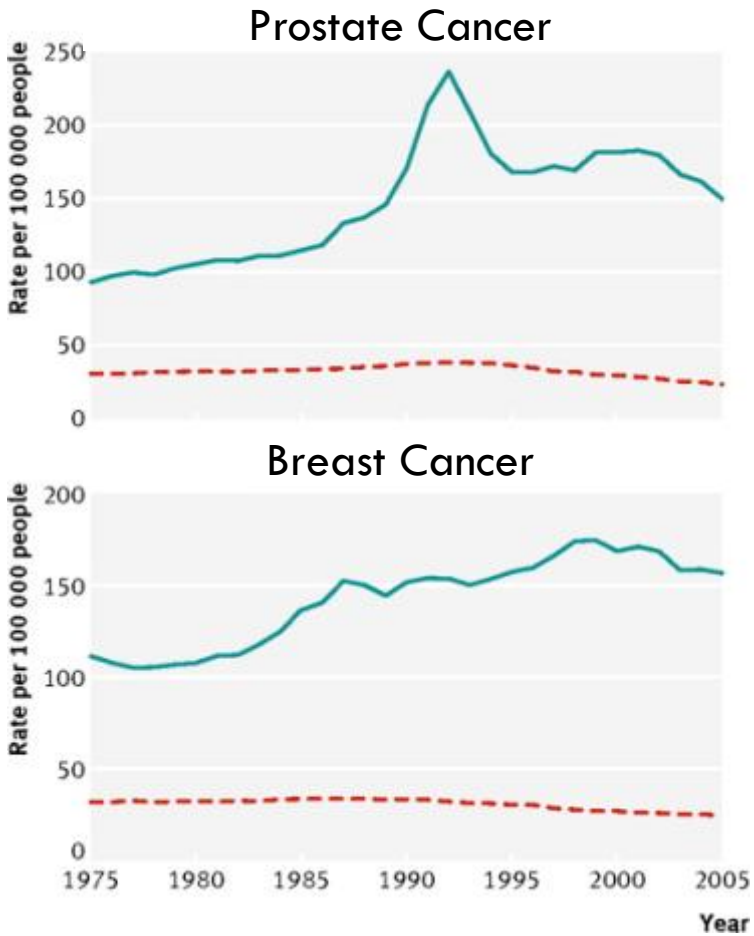
Scott I A, Internal Medicine Journal, 2013


All your labs are back. They show a serious overuse of unnecessary and inappropriate tests and procedures.
SEMELROTH ©'13

