Choosing wisely **aneb vybírej moudře ...v praxi ČR?**

Dan Rakušan, Jiří Cyrany, Petr Grenar, Radovan Malý, Jiří Nový

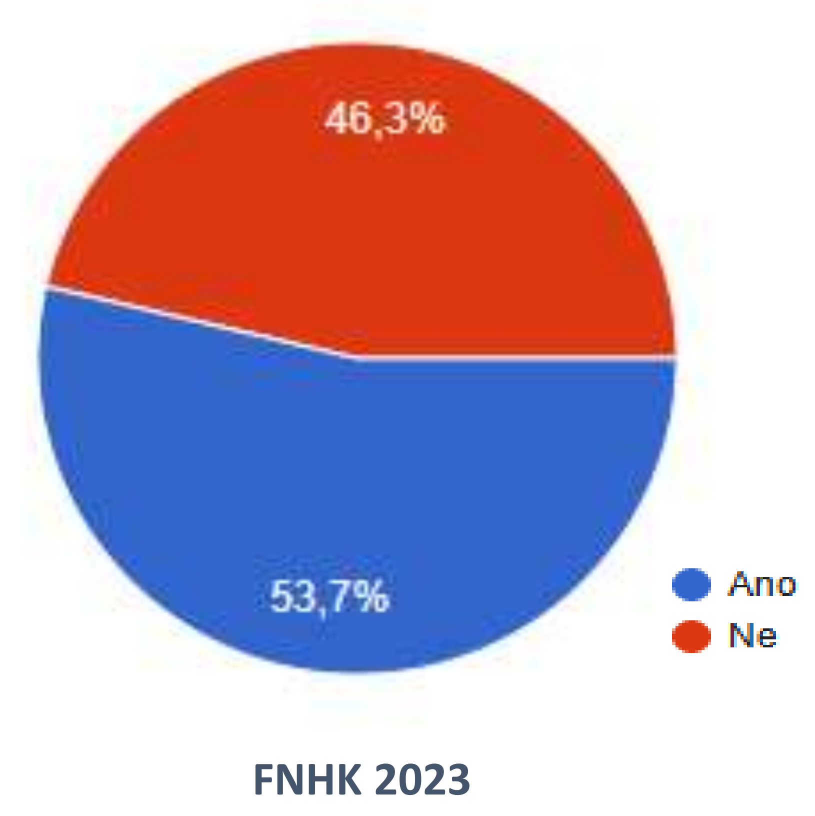
ANKETA Choosing Wisely ve FNHK

- dotazník Choosing Wisely ve FNHK 2023
- květen / červen 2023
- 41 respondentů (lékaři interních oborů FNHK)

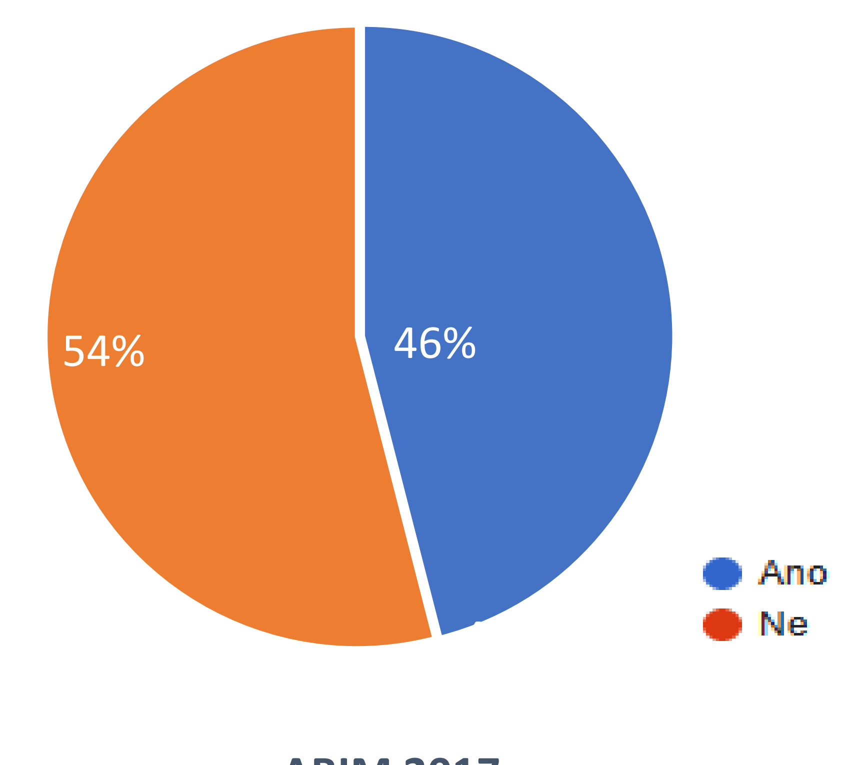
- dotazník Choosing wisely při ABIM 2017
- 610 respondentů (310 lékařů primární péče, 241 specialistů)

ABIM: American Board of Internal Medicine
Zdroj.: Summary-Research-Report-Survey-2017.pdf (choosingwisely.org)

Slyšeli jste o kampani Choosing Wisely?



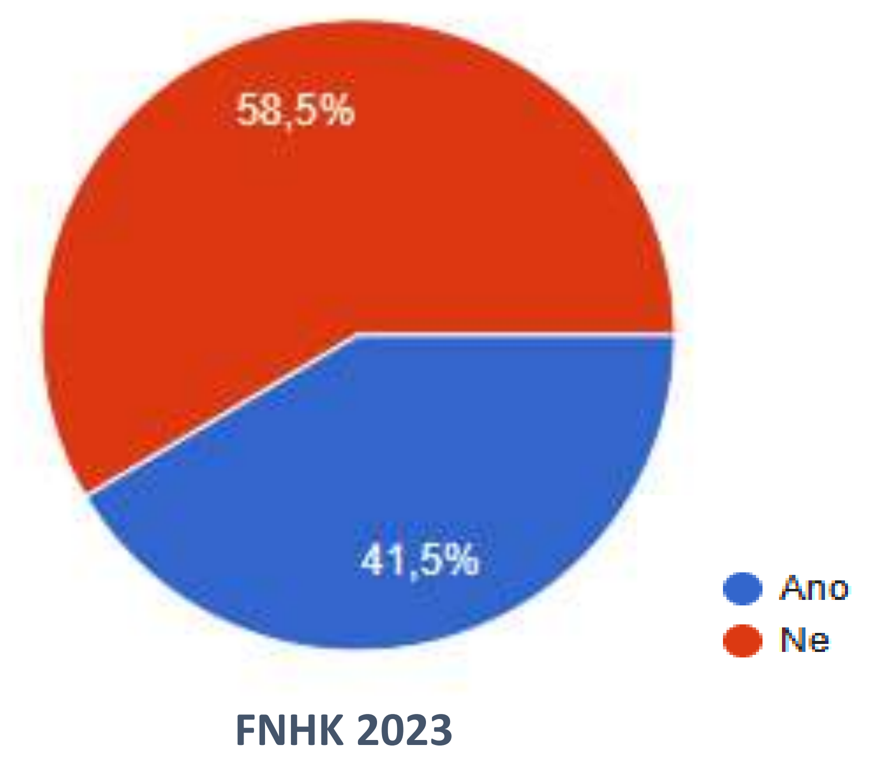
FNHK 2023



ABIM 2017

ABIM: American Board of Internal Medicine
Zdroj.: Summary-Research-Report-Survey-2017.pdf (choosingwisely.org)

Znáte termín low value care?

