

Five Things Physicians and Patients Should Question

1

Avoid computed tomography (CT) scans of the head in emergency department patients with minor head injury who are at low risk based on validated decision rules.

Minor head injury is a common reason for visiting an emergency department. The majority of minor head injuries do not lead to injuries such as skull fractures or bleeding in the brain that need to be diagnosed by a CT scan. As CT scans expose patients to ionizing radiation, increasing patients' lifetime risk of cancer, they should only be performed on patients at risk for significant injuries. Physicians can safely identify patients with minor head injury in whom it is safe to not perform an immediate head CT by performing a thorough history and physical examination following evidence-based guidelines. This approach has been proven safe and effective at reducing the use of CT scans in large clinical trials. In children, clinical observation in the emergency department is recommended for some patients with minor head injury prior to deciding whether to perform a CT scan.

2

Avoid placing indwelling urinary catheters in the emergency department for either urine output monitoring in stable patients who can void, or for patient or staff convenience.

Indwelling urinary catheters are placed in patients in the emergency department to assist when patients cannot urinate, to monitor urine output or for patient comfort. Catheter-associated urinary tract infection (CAUTI) is the most common hospital-acquired infection in the U.S., and can be prevented by reducing the use of indwelling urinary catheters. Emergency physicians and nurses should discuss the need for a urinary catheter with a patient and/or their caregivers, as sometimes such catheters can be avoided. Emergency physicians can reduce the use of indwelling urinary catheters by following the Centers for Disease Control and Prevention's evidence-based guidelines for the use of urinary catheters. Indications for a catheter may include: output monitoring for critically ill patients, relief of urinary obstruction, at the time of surgery and end-of-life care. When possible, alternatives to indwelling urinary catheters should be used.

3

Don't delay engaging available palliative and hospice care services in the emergency department for patients likely to benefit.

Palliative care is medical care that provides comfort and relief of symptoms for patients who have chronic and/or incurable diseases. Hospice care is palliative care for those patients in the final few months of life. Emergency physicians should engage patients who present to the emergency department with chronic or terminal illnesses, and their families, in conversations about palliative care and hospice services. Early referral from the emergency department to hospice and palliative care services can benefit select patients resulting in both improved quality and quantity of life.

4

Avoid wound cultures in emergency department patients with uncomplicated skin and soft tissue abscesses after successful incision and drainage and with adequate medical follow-up.

Skin and soft tissue infections are a frequent reason for visiting an emergency department. Some infections, called abscesses, become walled off and form pus under the skin. Opening and draining an abscess is the appropriate treatment. Culture of the drainage is not needed as the result will not routinely change treatment.

5

Avoid instituting intravenous (IV) fluids before doing a trial of oral rehydration therapy in uncomplicated emergency department cases of mild to moderate dehydration in children.

Many children who come to the emergency department with dehydration require fluid replacement. To avoid the pain and potential complications of an IV catheter, it is preferable to give these fluids by mouth. Giving a medication for nausea may allow patients with nausea and vomiting to accept fluid replenishment orally. This strategy can eliminate the need for an IV. It is best to give these medications early during the ED visit, rather than later, in order to allow time for them to work optimally.

Five More Things Physicians and Patients Should Question

6

Avoid CT of the head in asymptomatic adult patients in the emergency department with syncope, insignificant trauma and a normal neurological evaluation.

Syncope (passing out or fainting) or near syncope (lightheadedness or almost passing out) is a common reason for visiting an emergency department and most episodes are not serious. Many tests may be ordered to identify the cause of such episodes. However, diagnostic tests for syncope should not be routinely ordered, and the decision to order any tests should be guided by information obtained from the patient's history or physical examination. CT scans of the brain are frequently ordered for this problem to look for bleeding or strokes, but published research has confirmed that abnormalities are rarely found. CT scans are expensive, and may unnecessarily expose patients to radiation. If a head injury is associated with a syncopal episode (fainting spell), then a CT scan of the brain may be indicated. In addition, if there were symptoms of a stroke (i.e., headache, garbled speech, weakness in one arm or leg, trouble walking or confusion) before or after a syncopal episode, a CT scan may be indicated. However, in the absence of head injury or signs of a stroke, a CT scan of the brain should not be routinely ordered.

7

Avoid CT pulmonary angiography in emergency department patients with a low-pretest probability of pulmonary embolism and either a negative Pulmonary Embolism Rule-Out Criteria (PERC) or a negative D-dimer.

Advances in medical technology have increased the ability to diagnose even small blood clots in the lung. Now, the most commonly used test is known as a CT pulmonary angiogram (CTPA). It is readily available in most hospitals and emergency rooms. However, disadvantages of the CTPA include patient exposure to radiation, the use of dye in the veins that can damage kidneys and high cost.