EXEMPLOS

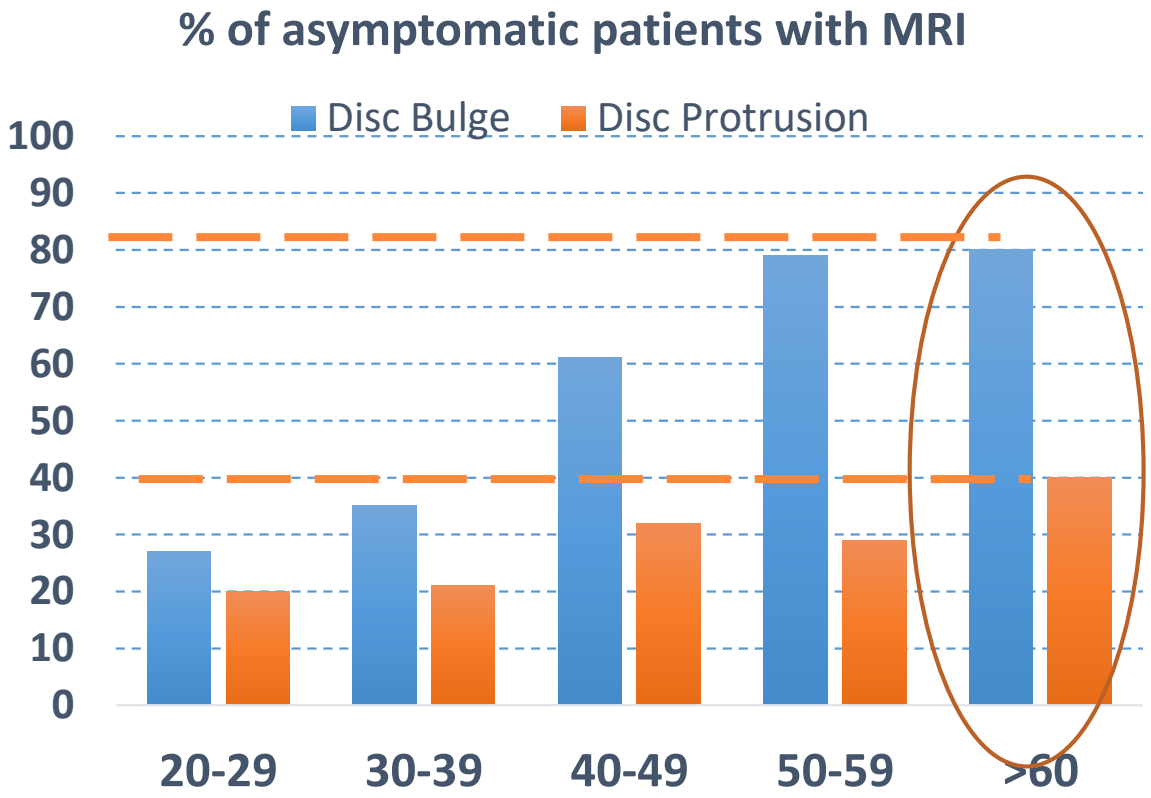
A. Overdetection: 4 cancers

An epidemic of diagnosis, not an epidemic of cancer!



Source: AIHW

Incidentalomas in MRI of spine



Disc protrusion in 24 year old with no back pain

Jensen MC, NEJM, 1994

PERCUTANEOUS ENDOSCOPIC GASTROSTOMY (PEG) TUBE FEEDING OF NURSING HOME RESIDENTS IS NOT ASSOCIATED WITH IMPROVED BODY COMPOSITION PARAMETERS

S. KIMYAGAROV, D. TURGEMAN, Y. FLEISSIG, R. KLID, B. KOPEL, A. ADUNSKY

adunger1@sheba.health.gov.il

Body composition and nutrient intake, by feeding modality of dysphagic residents (60pts.)

Characteristics	Orally fed (21)	PEG-fed (39)	p
Age	84.6±6.9	84.1±8.5	NS
Body mass index (kg/m2)	23.5±3.7	24.2±3.1	NS
Fat free mass index (kg/m2)	15.8±2.7	15.7±3.0	NS
Fat mass index (kg/m2)	7.5±4.3	8.5±3.0	NS
Skeletal muscle mass index (kg/m2)	7.5±1.4	7.2±1.4	NS
Basal metabolic rate	1207±152	1198±161	NS
Daily protein intake	57.4±10.3	72.3±9.9	<0.001
Daily energy intake	1298±304	1585±329	<0.001
Daily energy intake/basal metabolic rate	1.0±0.2	1.3±0.4	0.012
Daily protein intake/body weight	0.9±0.2	1.2±0.3	0.002
Daily energy intake/body weight	23.1±6.9	31.8±9.4	<0.001
Protein related energy intake (%)	16.7±1.1	16.1±0.9	0.002
Nitrogen balance	-1.7±2.6	0.1±2.6	0.012

The Journal of Nutrition, Health & Aging©
Volume 17, Number 2, 2013

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American C *e Committee*

POSIT

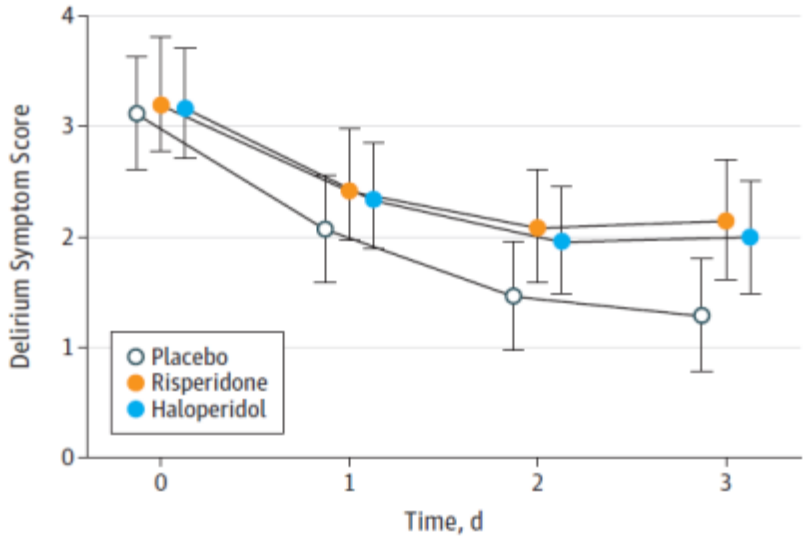
1. Fee adults
with a uld be
offerec feeding
is at l mes of
death, l com-
fort. T ter use
of physical and chemical restraints, greater healthcare use due to tube-related complications, and development of new pressure ulcers.