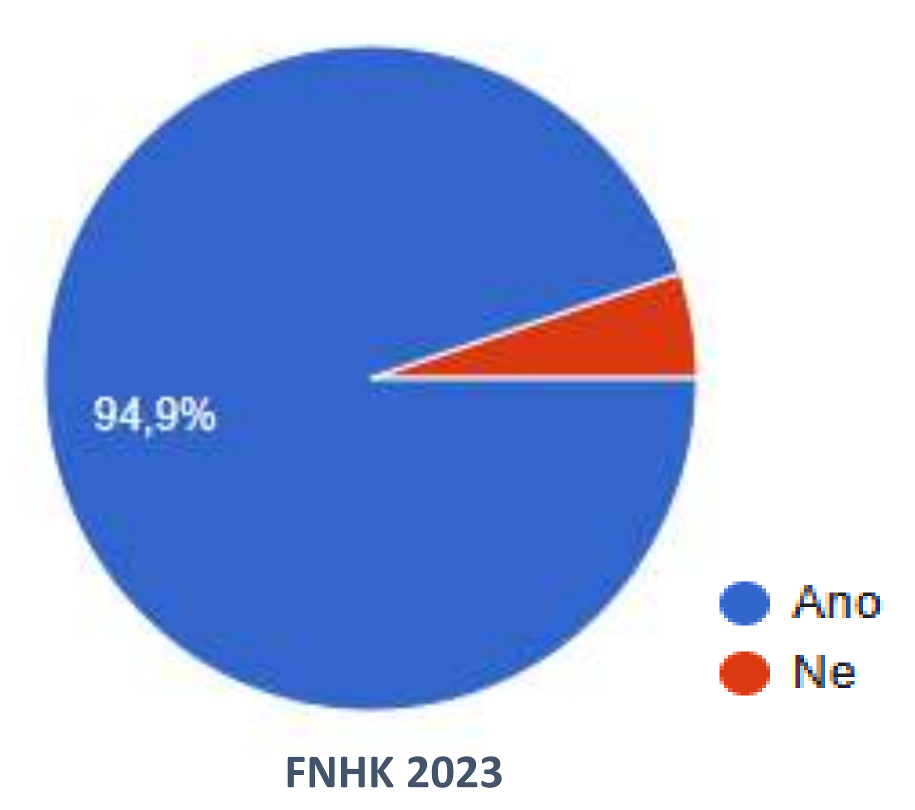


FNHK 2023

LOW-VALUE CARE
Péče, která přináší malý nebo žádný užitek. Pacienta potenciálně poškozující.

Dle ABIM 20 – 30% prostředků je vynakládáno na low-value

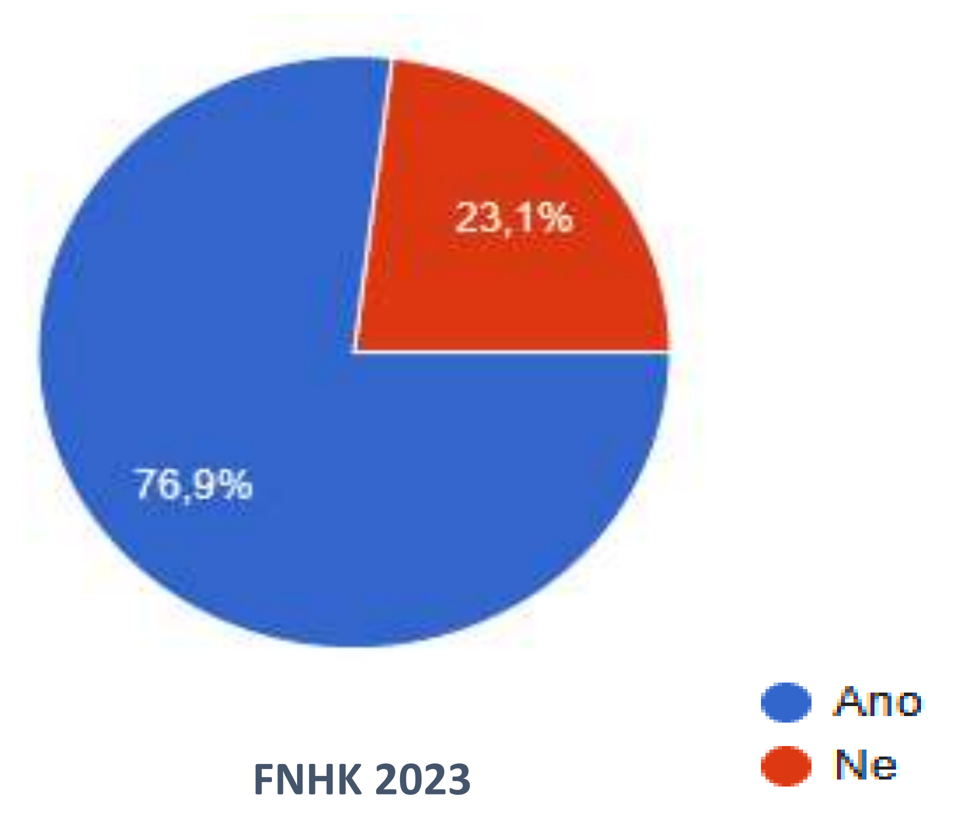
Máte pocit, že se některá vyšetření provádějí nadbytečně?



Pokud ANO, která?

1/ laboratorní vyšetření (bch, koag., KO)
2/ CT vyšetření (CTAG, CT mozku)
3/ RTG (RTG SP, RTG kloubů …)
4/ sonografie (UZ břicha, ECHOkardiografie)
5/ MR

Máte pocit, že se některé léky předepisují nadbytečně?

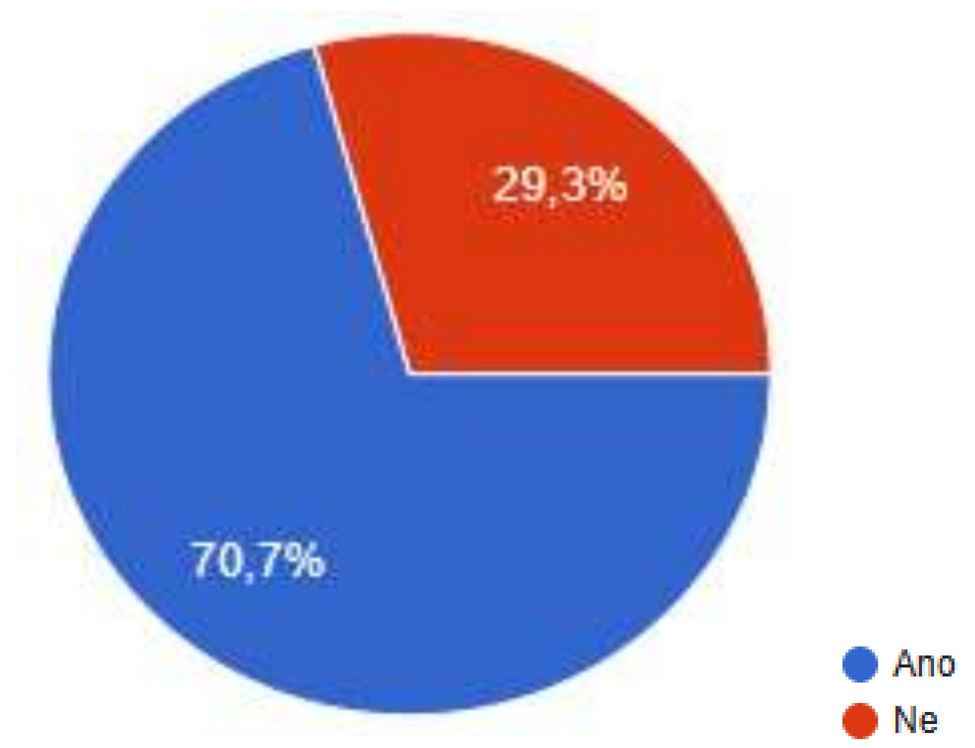


FNHK 2023

Pokud ANO, které?

