Choosing Wisely®

An initiative of the ABIM Foundation

Society of American Gastrointestinal and Endoscopic Surgeons

Ten Things Physicians and Patients Should Question

1 Don't discharge patients presenting emergently with acute cholecystitis without first offering laparoscopic cholecystectomy.

Surgeons often debate the timing of cholecystectomy in patients with uncomplicated acute cholecystitis. Evidence suggests that cholecystectomy during the index hospitalization is both safe and cost effective. Interval cholecystectomy may be associated with higher chance of requiring open surgery or readmission, increasing costs. Finally, acute cholecystitis patients that are discharged without undergoing surgery may have a higher risk of presenting with complications of cholelithiasis, which can be more morbid than the initial presentation.

2 Avoid routine cholecystectomy for patients with asymptomatic cholelithiasis.

10–20% of people in Western countries have gallstones and 50–70% of these are asymptomatic. Incidental discovery of gallstones on imaging performed for unrelated reasons is common, often prompting surgical consultation. Treatment with observation alone is indicated for asymptomatic patients with incidental cholelithiasis, unless diagnosed with related hematologic disease. Cholecystectomy for patients with asymptomatic cholelithiasis is too aggressive. For asymptomatic cholelithiasis patients undergoing an unrelated abdominal operation, such as gastric bypass, concomitant cholecystectomy may be considered.

3 Avoid other imaging tests apart from ultrasound for the initial evaluation of patients with suspected gallstone disease.

The diagnostic workup of acute right upper quadrant pain is informed by risk factors for cholecystitis. When acute cholecystitis is suspected the initial imaging modality of choice is ultrasound based on availability, examination time, lack of ionizing radiation, morphologic evaluation, confirmation of the presence or absence of gallstones, evaluation of bile ducts, and identification or exclusion of alternative diagnoses. When the clinical features, examination, laboratory and ultrasound findings are congruent, no further imaging is required.

4 Avoid the routine use of ultrasound in evaluating clinically apparent inguinal hernia.

The diagnosis of, and subsequent treatment decisions for, palpable abdominal wall hernias are reliably made by patient history and physical examination alone. While the use of ultrasonography has been shown to be of some benefit in the diagnosis of occult hernias, there is no place for its routine use in the setting of a clearly palpable defect, as it only adds unnecessary cost and treatment delay with no useful contribution to definitive surgical care.

5 Avoid opioid-only modalities for post-operative pain control.

Opioid overdose has become one of the leading causes of injury related death in the United States and can be linked to the rising rates of opioid prescriptions. Many surgical patients report unused opioid prescriptions following surgery and there is a growing call for better standardization of opioid prescribing practices. Surgeons should utilize additional strategies such as locoregional anesthetic blocks and non-opioid medications (acetaminophen, NSAIDS and others) for pain management where possible.

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6

Avoid elective hernia repair for minimally symptomatic ventral hernias in patients with severe obesity without consideration for obesity management.

Obesity is an independent risk factor for complications following ventral hernia repair. These include longer length of hospital stay, surgical site infection, and recurrence. Ventral hernia patients with asymptomatic or mild symptoms that do not interfere with daily function may be at low risk for developing acute symptoms (bowel obstruction, strangulation). Patients with severe obesity and ventral hernias should be considered for multidisciplinary evaluation with the intent to improve their weight and related diseases, prior to proceeding with elective hernia repair.

7

Avoid unnecessary perioperative fasting for elective general surgical procedures.

Fasting after midnight used to be the standard of care before surgery, but there is adequate data that prolonged fasting is associated with increased perioperative insulin resistance, delayed recovery and poorer outcomes. Based on this, the American Society of Anesthesiologists and other organizations recommend refraining from solid food for 6–8 hours before surgery without increased aspiration or regurgitation in healthy patients.

8

Avoid open surgery for elective repair of bilateral inguinal hernias if minimally invasive approaches are feasible.

Minimally invasive inguinal hernia repair is associated with faster return to work, less postoperative pain, and lower incidence of chronic groin pain compared to open surgery. For bilateral inguinal hernia, the benefits are increased as both hernias can be repaired through the same incisions in one operation. Modeled analyses suggest that a laparoscopic approach is more cost-effective for bilateral hernias compared to open surgery.

9

Avoid elective abdominal surgery in the setting of adult patients with poorly controlled diabetes (hemoglobin A1c > 8%).

Poorly controlled type-2 diabetes in adults is associated with higher risk for infectious complications. Multiple studies have demonstrated association with hemoglobin A1c and infectious complications (HgA1c>7%), prolonged length of stay (HgA1c>8%), and mortality (HgA1c>9%) following surgery. Since diabetes control is often the primary indication for metabolic and bariatric surgery, it is reasonable and advisable to proceed with metabolic and bariatric surgery if the HgA1c remains >8% despite attempts at optimization.

10

Avoid elective repair of minimally symptomatic abdominal wall hernias in patients that are actively smoking.

Current smoking is an independent predictor of perioperative morbidity. In the hernia literature specifically, smoking has been associated with increased risk of wound infection, major operative complications, readmission, and perioperative respiratory complications in addition to increased risk of hernia recurrence. As an independent and modifiable predictor of worsened outcomes, avoiding elective surgery in the setting of smoking may ultimately contribute to improved post-operative outcomes.

How This List Was Created

The SAGES Quality, Outcomes and Safety (QOS) Committee appointed a task force (composed of active members of the committee) to develop a list of potential recommendations after being provided with information and links to the *Choosing Wisely*® website. This group compiled a list of recommendations which fit the criteria outlined by the ABIM Foundation. A literature search was performed to ensure the recommendations were evidence-based. The task force then distributed the list to the full membership of the SAGES QOS Committee, asking the members of the committee to rank the recommendations by level of importance and clinical relevance. The top recommendations were discussed by the committee and selected for inclusion in this list. The list was reviewed and approved by the SAGES Executive Committee and SAGES Board of Governors.

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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 Society of American Gastrointestinal and Endoscopic Surgeons

The Society of American Gastrointestinal and Endoscopic Surgeons (SAGES) was founded in 1981 and now represents a global community of over 6,000 surgeons who can bring minimal access surgery, endoscopy and emerging techniques to patients worldwide. SAGES vision is reimagining surgical care for a healthier world. SAGES mission is to innovate, educate and collaborate to improve patient care. SAGES is committed to the following Values: inclusivity, innovation, service, excellence, global community (and an unofficial value of FUN). SAGES is honored to be a partner in the *Choosing Wisely* Campaign.

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