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;

Figure 2. Secondary Multivariable Mixed-Model Analysis of Delirium

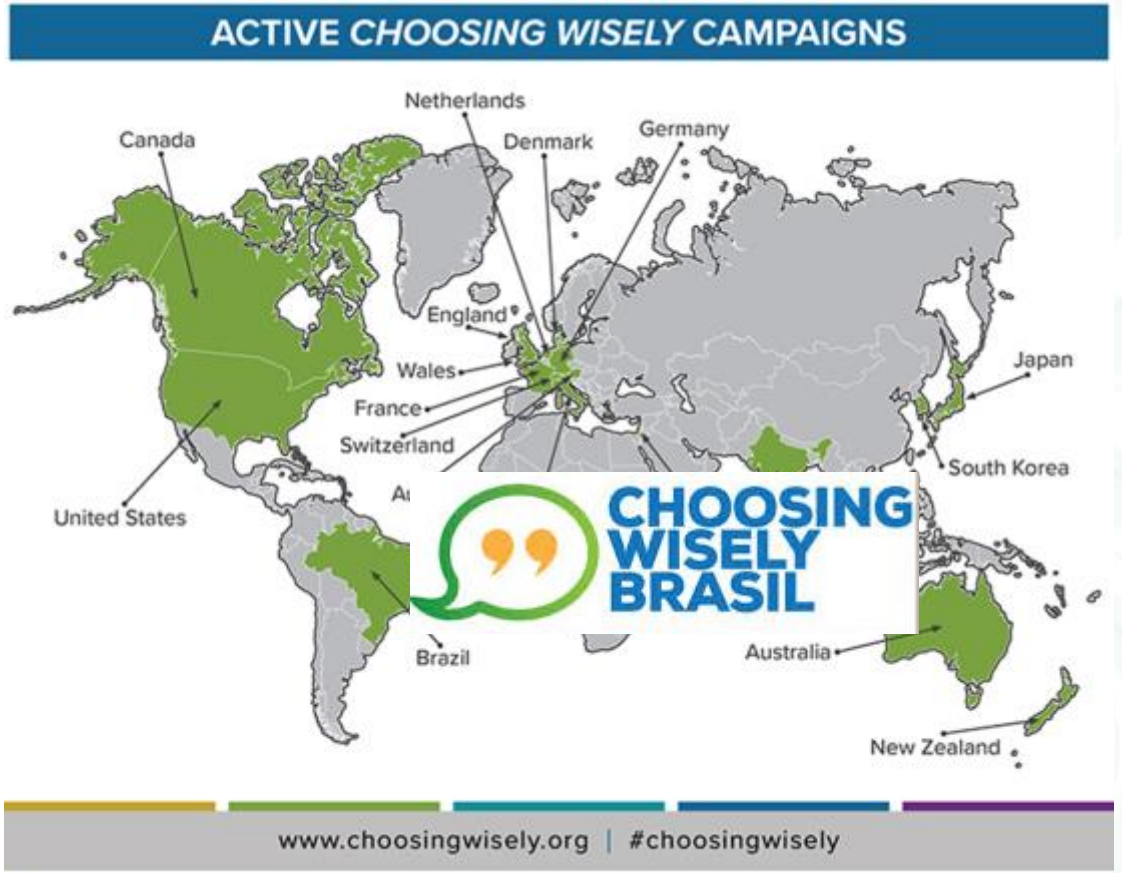


No. at risk				
Placebo	84	63	59	55
Risperidone	82	58	49	39
Haloperidol	81	64	55	51

JAMA Intern Med. doi:10.1001/jamainternmed.2016.7491
Published online December 5, 2016.

Como Agir?

O QUE É A CHOOSING WISELY?