1/ antibiotika, antivirotika
2/ inhibitory protonové pumpy
3/ hypnotika, BZD
4/ alopurinol
5/ analgetika

Ordinujete ve své každodenní praxi diagnostické či terapeutické kroky **o jejichž účelnosti a užitečnosti** nejste **přesvědčeni?**



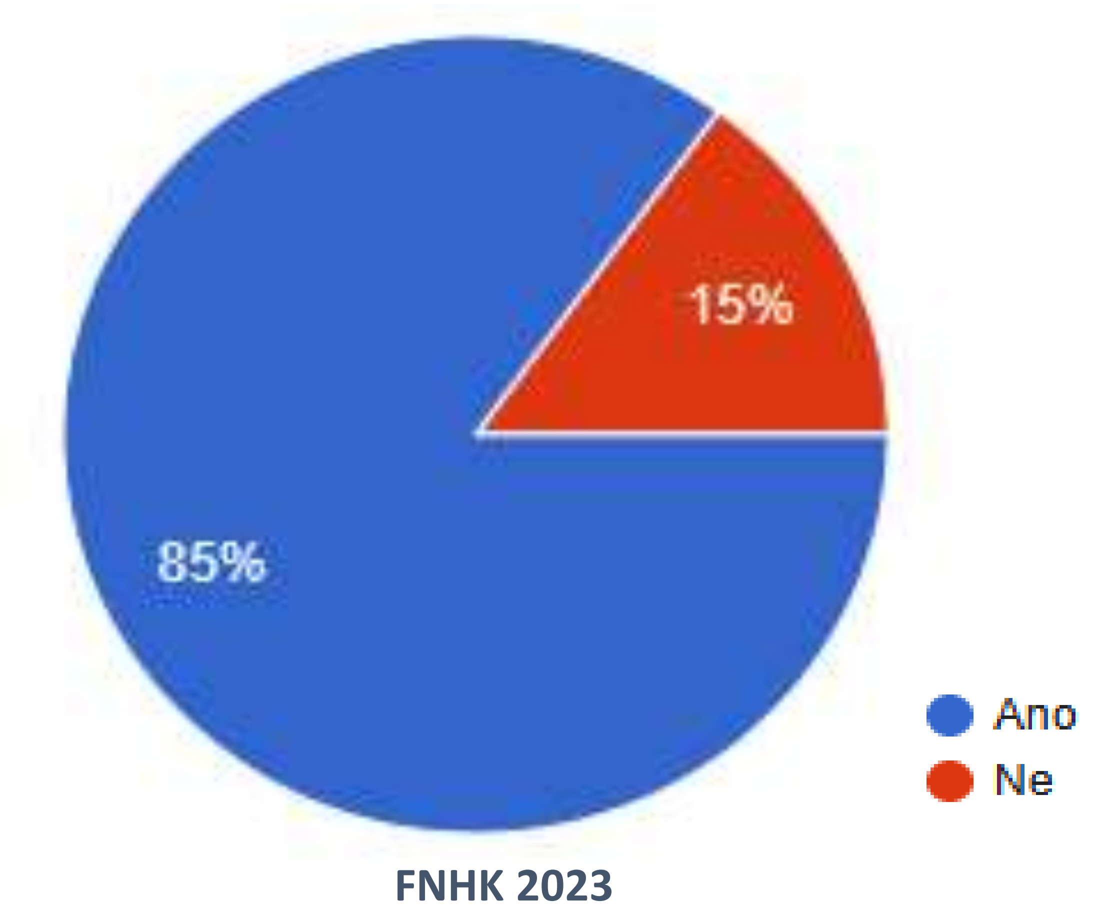
Ordinujete ve své každodenní praxi diagnostické či terapeutické kroky **o jejichž účelnosti a užitečnosti** nejste **přesvědčeni?**

Pokud ano - proč? (např. trvá na tom pacient, bojím se stížnosti atd.)

FNHK 2023
1/ vyžaduje starší lékař/nadřízený
2/ „standardní postup“, zaběhnutá praxe
3/ strach ze stížnosti - žaloby
4/ trvá na tom pacient, rodina pacienta..
5/ „pro jistotu …“, ujištění se

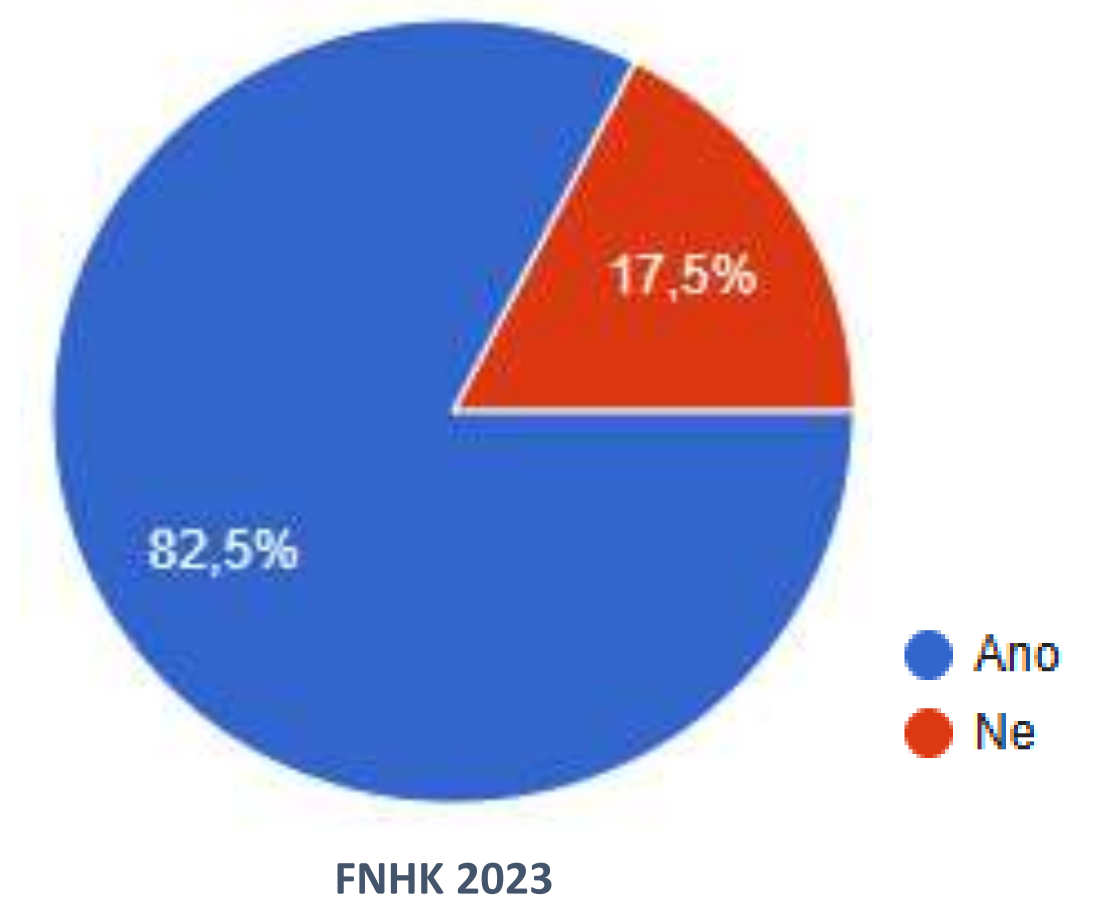
ABIM 2017
1/ strach ze stížnosti – žaloby
2/ ujištění se
3/ trvá na tom pacient
4/ nedostatek času na pacienta
5/ tlak ze strany instituce, kolegů

