Choosing Wisely®

An initiative of the ABIM Foundation

American Academy of Family Physicians

AAFP

AMERICAN ACADEMY OF FAMILY PHYSICIANS

Twenty Things Physicians and Patients Should Question

1 Don't do imaging for low back pain within the first six weeks, unless red flags are present.

Red flags include, but are not limited to, severe or progressive neurological deficits or when serious underlying conditions such as osteomyelitis are suspected. Imaging of the lower spine before six weeks does not improve outcomes, but does increase costs. Low back pain is the fifth most common reason for all physician visits.

2 Don't routinely prescribe antibiotics for acute mild-to-moderate sinusitis unless symptoms last for ten or more days, or symptoms worsen after initial clinical improvement.

Symptoms must include discolored nasal secretions and facial or dental tenderness when touched. Most sinusitis in the ambulatory setting is due to a viral infection that will resolve on its own. Despite consistent recommendations to the contrary, antibiotics are prescribed in more than 80 percent of outpatient visits for acute sinusitis. Sinusitis accounts for 16 million office visits and $5.8 billion in annual health care costs.

3 Don't use dual-energy x-ray absorptiometry (DEXA) screening for osteoporosis in women younger than 65 or men younger than 70 with no risk factors.

DEXA is not cost effective in younger, low-risk patients, but is cost effective in older patients.

4 Don't order annual electrocardiograms (EKGs) or any other cardiac screening for low-risk patients without symptoms.

There is little evidence that detection of coronary artery stenosis in asymptomatic patients at low risk for coronary heart disease improves health outcomes. False-positive tests are likely to lead to harm through unnecessary invasive procedures, over-treatment and misdiagnosis. Potential harms of this routine annual screening exceed the potential benefit.

5 Don't perform Pap smears on women younger than 21 or who have had a hysterectomy for non-cancer disease.

Most observed abnormalities in adolescents regress spontaneously, therefore Pap smears for this age group can lead to unnecessary anxiety, additional testing and cost. Pap smears are not helpful in women after hysterectomy (for non-cancer disease) and there is little evidence for improved outcomes.

Released April 4, 2012 (1-5), February 21, 2013 (6-10), September 24, 2013 (11-15) and August 8, 2018 (16-20); #2, 11 and 13 updated and #14 withdrawn July 18, 2018; #7 withdrawn October 11, 2019

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Don't schedule elective, non-medically indicated inductions of labor or Cesarean deliveries before 39 weeks, 0 days gestational age.

Delivery prior to 39 weeks, 0 days has been shown to be associated with an increased risk of learning disabilities and a potential increase in morbidity and mortality. There are clear medical indications for delivery prior to 39 weeks and 0 days based on maternal and/or fetal conditions. A mature fetal lung test, in the absence of appropriate clinical criteria, is not an indication for delivery.

7

Due to recently-published evidence related to induction of labor between 39 and 41 weeks gestation, the AAFP has withdrawn this recommendation.

8

Don't screen for carotid artery stenosis (CAS) in asymptomatic adult patients.

There is good evidence that for adult patients with no symptoms of carotid artery stenosis, the harms of screening outweigh the benefits. Screening could lead to non-indicated surgeries that result in serious harms, including death, stroke and myocardial infarction.

9

Don't screen women older than 65 years of age for cervical cancer who have had adequate prior screening and are not otherwise at high risk for cervical cancer.

There is adequate evidence that screening women older than 65 years of age for cervical cancer who have had adequate prior screening and are not otherwise at high risk provides little to no benefit.

10

Don't screen women younger than 30 years of age for cervical cancer with HPV testing, alone or in combination with cytology.*

There is adequate evidence that the harms of HPV testing, alone or in combination with cytology, in women younger than 30 years of age are moderate. The harms include more frequent testing and invasive diagnostic procedures such as colposcopy and cervical biopsy. Abnormal screening test results are also associated with psychological harms, anxiety and distress.

** Recommendation currently under review*

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Don't routinely prescribe antibiotics for otitis media in children aged 2–12 years with non-severe symptoms where the observation option is reasonable.

The "observation option" refers to deferring antibacterial treatment of selected children for 48 to 72 hours and limiting management to symptomatic relief. The decision to observe or treat is based on the child's age, diagnostic certainty and illness severity. To observe a child without initial antibacterial therapy, it is important that the parent or caregiver has a ready means of communicating with the clinician. There also must be a system in place that permits reevaluation of the child.

12

Don't perform voiding cystourethrogram (VCUG) routinely in first febrile urinary tract infection (UTI) in children aged 2–24 months.

The risks associated with radiation (plus the discomfort and expense of the procedure) outweigh the risk of delaying the detection of the few children with correctable genitourinary abnormalities until their second UTI.

13

Do not routinely screen for prostate cancer using a prostate-specific antigen (PSA) test or digital rectal exam. For men who desire PSA screening, it should only be performed after engaging in shared decision making.

Screening for prostate cancer using PSA may prevent mortality from prostate cancer for a small number of men, while putting many men at risk for long term harms, such as urinary incontinence and erectile dysfunction. Whether this potentially small benefit in mortality outweighs the potential harms is dependent on the values and preferences of individual men. Therefore, for men who express a desire for prostate cancer screening, it should only be performed following a discussion of the potential benefits and harms. Routine screening for prostate cancer should not be done. PSA-based prostate cancer screening should not be performed in men over 70 years of age.

14

Due to recently published evidence related to screening adolescents for scoliosis, the AAFP has withdrawn this recommendation.

15

Don't require a pelvic exam or other physical exam to prescribe oral contraceptive medications.