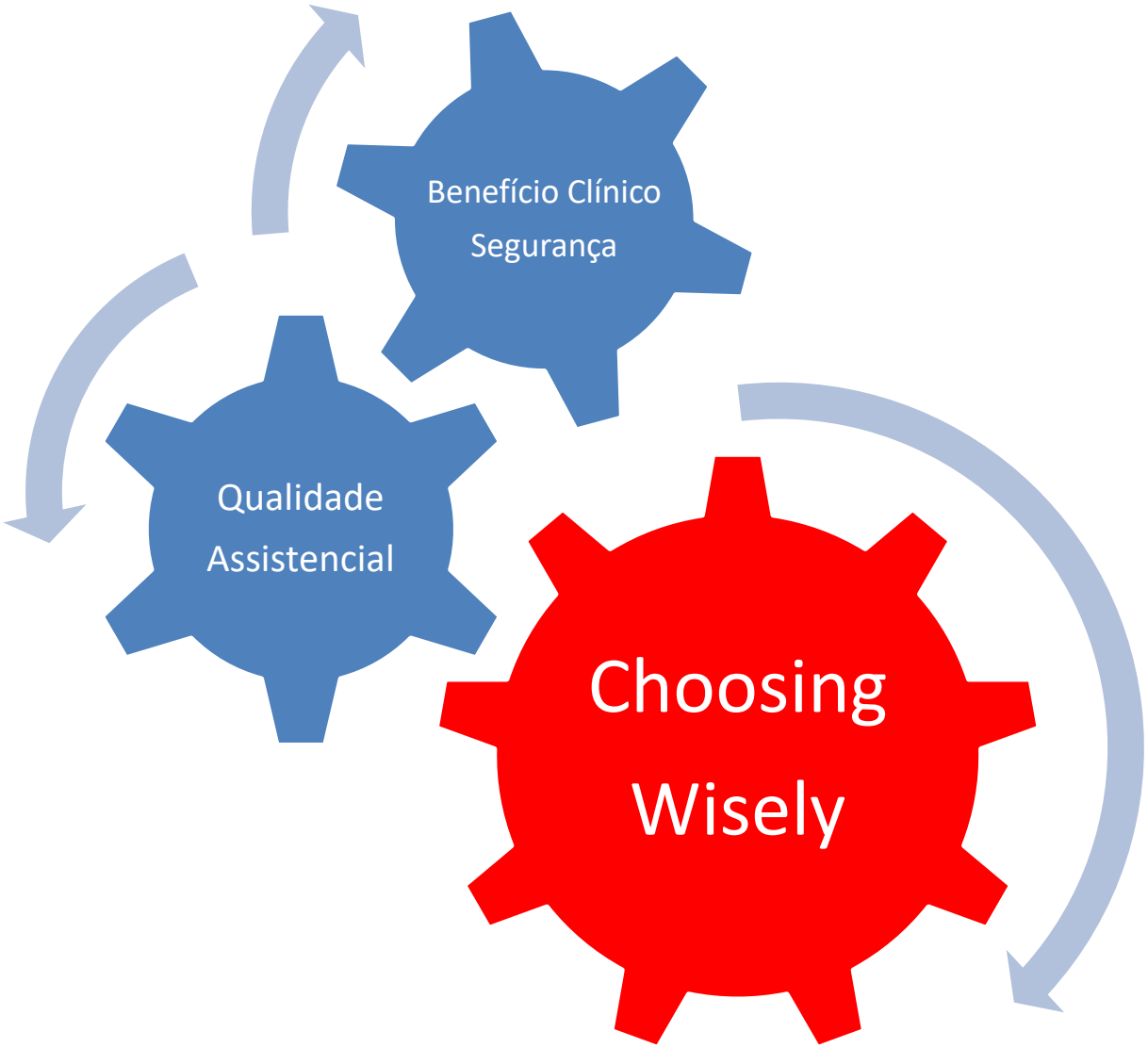


*Support for this program was provided by the Robert Wood Johnson Foundation. The views expressed here do not necessarily reflect the views of the Foundation.

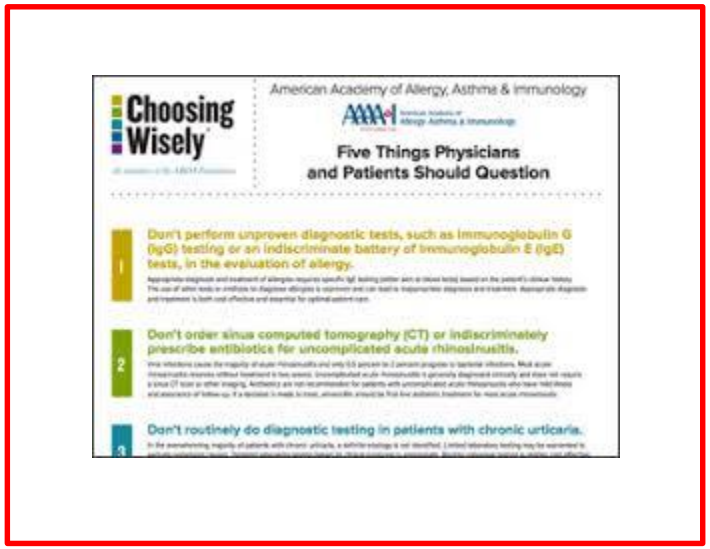
OBJETIVOS

Promover a conversação entre clínicos e pacientes:

1. Embasamento crítico em evidência
2. NÃO substituir diretrizes
3. Evitar dano iatrogênico
4. Focar no verdadeiramente necessário


Benefício Clínico
Segurança
Qualidade
Assistencial
Choosing
Wisely

COMO FAZER?