Pokud se **pacient dožaduje vyšetření, které je z vašeho** pohledu **zbytné, podaří se vám ho přesvědčit, že vyšetření není nutné?**



FNHK 2023

Máte pocit, že vaši pacienti by měli být více a podrobněji informováni o diagnostických a terapeutických krocích, které jim lékař doporučuje?



FNHK 2023

- výsledky provedené na omezeném počtu lékařů FNHK korelují s výsledky ankety ABIM z roku 2017

- častá příčina ordinace zbytných vyšetření je dle dotázaných lékařů tlak okolí (zaběhlá praxe, požadavek vedoucího lékaře …)

- možný pozitivní přínos vytvoření TOP 5 listů v rámci jednotlivých oddělení

Léčíme rozumem, nejsme kouzelníci , děláme vše pro dobro našich pacientů, abychom je zbavili bolesti a utrpení. Nemůžeme ničit vážnost našeho povolání planými sliby, že člověka vyléčíme nebo neuváženými pokusy léčit trvalé a nevyléčitelné choroby .

Wiliam Osler 1849- 1919

21. století

- Medicína je všemocná…
- Více je lépe…
- Jakou **další léčbu** nasadit?
- Jakou **další chorobu** léčit?
- Jakou **další diagnostickou metodu** použít?
- Snížení hranic mezi zdravím a nemocí
- Posun diagnostiky do předchorobí
- Overdiagnosis, labelling, overtreatment

Overdiagnosis

- označování abnormálního stavu nebo nálezu, který by dané osobě nezpůsobil újmu, pokud by zůstal neobjeven jako nemoc
- nakonec vede k větší újmě než prospěchu
- overdetection
- overdefinition
- labelling
- overtreatment
- terapeutická iluze

Polypragmázie

- v letech 1995-2010 pacienti s 5 a více léky z **10% na 20%** / GB /
- pacienti s více než 10 léky – z **2% na 6%** /GB/
- pravděpodobnost nežádoucích účinků u 3 léků **13%**, u 5 léků **58%**, u 7 léků **82%**
- v letech 1999-2008 - **77 %** vzestup hospitalizací pro nežádoucí účinky /GB/
- nežádoucí účinky léků patří mezi 5 nejčastějších příčin smrti v nemocnici /USA/
- 17% přijetí pacientů starších 65 let / USA/

Compliance to Medications

Nové obtíže - nežádoucí účinek léčby??
KRVÁCENÍ
KAŠEL
SELHÁNÍ LEDVIN
ZVRACENÍ
OTOKY
FIBRILACE SÍNÍ
ARYTMIE
PÁDY
SLABOST
INFEKCE
SLABOST
MYALGIE
IKTERUS
HEMOLÝZA
TEPLOTY
CHOOSING WISELY
CZECH

Defenzivní medicína

- Strach z propásnutí diagnosy - použití diagnostických testů v situaci nízké pravděpodobnosti choroby - falešně pozitivní výsledek - diagnosa atd.
- Použití drahých vyšetřovacích metod a odesílání pacientů do nemocnice koreluje s obavou lékaře ze stížnosti či žaloby
- Netrpělivost a nedůvěra ve vlastní klinické zkušenosti a diagnostické schopnosti
- Nesnášenlivost pocitu nejistoty - touha věřit „objektivnímu" vyšetření"
- Indikace diagnostiky či léčby pro vlastní klid lékaře nikoliv prospěch pacienta

Bayesův teorém v medicíně

Thomas Bayes 1701-1761

Čím vyšší je pravděpodobnost onemocnění před provedeným testem tím spíše můžeme věřit pozitivnímu nálezu.

Čím nižší je pravděpodobnost onemocnění před testem, tím spíše je test falešně pozitivní.

Senzitivita diagnostického testu je 100 %

Specificita testu je 95%

Prevalence onemocnění je 1 z 1000

<u>Jaká je pravděpodobnost, že osoba s pozitivním testem má skutečně chorobu ?</u>

95% byla průměrná odpověď cca 500 lékařů (JAMA 2021)

2% je SPRÁVNÁ odpověď

- Bayesova **věta**

P (D/+) = P(+/D) x P(D) / P(+)

P (D/+) = 1,00 x 0,001 / 1,00x0,001 +0,999 x 0,05

P (D/+) = **2% pozitivní test + choroba**

Relation between number of different screening tests ordered and percentage of normal people with at least one abnormal test result[1]

Number of tests	People with at least 1 abnormality (%)
1	5
5	23
20	64
100	99.4

Data from:

1. Sackett DL. Clinical diagnosis and the clinical laboratory. Clin Invest Med 1978; 1:37.

Reproduced with permission from: Prevention. In: Clinical Epidemiology: The Essentials, 6th ed, Fletcher G (Ed), Lippincott Williams and Wilkins 2020.

Graphic 89377 Version 7.0

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Co s tím?

- Brownlee S Overtreated: Why Too Much Medicine Is Making Us Sicker and Poorer. 2008 New York
- Gibson R, Singh JP The Treatment Trap: How the Overuse of Medical Care Is Wrecking Your Health and What You Can Do to Prevent It. 2010 Chicago,
- Grady D, Redberg RF. Less is more: How less health care can result in better health. Arch Intern Med. 2010
- Medicine's Ethical Responsibility for Health Care Reform – The Top Five List- Howard Brody, M.D., Ph.D., NEJM 2010

Kampaň Choosing Wisely 2012

- Výzva k The Top five list - 5 diagnostických či terapeutických úkonů v dané specializaci, které jsou dle lékařů nadužívané a neposkytující pacientům smysluplný prospěch
- 2012 spuštění kampaně (ABIM - 9 odborných společností)
- Nyní kolem 700 doporučení
- 80 odborných společností
- 30 zemí

Otázky, které by měl každý pacient položit svému lékaři

- Je to skutečně nutné?
- Jaká jsou rizika?
- Jsou i jiné možnosti?
- Co se stane, když nebudu dělat nic ?