Studies have demonstrated that certain findings in a patient's medical history put them at very low risk for having a blood clot in the lung. In some cases, a blood test called a D-dimer may be additionally used to screen for the possibility of a clot. If patient historical factors and physical examination findings are negative, along with a negative D-dimer (if the physician chooses to order it), evidence shows that the risk of an undiagnosed blood clot is the same as if the patient had a negative CTPA. Such a strategy saves the risk of radiation, kidney injury and the high cost of a CTPA.

8

Avoid lumbar spine imaging in the emergency department for adults with non-traumatic back pain unless the patient has severe or progressive neurologic deficits or is suspected of having a serious underlying condition (such as vertebral infection, cauda equina syndrome, or cancer with bony metastasis).

Low back pain without trauma is a common presenting complaint in the emergency department (ED). Most of the time, such pain is caused by conditions such as a muscle strain or a bulging disc that cannot be identified on an X-ray or CT scan. When a patient has symptoms or physical findings of a serious or progressive neurological condition, or is suspected of having a serious underlying condition such as cancer or a spinal infection, imaging may be appropriate and may include plain X-rays or advanced imaging (e.g., MRI or CT scan). Diagnostic imaging does not accurately identify the cause of most low back pain and does not improve the time to recovery. The vast majority of cases of back pain in the ED are related to muscle strain or inflammation. As a result, routine imaging of the low back should be avoided in order to reduce ionizing radiation exposure and unnecessary cost.

9

Avoid prescribing antibiotics in the emergency department for uncomplicated sinusitis.

Sinusitis is a common reason for patients to visit the emergency department. Most patients with acute sinusitis do not require antibiotic treatment, because approximately 98% of acute sinusitis cases are caused by a viral infection and resolve in 10-14 days without treatment. For some patients with sinusitis, antibiotics might be appropriate, such as those patients taking drugs that reduce the effectiveness of the immune system, those with prolonged, severe symptoms, or those with worsening symptoms. Antibiotics can cause many side effects and have potentially severe complications, and these risks usually outweigh the benefits of their use for sinusitis. In addition, inappropriate antibiotic use for sinusitis can contribute to the development of antibiotic-resistant infections and contributes to avoidable health care costs.

10

Avoid ordering CT of the abdomen and pelvis in young otherwise healthy emergency department (ED) patients (age <50) with known histories of kidney stones, or ureterolithiasis, presenting with symptoms consistent with uncomplicated renal colic.

Kidney stones can cause severe pain (called renal colic) and nausea, which can usually be relieved with medication. Most stones pass spontaneously in the urine in a few days, though kidney stones often do recur. CT scans may be needed to diagnose kidney stones, and rule out other problems that may mimic the pain of kidney stones. Many patients in the ED who are less than 50 years old and who have symptoms of recurrent kidney stones do not need a CT scan unless these symptoms persist or worsen, or if there is a fever or a history of severe obstruction with previous stones. CT scans of patients in the ED with symptoms of recurrent kidney stones usually do not change treatment decisions, and the cost and radiation exposure can often be avoided in these cases. Close follow-up by a primary care physician or specialist is necessary.

How This List Was Created (1–5)

The American College of Emergency Physicians (ACEP) developed five *Choosing Wisely*[®] recommendations through a multi-step process that included input from ACEP members, an expert panel of emergency physicians and the ACEP Board of Directors. In 2012, ACEP appointed a task force to address cost effective emergency care. The Cost Effective Care Task Force conducted a survey that was open to all ACEP members asking for strategies to reduce cost and improve value in emergency medicine. The task force received over 200 individual suggestions, which were grouped into a set of strategies. A technical expert panel, including representatives from all aspects of emergency medicine practice, reviewed and prioritized the recommendations using a modified Delphi technique. The panel prioritized the strategies using multiple rounds of voting based on contribution to cost reduction, benefit to patients and actionability by emergency physicians. A literature review including data on cost was assembled for the highest-rated strategies. Strategies were further refined and a final list of strategies that received majority support of the panelists was created. Five of these were ultimately selected by the Board of Directors to be included in *Choosing Wisely*[®].

How this list was Created (6–10)

The entire ACEP membership (30,000+) was surveyed and given an opportunity to provide input on what in their view would be cost effective and improve the quality of patient care. A Delphi panel of emergency physicians was convened and the list was winnowed using the Delphi process to the top twelve. To be included in the top twelve, there must be research to demonstrate cost effectiveness and improvement of patient care if implemented with reason, caution and explanation to the patient. Also of importance was the consideration that the recommendations would be or are also in concert with some of the other specialties participating in the *Choosing Wisely*[®] campaign.

ACEP's disclosure and conflict of interest policy can be found at www.acep.org.

Sources

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