Choosing Wisely

American Academy of Allergy, Asthma & Immunology

Five Things Physicians and Patients Should Question

1 Don't perform unproven diagnostic tests, such as immunoglobulin G (IgG) testing or an indiscriminate battery of immunoglobulin E (IgE) tests, in the evaluation of allergy.

2 Don't order sinus computed tomography (CT) or indiscriminately prescribe antibiotics for uncomplicated acute rhinosinusitis.

3 Don't routinely do diagnostic testing in patients with chronic urticaria.

Choosing Wisely Brasil®

Academia Brasileira de Medicina Hospitalar

Top Five ABMH

Recomendações Choosing Wisely Brasil da Medicina Hospitalar

1. Não indique ou mantenha sonda vesical de demora em pacientes internados sem indicação específica.
2. Não solicite exames laboratoriais ou métodos de imagem seriados "de rotina" em pacientes hospitalizados estáveis clinicamente.
3. Não transfunda concentrado de hemácias com base em limiares arbitrários de hematócrito ou hemoglobina na ausência de sintomas, doença coronariana ativa, insuficiência cardíaca ou AVC.
4. Não utilize benzodiazepínicos ou outros sedativos-hipnóticos em idosos como primeira escolha para insônia, agitação ou delirium.
5. Não prescreva medicações (inibidor de bomba de prótons ou bloqueador H2) para profilaxia de úlcera de estresse para pacientes internados sem uma indicação precisa.

www.abmh.med.br

CHOOSING WISELY BRASIL

Departamento de Tireoide

SBEM Sociedade Brasileira de Endocrinologia e Metabologia

TOP FIVE TIREOIDE SBEM

Recomendações Choosing Wisely Brasil do Departamento de Tireoide da Sociedade Brasileira de Endocrinologia e Metabologia

1 Não solicite T3 reverso (rT3) na avaliação de função tireoideana.

O T3 reverso é proveniente da inativação de T4, que ocorre predominantemente através enzima deiodinase tipo 3. É um hormônio inativo e a sua dosagem não reflete a função tireoideana. Desta forma, a sua dosagem tem indicações muito específicas (a maioria dela em cenário de pesquisa) e não deve ser feita na avaliação da função tireoideana.

2 Não solicite tireoglobulina sérica na avaliação inicial de nódulos de tireoide.

A tireoglobulina, por ser uma proteína tecido específica, é um dos principais parâmetros no seguimento dos pacientes com câncer de tireoide já submetidos a cirurgia. Os níveis séricos de tireoglobulina podem estar aumentados em diferentes doenças da tireoide (benignas e/ou malignas). Dessa forma, a dosagem da tireoglobulina sérica não adiciona informações sobre a natureza de nódulo de tireoide, e não tem papel no rastreamento de câncer de tireoide.

3 Não utilize marcadores moleculares na avaliação inicial de pacientes com nódulo de tireoide.

A citologia de material de punção aspirativa com agulha fina (PAAF) é o método mais preciso e de baixo custo para avaliar nódulos tireoidianos. Marcadores moleculares só devem ser usados se melhorarem a tomada de decisão clínica. A utilidade de um teste molecular deve ser fundamentada em fortes evidências comprovando que o uso do marcador melhora a tomada de decisão o suficiente para justificar a sua incorporação na prática clínica. Esse não é o cenário de nódulos de tireoide, que tem sua natureza esclarecida em cerca de 85% dos pacientes submetidos a PAAF. O papel dos marcadores moleculares pode ser justificado em alguns casos de nódulos sem diagnóstico definido na PAAF, respeitando o contexto do paciente e do cenário de saúde no qual está inserido.