Implementace CHW / deimplementace low value care

- nedodržování restriktivní transfusní politiky
- nadbytečná a příliš dlouhá ATB terapie
- neredukování zbytné medikace geriatrických pacientů
- nadužívání a přílišná frekvence každodenních laboratorních odběrů
- nadužívání invazivních vyšetření u fragilních pacientů
- neindikování paliativní péče
- nadužívání zobrazovacích vyšetření

Překážky implementace

- Lepší lékař více ordinuje
- Pacient trvá na své medikaci
- Pacient se dožaduje vyšetření
- Více času někdy stojí vysvětlit, proč není vyšetření či léčba indikována, než ji předepsat
- Strach ze stížností a žalob
- „Nebudu na svých pacientech šetřit"
- „U nás děláme špičkovou medicínu"

Choosing Wisely - implementace

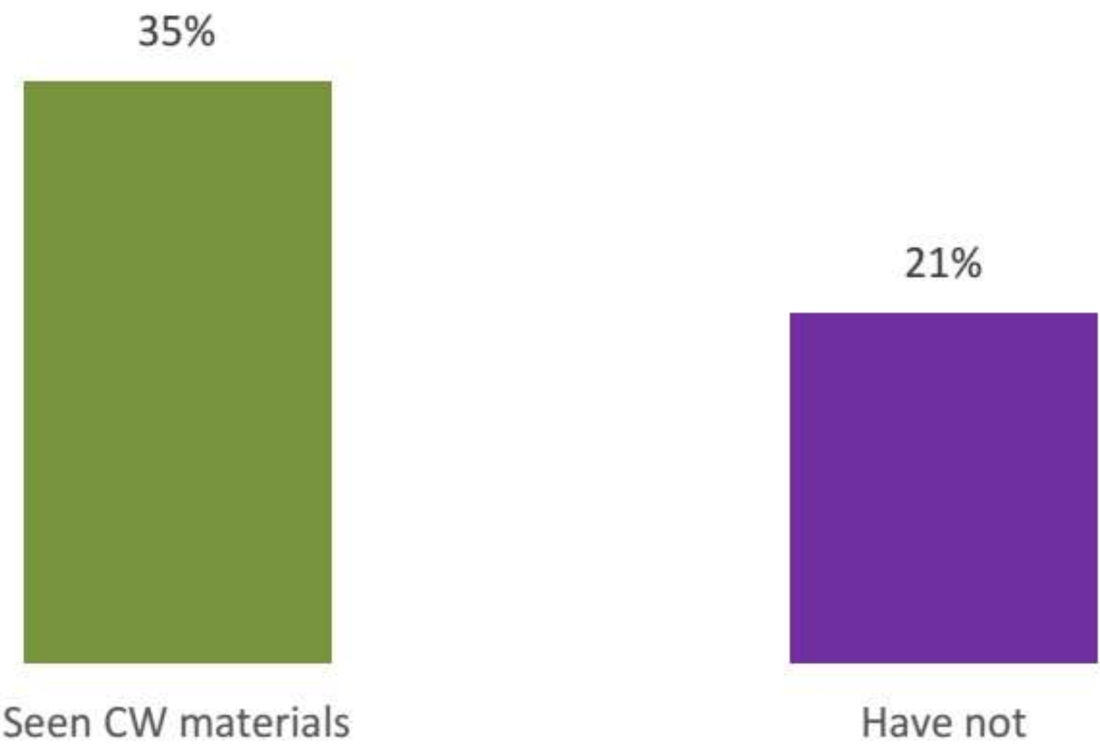
- Zmapování oblastí s potenciální low value care
- Sběr dat, podíl overdiagnosis, overtreatment
- Benchmarking
- Formulování vlastního TOP Five, Top Ten list
- Zapojení klíčových hráčů
- Intervenování / de-implementace neúčelné péče
- Edukační intervence
- Monitorování medicínského a ekonomického dopadu
- Udržení žádoucí změny, příznivých trendů
- Rozšíření aktivit – na další oblasti, oddělení, nemocnici

Cedars Sinai Medical Center LA

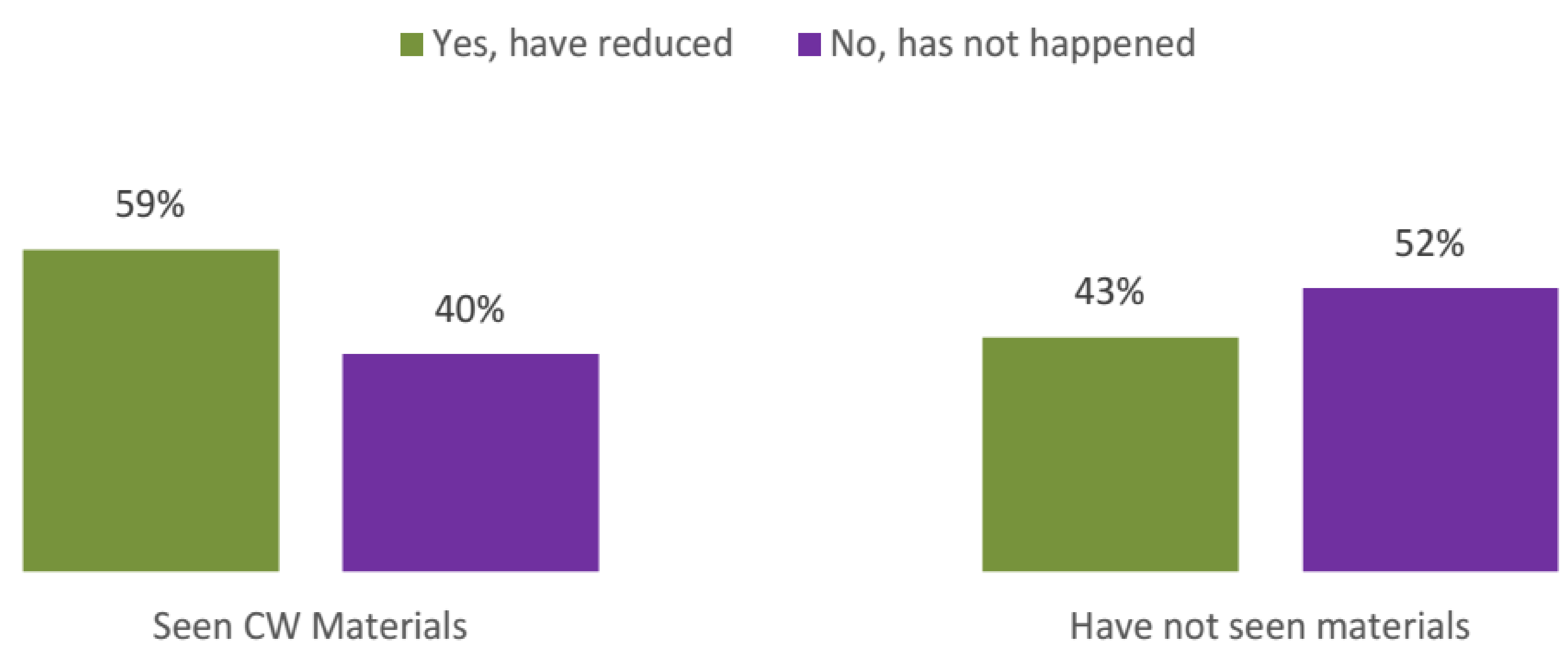
- <u>Implementace CW doporučení jako výstrah do klinického informačního systému</u>
- 180 doporučení
- „soft stops“ ....“medium stops“
- Úspora 6 millionů $ za rok
- 30 % snížení komplikací
- 15 % snížení rehospitalizací
- Vzdělávací efekt

Physicians who have seen *Choosing Wisely* materials are 14 points more likely to say it has gotten easier over the past few years to talk to patients about avoiding unnecessary care.

Over the last few years, has it gotten easier or harder to talk to patients about why they should avoid a test or procedure? (% Easier)



Respondents who have not seen the campaign's materials are 16 points less likely to say they have reduced unnecessary care.



