

Allergy & Clinical Immunology

Seven Things Clinicians and Patients Should Question

by

Canadian Society of Allergy and Clinical Immunology

Last updated: August 2021



1 **Don't order specific IgG testing to panels of foods.**

The presence of IgG to a specific food indicates previous exposure not hypersensitivity. The use of methods other than serum-specific IgE evaluation or skin prick testing in diagnosing allergies is not proven and can result in inappropriate diagnosis and treatment.

2 **Don't order specific immunoglobulin E (IgE) tests (skin or serum) unless indicated by the patient's history specific to that food.**

Specific IgE to foods may be detectable when the patient is clinically tolerant. Frequent false positives lead to incorrect diagnosis of food allergies and unnecessary dietary restrictions. Appropriate diagnosis and treatment of allergies requires specific IgE testing (either skin or blood tests) based on the patient's clinical history of signs and symptoms to optimize both cost effectiveness and patient care.

3 **Don't use antihistamines as first-line treatment in anaphylaxis.**

Epinephrine is the drug of choice to treat anaphylaxis. Overuse of antihistamines in anaphylaxis is associated with increased morbidity. H1 antagonists serve as second-line treatment for cutaneous non-life-threatening symptoms such as urticaria but should not be used in place of epinephrine. They do not alleviate or prevent cardiovascular or respiratory symptoms of anaphylaxis and can delay the administration of epinephrine, increasing the risk of potential consequences such as disability or fatality. Prompt use of epinephrine is important for the emergency treatment of anaphylaxis.

4 **Don't diagnose or manage current or chronic or persistent asthma in patients >6 years of age without objective testing such as spirometry or a methacholine challenge.**

Findings on a patient's history and physical exam such as cough, wheeze and dyspnea may be caused by many conditions, including asthma. When the diagnosis of current or persistent asthma is suspected it must be confirmed with objective testing, as up to one third of patients with suspected asthma show no objective evidence when later tested and may have went into sustained clinical remission or never had asthma. Misdiagnosis leads to delayed treatment of the underlying condition and unnecessary exposure to medication side effects. Objective methods of confirming the diagnosis of asthma in patients in whom asthma is suspected should be used such as spirometry, methacholine challenge, exercise challenge or peak flow variability. These tests may be normal when on treatment.

5 **Don't prescribe antibiotics for uncomplicated acute rhinosinusitis.**

Viral infections are the primary cause of acute rhinosinusitis, whereby only 0.5% to 2% develop into bacterial infections. Most cases of clinically diagnosed acute rhinosinusitis improve without treatment within two weeks. For those with uncomplicated acute rhinosinusitis, who have a mild illness, observation without use of antibiotics is recommended. If a decision is made to treat, clinicians should prescribe amoxicillin as first-line antibiotic therapy for most cases of acute rhinosinusitis.

6 **Don't order sinus computed tomography (CT) for uncomplicated acute rhinosinusitis.**

Abnormal images of the sinuses cannot stand alone as diagnostic evidence of bacterial rhinosinusitis. Radiologic changes such as mucosal thickening are present in most cases of acute viral infections of the upper respiratory tract when sensitive detection methods such as CT scanning are used. Incidental findings of mucosal thickening can also be seen in a high percentage of asymptomatic individuals.

7 Don't order non-beta lactam antibiotics in patients with a history of penicillin allergy, without an appropriate evaluation.

While a history of penicillin allergy is self-reported by approximately 6-25% of patients, most are able to tolerate penicillin. In those with penicillin allergy, it may remit over time. Patients deemed 'penicillin-allergic' are more likely to: be treated with broad-spectrum alternative antibiotics (such as vancomycin, quinolones and clindamycin); experience longer hospital stays; and develop complications such as infections with methicillin-resistant *Staphylococcus aureus*, vancomycin-resistant *Enterococcus*, and *Clostridium difficile*. IgE-mediated penicillin allergy can be evaluated through skin testing or graded oral challenge.

How the list was created

The CSACI president created a task force to lead work on Choosing Wisely. Through multiple society notifications, CSACI members were invited to offer feedback and recommend elements to be included in the list. A targeted email was also sent to an extended group of CSACI leadership inviting them to participate. The work group reviewed the submissions to ensure the best science in the specialty was included. Suggested elements were considered for appropriateness, relevance to the core of the specialty, potential overuse of resources and opportunities to improve patient care. They were further refined to maximize impact and eliminate overlap, and then ranked in order of potential importance both for the specialty and for the public. Finally, the work group chose its top recommendations which were then approved by the Executive Committee.