4 Não utilize triiodotironina (LT3), isolado ou em associação com levotiroxina (LT4), no tratamento de hipotireoidismo.

Apesar da tiroide produzir pequenas quantidades de T3, não existem evidencias de que o tratamento do hipotireoidismo deva incluir T3 procurando melhora dos sintomas. A levotiroxina é barata, tem rápida absorção intestinal e tem uma meia vida longa (7 dias) o que permite tomadas únicas diárias. Isto promove uma estabilidade plasmática de T3 e T4. A levotiroxina depende da deiodinação tecidual para conversão em triiodotironina. A triodotironina tem uma meia vida curta e necessitaria múltiplas tomadas diárias. Apesar de evidências em animais que a combinação de levotiroxina e triiodotironina pode ser superior a levotiroxina isolada, não há evidência clara em humanos disto, por isto a combinação não é recomendada de rotina.

5 Não repita exames de auto-anticorpos [anti-tireoperoxidase (Anti-TPO) e/ou anti-tireoglobulina] no seguimento de pacientes com hipotireoidismo por tireoidite de Hashimoto com exame anterior positivo.

Uma vez positivos os auto-anticorpos [antitireoperoxidase (anti-TPO) e/ou antitireoglobulina], já esta definido a etiologia do hipotireoidismo, não havendo qualquer necessidade de repeti-los.

Choosing Wisely
escolhas sensatas em saúde
QUALIDADE
É PENSAR NO
PACIENTE.
Recomendação do Serviço de Patologia Clínica:
NÃO PEÇA BIOQUÍMICA BÁSICA E HEMOGRAMA DIARIAMENTE EM PACIENTES INTERNADOS COM ESTABILIDADE CLÍNICA.
Pacotes de exames diários aumentam a taxa de falsos positivos, causam dor e desconforto no paciente e geralmente não geram resultados que modifiquem condutas clínicas.
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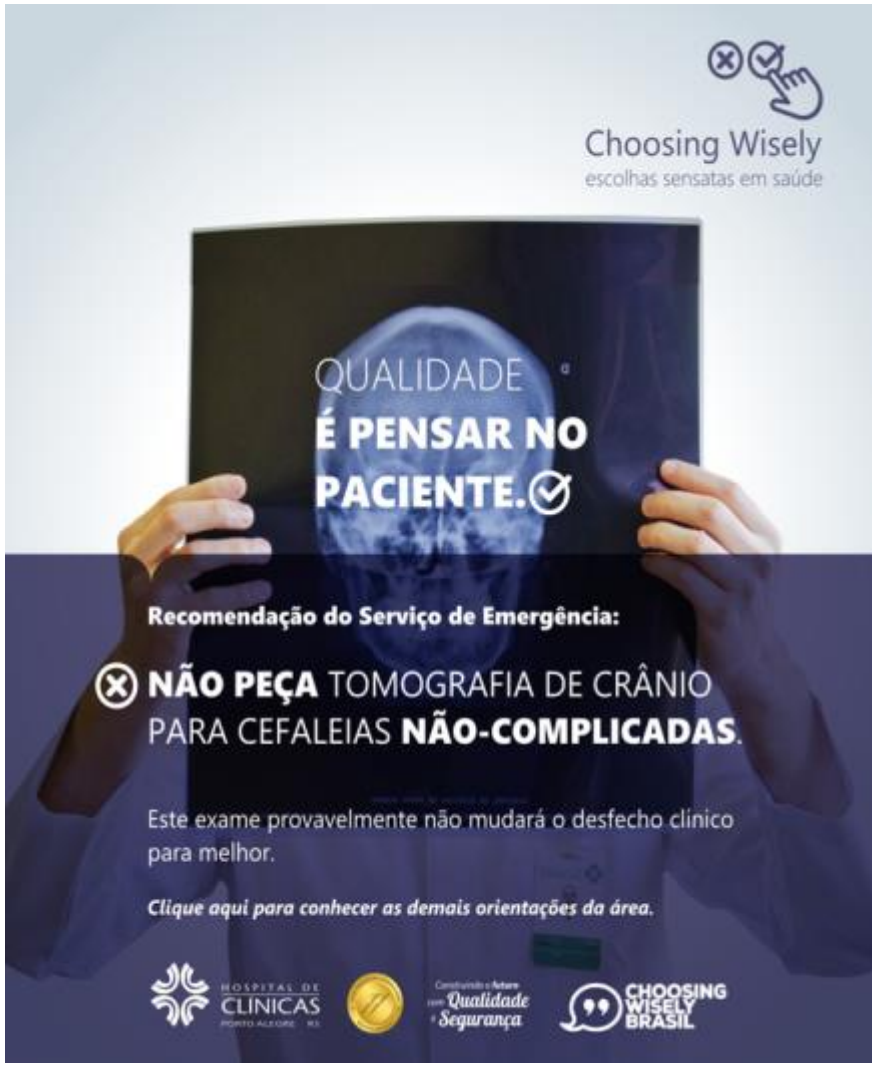
Choosing Wisely
escolhas sensatas em saúde
QUALIDADE
É PENSAR NO
PACIENTE.
Recomendação do Serviço de Emergência:
NÃO PEÇA TOMOGRAFIA DE CRÂNIO PARA CEFALEIAS NÃO-COMPLICADAS.
Este exame provavelmente não mudará o desfecho clínico para melhor.
Clique aqui para conhecer as demais orientações da área.
HOSPITAL DE CLÍNICAS
Qualidade e Segurança
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Choosing Wisely®