Předpoklady úspěchu iniciativy CHW

- Připusťme si overdiagnosis a overtreatment
- Mysleme statisticky (bayesovsky)
- Zapojme do rozhodování pacienta
- Nebojme se de-implementace
- Zvolme multidimenzionální přístup

- Use of antibiotics in patients with upper respiratory infections American Academy of Allergy, Asthma, & Immunology, American Academy of Family Physicians, American Academy of Pediatrics, American College of Emergency Physicians and Infectious Diseases Society of America
- Imaging for nonspecific low back pain American Academy of Family Physicians, American Association of Neurological Surgeons and Congress of Neurological Surgeons, American Chiropractic Association, American College of Emergency Physicians, American College of Physicians, American Society of Anesthesiologists-Pain Management and North American Spine Society
- Imaging for uncomplicated or stable headaches American College of Radiology
- Vitamin-D testing American Academy of Pediatrics, American Society for Clinical Pathology and Endocrine Society
- Repetitive CBC and labs Critical Care Societies Collaborative and Society of Hospital Medicine
- In-patient blood utilization AABB, American College of Obstetricians and Gynecologists, American Society of Anesthesiologists, American Society of Hematology, Critical Care Societies Collaborative and Society of Hospital Medicine
- Routine annual cervical cytology screening (Pap tests) American College of Obstetricians and Gynecologists and American Society for Colposcopy and Cervical Pathology
- Benzodiazepines for adults 65 years of age and older American Academy of Nursing and American Geriatrics Society
- Preoperative testing in patients scheduled to undergo low- and/or intermediate-risk non-cardiac surgery American Academy of Ophthalmology, American College of Physicians, American College of Radiology, American College of Surgeons, American Society of Anesthesiologists, American Society for Clinical Pathology, American Society of Echocardiography and Society of Thoracic Surgeons
- Telemetry in non-intensive care unit Society of Hospital Medicine
- Antibiotics beyond 72 hours for inpatients with no signs of infection Society for Healthcare Epidemiology of America
- DEXA scans American Academy of Family Physicians and American College of Rheumatology)

TOP 12 list of choosing wisely

Five Things Physicians and Patients Should Question

1 Don't treat asymptomatic bacteruria with antibiotics.

Inappropriate use of antibiotics to treat asymptomatic bacteruria (ASB), or a significant number of bacteria in the urine that occurs without symptoms such as burning or frequent urination, is a major contributor to antibiotic overuse in patients. With the exception of pregnant patients, patients undergoing prostate surgery or other invasive urological surgery, and kidney or kidney pancreas organ transplant patients within the first year of receiving the transplant, use of antibiotics to treat ASB is not clinically beneficial and does not improve morbidity or mortality. The presence of a urinary catheter increases the risk of bacteruria, however, antibiotic use does not decrease the incidence of symptomatic catheter-associated urinary tract infection (CAUTI), and unless there are symptoms referable to the urinary tract or symptoms with no identifiable cause, catheter-associated asymptomatic bacteruria (CA-ASB) does not require screening and antibiotic therapy. The overtreatment of ASB with antibiotics is not only costly, but can lead to C. difficile infection and the emergence of resistant pathogens, raising issues of patient safety and quality.

2 Avoid prescribing antibiotics for upper respiratory infections.

The majority of acute upper respiratory infections (URIs) are viral in etiology and the use of antibiotic treatment is ineffective, inappropriate and potentially harmful. However, proven infection by Group A Streptococcal disease (Strep throat) and pertussis (whooping cough) should be treated with antibiotic therapy. Symptomatic treatment for URIs should be directed to maximize relief of the most prominent symptom(s). It is important that health care providers have a dialogue with their patients and provide education about the consequences of misusing antibiotics in viral infections, which may lead to increased costs, antimicrobial resistance and adverse effects.

3 Don't use antibiotic therapy for stasis dermatitis of lower extremities.

Stasis dermatitis is commonly treated with antibiotic therapy, which may be a result of misdiagnosis or lack of awareness of the pathophysiology of the disease. The standard of care for the treatment of stasis dermatitis affecting lower extremities is a combination of leg elevation and compression. Elevation of the affected area accelerates improvements by promoting gravity drainage of edema and inflammatory substances. The routine use of oral antibiotics does not improve healing rates and may result in unnecessary hospitalization, increased health care costs and potential for patient harm.

4 Avoid testing for a Clostridium difficile infection in the absence of diarrhea.

Testing for C. difficile or its toxins should be performed only on diarrheal (unformed) stool, unless ileus due to C. difficile is suspected. Because C. difficile carriage is increased in patients on antimicrobial therapy, and patients in the hospital, only diarrheal stools warrant testing. In the absence of diarrhea, the presence of C. difficile indicates carriage and should not be treated and therefore, not tested.

5 Avoid prophylactic antibiotics for the treatment of mitral valve prolapse.

Antibiotic prophylaxis is no longer indicated in patients with mitral valve prolapse for prevention of infective endocarditis. The risk of antibiotic-associated adverse effects exceeds the benefit (if any) from prophylactic antibiotic therapy. Limited use of prophylaxis will likely reduce the unwanted selection of antibiotic-resistant strains and their unintended consequences such as C. difficile-associated colitis.

These items are provided solely for informational purposes and are not intended as a substitute for consultation with a medical professional. Patients with any specific questions about the items on this list or their individual situation should consult their physician.

February 23, 2015

How This List Was Created

The Infectious Diseases Society of America's (IDSA) Quality Improvement Committee (QIC) directed the development of IDSA's *Choosing Wisely®* list of Five Things Physicians and Patients Should Question. The Committee identified a preliminary list of inappropriate and overused clinical practices. A list of five items was drafted and then vetted by the QIC and revisions were made according to a workgroup consensus. The finalized list was then submitted for approval to the IDSA Board of Directors.

IDSA's disclosure and conflict of interest policy can be found at www.idsociety.org/Index.aspx.

Sources

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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 Infectious Diseases Society of America