The CSACI's disclosure and conflict of interest policy can be found at www.csaci.ca.

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About the Canadian Society of Allergy and Clinical Immunology

The Canadian Society of Allergy & Clinical Immunology (CSACI) represents allergists, asthma specialists, clinical immunologists, allied health professionals, and others with a special interest in the research and treatment of allergic and immunologic diseases. The Canadian Society of Allergy and Clinical Immunology is one of the oldest specialty societies in Canada. It was founded in 1945 as the Canadian Society for the Study of Allergy and changed its name in 1954 to the Canadian Academy of Allergy. In 1967, it adopted the present name, The Canadian Society of Allergy and Clinical Immunology (CSACI). For more information or questions, please visit www.csaci.ca.



About Choosing Wisely Canada

Choosing Wisely Canada is the national voice for reducing unnecessary tests and treatments in health care. One of its important functions is to help clinicians and patients engage in conversations that lead to smart and effective care choices.

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Anesthesiology

Five Things Clinicians and Patients Should Question

by
Canadian Anesthesiologists' Society
Last updated: November 2020



1 **Don't order baseline laboratory studies (complete blood count, coagulation testing, or serum biochemistry) for asymptomatic patients undergoing low-risk non-cardiac surgery.**

Conducting baseline laboratory investigations before low-risk non-cardiac surgery contributes little value to perioperative care. A focused clinical history and physical examination may reliably identify relevant abnormalities sought by routine laboratory testing before low-risk surgery. In addition, evidence suggests that abnormal results in this setting only rarely influence management and do not improve clinical outcomes. Preoperative testing may add value in the setting of a symptomatic patient or higher-risk surgery, but should not be performed routinely before low-risk surgery on asymptomatic patients.

2 **Don't order a baseline electrocardiogram for asymptomatic patients undergoing low-risk non-cardiac surgery.**

Electrocardiograms (ECGs) performed before elective, non-cardiac, surgeries are frequently abnormal. This is especially true when this test is done in older patients. Despite the frequency of these abnormalities, ECGs do little to improve risk prediction beyond simply asking patients about their health. Serious cardiac events like heart attack are rare following low-risk surgeries; there is little that physicians can do to further lower this risk. A preoperative ECG will therefore not improve outcome but may lead to more testing or treatment that is of little benefit. ECGs used to identify the cause of symptoms (palpitations, chest pain, dyspnea, etc.) remain useful diagnostic tools regardless of whether the patient is having surgery.

3 **Don't order a baseline chest X-ray in asymptomatic patients, except as part of surgical or oncological evaluation.**

While chest X-rays (CXRs) remain an important part of surgeon's evaluation before cancer or thoracic surgeries, it is better if these staging examinations are complete before committing a patient to surgery. CXRs are not indicated in the routine pre-anesthetic assessment. In the absence of symptoms, CXRs yield few diagnoses and many false positives. CXRs do not improve risk prediction or stratification. CXR in the pre-anesthetic evaluation should be reserved for patients with symptoms consistent with acute cardiopulmonary illness (dyspnea, wheeze, productive sputum, etc.).

4 **Don't perform resting echocardiography as part of preoperative assessment for asymptomatic patients undergoing low to intermediate-risk non-cardiac surgery.**

Resting echocardiography has a clear role for resolving diagnostic questions in surgical patients, such as identifying the basis for suspicious systolic murmurs or new dyspnea on exertion. Outside these indications, resting echocardiography does not contribute significant additional prognostic information to usual clinical evaluation. It is not useful as a screening tool to identify surgical patients at risk for cardiac complications.

5 **Don't perform cardiac stress testing for asymptomatic patients undergoing low to intermediate risk non-cardiac surgery.**

Stress testing can help resolve diagnostic uncertainty in surgical patients, such as determining whether individuals with chest discomfort and vascular risk factors have undiagnosed coronary artery disease. It can also help identify patients at elevated risk for cardiac complications after major vascular surgery. Nonetheless, asymptomatic individuals with good functional capacity have a very low risk of cardiac complications after low-to-intermediate non-cardiac surgery. Stress testing in such individuals is not useful for delineating expected perioperative risk and guiding clinical care.