An initiative of the ABIM Foundation

American Geriatrics Society

AGS Geriatrics Healthcare Professionals

Leading Change. Improving Care for Older Adults.

Ten Things Clinicians and Patients Should Question

http://www.choosingwisely.org/societies/american-geriatrics-society/

1 Don't recommend percutaneous feeding tubes in patients with advanced dementia; instead offer oral assisted feeding.

Careful hand feeding for patients with severe dementia is at least as good as tube feeding for the outcomes of death, aspiration pneumonia, functional status and patient comfort. Food is the preferred nutrient. Tube feeding is associated with agitation, increased use of physical and chemical restraints and worsening pressure ulcers.

2 Don't use antipsychotics as the first choice to treat behavioral and psychological symptoms of dementia.

People with dementia often exhibit aggression, resistance to care and other challenging or disruptive behaviors. In such instances, antipsychotic medicines are often prescribed, but they provide limited and inconsistent benefits, while posing risks, including over sedation, cognitive worsening and increased likelihood of falls, strokes and mortality. Use of these drugs in patients with dementia should be limited to cases where non-pharmacologic measures have failed and patients pose an imminent threat to themselves or others. Identifying and addressing causes of behavior change can make drug treatment unnecessary.

3 Avoid using medications other than metformin to achieve hemoglobin A1c <7.5% in most older adults; moderate control is generally better.

There is no evidence that using medications to achieve tight glycemic control in most older adults with type 2 diabetes is beneficial. Among non-older adults, except for long-term reductions in myocardial infarction and mortality with metformin, using medications to achieve glycated hemoglobin levels less than 7% is associated with harms, including higher mortality rates. Tight control has been consistently shown to produce higher rates of hypoglycemia in older adults. Given the long time frame to achieve theorized microvascular benefits of tight control, glycemic targets should reflect patient goals, health status and life expectancy. Reasonable glycemic targets would be 7.0 – 7.5% in healthy older adults with long life expectancy, 7.5 – 8.0% in those with moderate comorbidity and a life expectancy < 10 years, and 8.0 – 9.0% in those with multiple morbidities and shorter life expectancy.

4 Don't use benzodiazepines or other sedative-hypnotics in older adults as first choice for insomnia, agitation or delirium.

Large-scale studies consistently show that the risk of motor vehicle accidents, falls and hip fractures leading to hospitalization and death can more than double in older adults taking benzodiazepines and other sedative-hypnotics. Older patients, their caregivers and their providers should recognize these potential harms when considering treatment strategies for insomnia, agitation or delirium. Use of benzodiazepines should be reserved for alcohol withdrawal symptoms/delirium tremens or severe generalized anxiety disorder unresponsive to other therapies.

5 Don't use antimicrobials to treat bacteriuria in older adults unless specific urinary tract symptoms are present.

Cohort studies have found no adverse outcomes for older men or women associated with asymptomatic bacteriuria. Antimicrobial treatment studies for asymptomatic bacteriuria in older adults demonstrate no benefits and show increased adverse antimicrobial effects. Consensus criteria has been developed to characterize the specific clinical symptoms that, when associated with bacteriuria, define urinary tract infection. Screening for and treatment of asymptomatic bacteriuria is recommended before urologic procedures for which mucosal bleeding is anticipated.

6 Don't prescribe cholinesterase inhibitors for dementia without periodic assessment for perceived cognitive benefits and adverse gastrointestinal effects.

Although some randomized control trials suggest that cholinesterase inhibitors may improve cognitive testing results, it is unclear whether these changes are clinically meaningful. It is uncertain whether these medicines delay institutionalization, improve quality of life or lessen caregiver burden. No studies have investigated benefits beyond a year nor clarified the risks and benefits of long-term therapy. Clinicians, patients and their caregivers should discuss treatment goals of practical value that can be easily assessed and the nature and likelihood of adverse effects before beginning a trial of Cholinesterase inhibitors. If the desired effects (including stabilization of cognition) are not perceived within 12 weeks or so, the inhibitors should be discontinued.