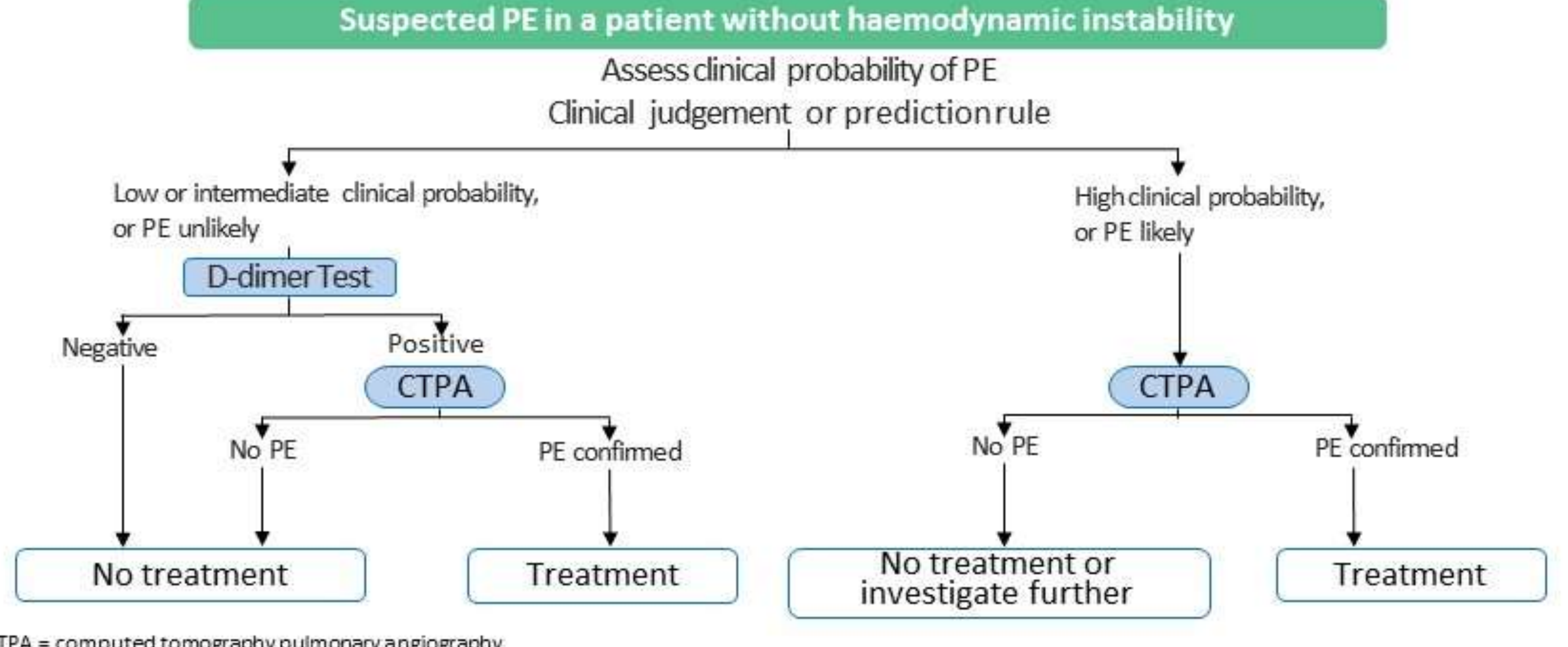
The Infectious Diseases Society of America (IDSA) is proud to partner with the *Choosing Wisely®* campaign to raise awareness of inappropriate, wasteful clinical actions that harm patients and lead to costly health care. Supporting the aims of *Choosing Wisely*, IDSA is committed to evidence-based medicine and develops clinical practice guidelines that inform the use of high-quality, truly necessary medicine. Founded in 1963, IDSA represents more than 10,000 infectious diseases physicians and scientists devoted to patient care, prevention, population health, education and research in the area of infectious disease (ID). Our members care for patients of all ages with serious infections, including meningitis, pandemic influenza, pneumonia, tuberculosis, surgical infections, immunocompromised cancer or transplant patients who have life-threatening infections caused by uncommon or drug-resistant microorganisms, HIV and AIDS patients, and new and emerging infections, such as Middle East respiratory syndrome (MERS), and Ebola.

For more information on infectious diseases specialists and IDSA, please visit the IDSA website, www.idsociety.org.

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

4.4.2 D-dimer cut-offs adapted to clinical probability

A prospective management trial used the 'YEARS' clinical decision rule, which consists of three clinical items of the Wells score (see Supplementary Data Table 1)—namely signs of DVT, haemoptysis, and PE more likely than an alternative diagnosis—plus D-dimer concentrations. [107] PE was considered to be excluded in patients without clinical items and D-dimer levels <1000 ng/mL….



Pulmonary embolism prevalence among emergency department cohorts: A systematic review and meta-analysis by country of study

Federico Germini[1,2,3] | Sahar Zarabi[2] | Michelle Eventov[2] | Michelle Turcotte[2] | Meirui Li[2] | Kerstin de Wit[1,2]

J Thromb Haemost. 2021;19:173–185.

2. Avoid coagulation studies in emergency department patients unless there is a clearly defined specific clinical indication, such as for monitoring of anticoagulants, in patients with suspected severe liver disease, coagulopathy, or in the assessment of snakebite envenomation*.

Date reviewed: 22 April 2015

- Stanovení PT/INR a APTT má jen omezenou klinickou prospěšnost
- Anamnéza krvácení je nevýznamnějším faktorem pro dg. Vrozené krvácivé choroby
- INR a APTT není nutné stanovovat před výkony s nízkým rizikem krvácení a v intervenční radiologii
- Abnormálně zvýšená hodnota INR nebo APTT u nemocného s krvácením předpokládá potenciální naléhavost řešení
- Klinická anamnéza a farmakokinetika léku jsou mnohem důležitější než-li výsledky INR a APTT při určování klinického rozhodování léčby DOAC

Chornenki NLJ, Fralick M, Sholzberg M. CMAJ. 2022 Aug 29;194(33):E1135. doi: 10.1503/cmaj.220629.

Kdy indikovat koagulační testy (PT/INR a APTT) před operací?

PT/INR	APTT
terapie warfarinem	plánovaná léčba UFH i.v.
závažná jaterní choroba	podezření na hemofilii A/B, deficit faktoru XI
riziko deficitu vitamínu K (malnutrice, obstrukční ikterus, protrahovaná terapie ATB, vitamíny rozpustné v tucích)	suspektní antifosfolipidový syndrom

Elbaz C, Sholzberg M. Res Pract Thromb Haemost. 2020;4(5):761-73.
Patel IJ, et al. J Vasc Interv Radiol. 2019;30(8):1168-84 e1.

Kdy indikovat koagulační testy (PT/INR a APTT) před operací?

Kdy indikovat oba testy
Stanovení klinicky významného aktivního krvácení nebo při podezření na koagulopatii (včetně traumatu)
Hodnocení nevysvětlitelné osobní nebo rodinné anamnézy krvácení

Elbaz C, Sholzberg M. Res Pract Thromb Haemost. 2020;4(5):761-73.
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5 hlavních důvodů proč nedělat PT/INR a APTT

1. Součást rutinního krevního vyšetření
2. Rutinní předoperační screening u nemocných před málo rizikovým nekardiochirurgickým výkonem bez osobní nebo rodinné anamnézy krvácení
3. Sledování léčby DOAC (přímá orální antikogulancia)
4. Sledování léčby LMWH
5. Monitorace farmakologické tromboprofylaxe

Elbaz C, Sholzberg M. Res Pract Thromb Haemost. 2020;4(5):761-73.
Patel IJ, et al. J Vasc Interv Radiol. 2019;30(8):1168-84 e1.

Don't place, or leave in place, urinary catheters for incontinence or convenience or monitoring of output for non-critically ill patients (acceptable indications: critical illness, obstruction, hospice, perioperatively (if required) for <2 days or for urologic/pelvic procedures; use weights instead to monitor diuresis).

Catheter Associated Urinary Tract Infections (CAUTIs) are the most frequently occurring health care acquired infection (HAI). Use of urinary catheters for incontinence or convenience without proper indication or specified optimal duration of use increases the likelihood of infection and is commonly associated with greater morbidity, mortality and health care costs. Published guidelines suggest that hospitals and long-term care facilities should develop, maintain and promulgate policies and procedures for recommended catheter insertion indications, insertion and maintenance techniques, discontinuation strategies and replacement indications.

Don't prescribe medications for stress ulcer prophylaxis to medical inpatients.

According to published guidelines, medications for stress ulcer prophylaxis are not recommended for adult patients in non-ICU settings. Histamine-2 receptor antagonists (H2RAs) and proton-pump inhibitors (PPIs), commonly used to treat stress ulcers, are associated with adverse drug events and increased medication costs, and commonly enhance susceptibility to community-acquired nosocomial pneumonia and Clostridium difficile. Adherence to therapeutic guidelines will aid health care providers in reducing treatment of patients without clinically important risk factors for gastrointestinal bleeding.