How the list was created

The Canadian Anesthesiologists' Society (CAS) established its Choosing Wisely Canada (CWC) top 5 recommendations by engaging a small team of expert Canadian anesthesiologists to develop research methodology and carry out a survey to establish the CAS top five recommendations. The survey was based on similar work done by the American Society of Anesthesiologists who identified an evidence-based list of activities to question within anesthesiology as Five Things Physicians and Patients Should Question: American Society of Anesthesiologists. The CAS team defined a short list of twelve tests and procedures in perioperative care and asked members of the CAS to consider each and answer questions about their frequency of use, impact on quality of the care for patients, cost of the investigation, evidence to support the investigation and potential to avoid ordering the investigation. Five recommendations were selected through survey data collection and analysis by the CAS research team in conjunction with a professional survey consultant and expert consensus. The top five were presented at the CAS Annual Meeting in June 2015 and will be published in the Canadian Journal of Anesthesia.

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About the Canadian Anesthesiologists' Society

The CAS is the national specialty society for anesthesiology in Canada. The CAS was founded in 1943 as a not-for-profit, voluntary organization and is guided by its vision of innovative leadership and excellence in anesthesiology, perioperative care, and patient safety. The CAS represents 3,000 members (anesthesiologists, GP anesthetists, residents, Anesthesia Assistants, etc.) across Canada and around the world and is dedicated to promoting excellence in patient care through research, education and advocacy.



About Choosing Wisely Canada

Choosing Wisely Canada is the national voice for reducing unnecessary tests and treatments in health care. One of its important functions is to help clinicians and patients engage in conversations that lead to smart and effective care choices.

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Blood and Marrow Transplant

Five Things Clinicians and Patients Should Question

by

American Society for Transplantation and Cellular Therapy

Cell Therapy Transplant Canada

Last updated: January 2020



1 **Don't routinely use peripheral blood stem cells for patients with aplastic anemia when a suitable bone marrow donor is available due to a higher risk of graft-versus-host disease.**

While faster engraftment with filgrastim-mobilized peripheral blood stem cells results in quicker recovery of peripheral blood counts compared to bone marrow in patients with aplastic anemia, the higher rate of graft-versus-host disease may be detrimental.

2 **Don't use greater than 2 mg/kg/day of methylprednisolone (or equivalent) for the initial treatment of graft-versus-host disease.**

Published studies have shown no advantage to using methylprednisolone-equivalent doses higher than 2 mg/kg/day in acute graft-versus-host disease. In addition, using higher doses increases risks of corticosteroid related toxicity. Furthermore, at least in patients with grade I-II acute graft-versus-host disease, initial therapy with lower-dose corticosteroids at 1 mg/kg/day may be equivalent.

3 **Don't routinely use two cord blood units for standard umbilical cord blood transplantation when a single unit of adequate size is available, recognizing that higher cell doses are preferred when using units with greater HLA mismatch.**

Randomized trials demonstrate similar clinical outcomes after single-unit and double-unit umbilical cord blood transplantation, including comparable rates of relapse, engraftment failure, overall survival, and transplantation related mortality. Moreover, graft-versus-host disease may be more frequent after double-cord blood transplantation.

4 **Don't routinely use peripheral blood stem cells for matched unrelated donor transplantation using myeloablative conditioning and standard graft-versus-host disease prevention regimens when a suitable bone marrow donor is available.**

Patients undergoing myeloablative matched unrelated donor hematopoietic cell transplantation with standard graft-versus-host disease prophylaxis (calcineurin inhibitor and methotrexate) with a peripheral blood stem cell graft experience more symptomatic chronic graft-versus-host disease than those receiving bone marrow, without affecting relapse rates or overall survival. Peripheral blood stem cells may be considered in cases with substantial recipient/donor size discrepancy, donor preference, and for malignant diseases with high risk for graft failure.

5 **Don't routinely give immunoglobulin replacement to adult hematopoietic cell transplantation recipients in the absence of recurrent infections regardless of the IgG level.**

Meta-analyses of controlled trials conclude that immunoglobulin replacement offers no advantage for infection prevention and overall survival, and may predispose to a higher risk of hepatic sinusoidal obstruction syndrome, venous thromboembolism, and impair the efficacy of post-transplant vaccinations. There may be subsets of patients where prophylactic immunoglobulin replacement may be considered, such as in umbilical cord blood transplant recipients, in children undergoing transplantation for inherited or acquired disorders associated with B-cell deficiency, and in chronic graft-versus-host disease patients with recurrent sino-pulmonary infections.