7 Don't recommend screening for breast, colorectal, prostate or lung cancer without considering life expectancy and the risks of testing, overdiagnosis and overtreatment.

Cancer screening is associated with short-term risks, including complications from testing, overdiagnosis and treatment of tumors that would not have led to symptoms. For prostate cancer, 1,055 older men would need to be screened and 37 would need to be treated to avoid one death in 11 years. For breast and colorectal cancer, 1,000 older adults would need to be screened to prevent one death in 10 years. For lung cancer, much of the evidence for benefit from low dose CT screening for smokers is from healthier, younger patients under age 65. Further, although screening 1,000 persons would avoid four lung cancer deaths in six years, 273 persons would have an abnormal result requiring 36 to get an invasive procedure with eight persons suffering complications.

8 Avoid using prescription appetite stimulants or high-calorie supplements for treatment of anorexia or cachexia in older adults; instead, optimize social supports, discontinue medications that may interfere with eating, provide appealing food and feeding assistance, and clarify patient goals and expectations.

Unintentional weight loss is a common problem for medically ill or frail elderly. Although high-calorie supplements increase weight in older people, there is no evidence that they affect other important clinical outcomes, such as quality of life, mood, functional status or survival. Use of megestrol acetate results in minimal improvements in appetite and weight gain, no improvement in quality of life or survival, and increased risk of thrombotic events, fluid retention and death. In patients who take megestrol acetate, one in 12 will have an increase in weight and one in 23 will have an adverse event leading to death. The 2012 AGS Beers criteria lists megestrol acetate and cyproheptadine as medications to avoid in older adults. Systematic reviews of cannabinoids, dietary polyunsaturated fatty acids (DHA and EPA), thalidomide and anabolic steroids have not identified adequate evidence for the efficacy and safety of these agents for weight gain. Mirtazapine is likely to cause weight gain or increased appetite when used to treat depression, but there is little evidence to support its use to promote appetite and weight gain in the absence of depression.

9 Don't prescribe a medication without conducting a drug regimen review.

Older patients disproportionately use more prescription and non-prescription drugs than other populations, increasing the risk for side effects and inappropriate prescribing. Polypharmacy may lead to diminished adherence, adverse drug reactions and increased risk of cognitive impairment, falls and functional decline. Medication review identifies high-risk medications, drug interactions and those continued beyond their indication. Additionally, medication review elucidates unnecessary medications and underuse of medications, and may reduce medication burden. Annual review of medications is an indicator for quality prescribing in vulnerable elderly.

10 Don't use physical restraints to manage behavioral symptoms of hospitalized older adults with delirium.

Persons with delirium may display behaviors that risk injury or interference with treatment. There is little evidence to support the effectiveness of physical restraints in these situations. Physical restraints can lead to serious injury or death and may worsen agitation and delirium. Effective alternatives include strategies to prevent and treat delirium, identification and management of conditions causing patient discomfort, environmental modifications to promote orientation and effective sleep-wake cycles, frequent family contact and supportive interaction with staff. Nursing educational initiatives and innovative models of practice have been shown to be effective in implementing a restraint-free approach to patients with delirium. This approach includes continuous observation; trying re-orientation once, and if not effective, not continuing; observing behavior to obtain clues about patients' needs; discontinuing and/or hiding unnecessary medical monitoring devices or IVs; and avoiding short-term memory questions to limit patient agitation. Pharmacological interventions are occasionally utilized after evaluation by a medical provider at the bedside, if a patient presents harm to him or herself or others. If physical restraints are used, they should only be used as a last resort, in the least-restrictive manner, and for the shortest possible time.

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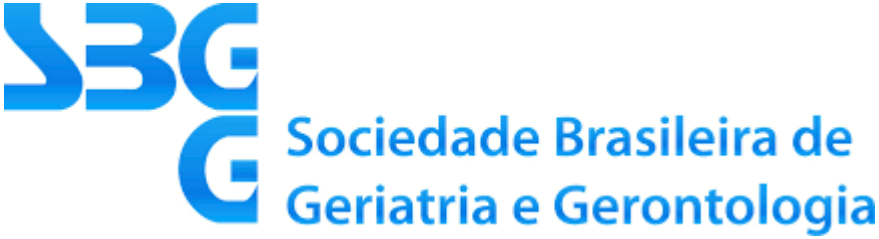
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