Don’t perform repetitive CBC and chemistry testing in the face of clinical and lab stability.

Hospitalized patients frequently have considerable volumes of blood drawn (phlebotomy) for diagnostic testing during short periods of time. Phlebotomy is highly associated with changes in hemoglobin and hematocrit levels for patients and can contribute to anemia. This anemia, in turn, may have significant consequences, especially for patients with cardiorespiratory diseases. Additionally, reducing the frequency of daily unnecessary phlebotomy can result in significant cost savings for hospitals.

Don’t maintain a peripheral capillary oxygen saturation (SpO2) of higher than 96% when using supplemental oxygen, unless for carbon monoxide poisoning, cluster headaches, sickle cell crisis, or pneumothorax.

Ideal oxygen saturation levels for patients getting supplemental oxygen therapy is at or below 96%. The overuse of supplemental oxygen has been shown to increase mortality in numerous studies of patients with a variety of critical illnesses, including cardiac arrest, stroke, and trauma, as well as following emergency surgery. Higher oxygen levels may be needed for those with certain medical conditions such as carbon monoxide poisoning, special types of headaches like cluster headaches, sickle cell crisis, or pneumothorax. An important caveat to this recommendation is the higher incidence of occult hypoxemia, defined as an arterial oxygen saturation of less than 88% with a pulse oximetry measurement of 92 to 96%, in black patients compared to white patients.

Don’t wake patients at night for routine care; redesign workflow to promote sleep at night.

Inadequate sleep in hospitalized patients has been associated with poor outcomes including high blood pressure, hyperglycemia, immune dysfunction, and delirium. Environmental factors (noise, light disruptions), care-related factors (blood draws, vital signs), and patient factors (illness, pain) all contribute to sleep disruption. It is generally recommended that non-pharmacologic interventions be the first line of prevention. Although data are limited, multifaceted interventions targeting modifiable factors including nighttime interventions to decrease noise and light, group care activities and minimize unnecessary patient contact (i.e. decreasing vital sign frequency, blood draws) may improve sleep quality and duration. Non-pharmacologic sleep aids including earplugs, eye masks and relaxation techniques can be easily adopted and may provide some benefit.

Avoid transfusions of red blood cells for arbitrary hemoglobin or hematocrit thresholds and in the absence of symptoms caused by anemia.

The AABB recommends adhering to a restrictive transfusion strategy (7 to 8 g/dL) in hospitalized, stable patients. The AABB suggests that transfusion decisions be influenced by symptoms as well as hemoglobin concentration. According to a National Institutes of Health Consensus Conference, no single criterion should be used as an indication for red cell component therapy. Instead, multiple factors related to the patient’s clinical status and oxygen delivery should be considered.

Don't transfuse more units of red blood cells or other components than absolutely necessary.

- For red blood cells, a restrictive threshold (7.0-8.0g/dL) should be used for the vast majority of hospitalized, stable patients without evidence of inadequate tissue oxygenation (evidence supports a threshold of 8.0g/dL in patients with pre-existing cardiovascular disease). Transfusion decisions should be influenced by symptoms and hemoglobin concentration. Single unit red cell transfusions should be the standard for non-bleeding, hospitalized patients. Additional units should only be prescribed after re-assessment of the patient and their hemoglobin value.
- For plasma, do not transfuse plasma to correct coagulopathy in non-bleeding patients or patients.
- Do not transfuse platelets without laboratory guidance outside of fixed-ratio massive transfusions.

Don't routinely use blood products to reverse warfarin.

Patients requiring reversal of warfarin can often be reversed with vitamin K or discontinuation of warfarin alone. Prothrombin complex concentrates or plasma should only be used for patients with serious bleeding or requiring emergency surgery.

Don't treat asymptomatic bacteruria with antibiotics.

Inappropriate use of antibiotics to treat asymptomatic bacteruria (ASB), or a significant number of bacteria in the urine that occurs without symptoms such as burning or frequent urination, is a major contributor to antibiotic overuse in patients. With the exception of pregnant patients, patients undergoing prostate surgery or other invasive urological surgery, and kidney or kidney pancreas organ transplant patients within the first year of receiving the transplant, use of antibiotics to treat ASB is not clinically beneficial and does not improve morbidity or mortality. The presence of a urinary catheter increases the risk of bacteruria, however, antibiotic use does not decrease the incidence of symptomatic catheter-associated urinary tract infection (CAUTI), and unless there are symptoms referable to the urinary tract or symptoms with no identifiable cause, catheter-associated asymptomatic bacteruria (CA-ASB) does not require screening and antibiotic therapy. The overtreatment of ASB with antibiotics is not only costly, but can lead to C. difficile infection and the emergence of resistant pathogens, raising issues of patient safety and quality.

Avoid prescribing antibiotics for upper respiratory infections.

The majority of acute upper respiratory infections (URIs) are viral in etiology and the use of antibiotic treatment is ineffective, inappropriate and potentially harmful. However, proven infection by Group A Streptococcal disease (Strep throat) and pertussis (whooping cough) should be treated with antibiotic therapy. Symptomatic treatment for URIs should be directed to maximize relief of the most prominent symptom(s). It is important that health care providers have a dialogue with their patients and provide education about the consequences of misusing antibiotics in viral infections, which may lead to increased costs, antimicrobial resistance and adverse effects.

4. For emergency department patients approaching end-of-life, ensure clinicians, patients and families have a common understanding of the goals of care.

Date reviewed: 22 April 2015

The emergency department is a challenging environment for end-of-life care, presenting ethical and quality of life issues. Research indicates that over 50% of Australians who die an 'anticipated' or 'expected' death, will die in acute hospitals, even though the majority approaching end-of-life wish to die at home. In this context, clinicians, patients and their families should work together to ensure they have a common understanding of the goals of care. Values and wishes around medical treatment should be documented. Monitoring and investigations should be appropriate. Clinicians should advocate for the patient by initiating discussion about end-of-life care with inpatient clinicians and community health professionals. When possible, arrange for end-of-life patients to be transferred to a palliative care facility to avoid admission to acute wards.

Top 5 list - **standardní lůžkové oddělení**

- nepodávejte transfusní přípravky pokud hladina (Hb, INR...) nesplňuje pravidla restriktivní transfusní politiky
- nepodávejte ATB neindikovaně a při jejich indikovaném podání neprodlužujte dobu jejich podávání bez vážného důvodu
- nenasazujte zbytečně IPP a vysazujte je z chronické medikace v případě chybějící indikace
- neodebírejte D- dimery v neindikovaných případech
- neopakujte laboratorní vyšetření na denní bázi

Choosing wisely...

- nejedná se o alternativní medicínu
- primárním cílem není šetření nákladů, ale ušetření pacienta zbytných vyšetření a terapeutických procedur
- snaha o co nejméně zatěžující řešení nejpravděpodobnější diagnózy. Zhodnocení efektu v čase a případně přístup k dalším diagnosticko-terapeutickým krokům

Posláním choosing wisely **je...**

......podporovat rozhovory mezi lékaři a pacienty tím, že pacientům pomůžeme vybrat si péči, která je:

- podložena důkazy
- není duplicitní s jinými již provedenými testy nebo postupy
- nepřináší pacientovy újmu
- je opravdu nutná

VYBÍREJ MOUDŘE!

https://www.cisweb.cz/choosing-wisely