Hormonal contraceptives are safe, effective and well-tolerated for most women. Data do not support the necessity of performing a pelvic or breast examination to prescribe oral contraceptive medications. Hormonal contraception can be safely provided on the basis of medical history and blood pressure measurement.

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Don't perform pelvic exams on asymptomatic nonpregnant women, unless necessary for guideline-appropriate screening for cervical cancer.

Screening pelvic examinations, except for the purpose of performing cervical cancer screening at recommended intervals, have not led to reduction in mortality or morbidity, and expose asymptomatic women to unnecessary invasive testing. Noninvasive options to screen for sexually-transmitted infections are now available as alternatives to endocervical cultures. Screening pelvic examinations also add unnecessary costs to the health care system, included expenses from evaluations of false-positive findings. These pelvic exams can even lead to unnecessary surgery.

17

Don't routinely recommend daily home glucose monitoring for patients who have Type 2 diabetes mellitus and are 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 mellitus. However, daily finger glucose testing has no benefit in patients with type 2 diabetes mellitus who are not on insulin or medications associated with hypoglycemia, and small, but significant, patient harms are associated with 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.

18

Don't screen for genital herpes simplex virus infection (HSV) in asymptomatic adults, including pregnant women.

Serologic testing for HSV infection has low specificity and a high false-positive rate, and no confirmatory test is currently available. The serologic tests cannot determine site of infection. Given the prevalence of the infection in the United States, positive predictive value of the test is estimated at about 50%. A positive test can cause considerable anxiety and disruption of personal relationships.

19

Don't screen for testicular cancer in asymptomatic adolescent and adult males.

There is no benefit to screening for testicular cancer due to the low incidence of disease and high cure rates of treatment, even in patients who have advanced disease. There are potential harms associated with screening, which include false-positive results, anxiety, and harms from diagnostic tests or procedures.

20

Don't transfuse more than the minimum of red blood cell (RBC) units necessary to relieve symptoms of anemia or to return a patient to a safe hemoglobin range (7 to 8 g/dL in stable patients).

Unnecessary transfusion exposes patients to potential adverse effects without any likelihood of benefit and generates additional costs. Transfusion decisions should be influenced by a person's symptoms and hemoglobin concentration.

How This List Was Created (1–5)

The American Academy of Family Physicians (AAFP) list is an endorsement of the five recommendations for Family Medicine previously proposed by the National Physicians Alliance (NPA) and published in the Archives of Internal Medicine, as part of its Less is More™ series. The goal was to identify items common in primary care practice, strongly supported by the evidence and literature, that would lead to significant health benefits, reduce risks and harm, and reduce costs. A working group was assembled for each of the three primary care specialties; family medicine, pediatrics and internal medicine. The original list was developed using a modification of the nominal group process, with online voting. The literature was then searched to provide supporting evidence or refute the activities. The list was modified and a second round of field testing was conducted. The field testing with family physicians showed support for the final recommendations, the potential positive impact on quality and cost, and the ease with which the recommendations could be implemented.

More detail on the study and methodology can be found in the Archives of Internal Medicine article: The "Top 5" Lists in Primary Care.

How This List Was Created (6–10)

The American Academy of Family Physicians (AAFP) has identified this list of clinical recommendations for the second phase of the Choosing Wisely campaign. The goal was to identify items common in the practice of family medicine supported by a review of the evidence that would lead to significant health benefits, reduce risks, harms and costs. For each item, evidence was reviewed from appropriate sources such as evidence reviews from the Cochrane Collaboration, and the Agency for Healthcare Research and Quality. The AAFP's Commission on Health of the Public and Science and Chair of the Board of Directors reviewed and approved the recommendations.

In the case of the first two items on our list – "Don't schedule elective, non-medically indicated inductions of labor or Cesarean deliveries before 39 weeks, 0 days gestational age" and "Don't schedule elective, non-medically indicated inductions of labor between 39 weeks, 0 days and 41 weeks, 0 days unless the cervix is deemed favorable" – we collaborated with the American College of Obstetricians and Gynecologists in developing the final language.

How This List Was Created (11–15)

The American Academy of Family Physicians (AAFP) has identified this list of clinical recommendations for the third phase of the Choosing Wisely® campaign. The goal was to identify items common in the practice of family medicine supported by a review of the evidence that would lead to significant health benefits, reduce risks, harms and costs. For each item, evidence was reviewed from appropriate sources such as the Cochrane Collaboration, the Agency for Healthcare Research and Quality and other sources. The AAFP's Commission on Health of the Public and Science and Board of Directors reviewed and approved the recommendations.

How This List Was Created (16–20)

The American Academy of Family Physicians (AAFP) has identified this list of clinical recommendations for the fourth phase of the Choosing Wisely® campaign. Three recommendations were derived from AAFP Preventive Services Recommendations and two were based on other medical societies' Choosing Wisely recommendations.

The goal was to identify items common in the practice of family medicine supported by a review of the evidence that would lead to significant health benefits, reduce risks, harms and costs. For each item, evidence was reviewed from appropriate sources such as the Cochrane Collaboration, the Agency for Healthcare Research and Quality and other sources. The AAFP's Commission on Health of the Public and Science and Board of Directors reviewed and approved the recommendations.

AAFP's disclosure and conflict of interest policy can be found at www.aafp.org

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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 American Academy of Family Physicians

Founded in 1947, the American Academy of Family Physicians (AAFP) represents 131,400 physicians and medical students nationwide. It is the only medical society devoted solely to primary care. Approximately one in four of all doctor's office visits are made to family physicians. Family medicine's cornerstone is an ongoing, personal patient-physician relationship focused on integrated care.

For information about health care, health conditions and wellness, please visit the AAFPs award-winning consumer website, www.familydoctor.org.

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