How the list was created

The American Society for Transplantation and Cellular Therapy (ASTCT) and Cell Therapy Transplant Canada (CTTC) established a Choosing Wisely BMT Task Force whose objective was to create a list of top five practices in blood and marrow transplantation to be questioned. The Task Force consisted of representatives from ASTCT's Quality Outcomes, Education, and Practice Guidelines Committees, ASTCT's Pharmacy Special Interest Group, CTTC Program Directors, and Center for International Blood and Marrow Transplant Research (CIBMTR). Suggestions for current transplantation practices to question were elicited from the CTTC Program Directors, members of ASTCT's Quality Outcomes, Practice Guidelines and Education committees, and chairs of the CIBMTR scientific working committees. Suggestions were ranked based on their potential impact on harm reduction, cost reduction, necessity of the test or practice, and the strength of available evidence. Through a modified Delphi process, suggestions were narrowed down to six, which were then subjected to systematic reviews. After further discussion by the Task Force, the final five recommendations were generated.

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About the American Society for Transplantation and Cellular Therapy

The American Society for Transplantation and Cellular Therapy (ASTCT) is an international professional membership association of physicians, investigators and other healthcare professionals involved in blood and marrow transplantation and novel cellular therapies. The ASTCT represents the interests of transplant clinicians and investigators and the patients they serve in eight broad areas: research, representation, clinical standards, regulation, communications, accreditation, reimbursement, and recruiting and training clinical personnel.



About Cell Therapy Transplant Canada

Cell Therapy Transplant Canada (CTTC), formerly Canadian Blood and Marrow Transplant Group, is a member-led, national, multidisciplinary organization providing leadership and promoting excellence in patient care, research and education in the field of hematopoietic stem cell transplant and cellular therapy.



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Burns

Eleven Things Physicians and Patients Should Question

by

Burns Canada

Last updated: December 2020



1 Do not administer prophylactic antibiotics to patients presenting with acute burn injuries.

The available evidence does not support the routine use of early systemic antibiotic prophylaxis in the management of patients with acute burn injuries. In addition to exposing patients to side-effects, antibiotic use without indication encourages the development of resistance, thus reducing treatment options during the patient's hospital course. Topical antimicrobial dressings are the standard of care for these patients.

2 Do not routinely swab open wounds and do not prescribe systemic antibiotics based on these results, without clinical features of local or systemic infection.

Most wound swabs in the context of a burn injury will yield bacterial growth. These organisms may be commensal organisms not responsible for wound infection or sepsis, and do not warrant therapy. The use of systemic agents predisposes to antimicrobial resistance, is expensive, and may also expose patients to unnecessary side-effects. Burn wound swabs should form part of standardized admission surveillance programs for resistant organisms such as MRSA.

3 Do not transfuse red blood cells to patients with burn injuries who have haemoglobin levels greater than 70 g/l, unless there is active haemorrhage or myocardial ischaemia.

Blood products are a limited resource. Blood transfusion is associated with adverse effects, including transfusion reactions, immunosuppression, lung injury, and circulatory overload. In the context of stable patients with burn injuries, who are not actively bleeding or with active myocardial ischaemia, the current evidence supports a restrictive transfusion trigger to maintain haemoglobin above 70g/l. Unnecessary transfusions can also be avoided by ordering and infusing one unit of red blood cells at a time (with interval blood tests to confirm indication for a further unit), rather than ordering two units immediately.

4 Do not attempt to normalise albumin with albumin infusions following the acute phase of burn resuscitation.

Albumin infusions are part of the acute resuscitation strategy of many burn centres globally, and may be associated with the administration of smaller volumes of crystalloid. Patients with severe burn injuries frequently develop chronic hypoalbuminaemia following resuscitation, due to hypermetabolism, fluid and protein loss from wounds, and impaired albumin synthesis. Attempting to restore serum albumin levels with the continuous infusion of human albumin solutions does not appear to improve outcomes in burn patients, and is costly.

5 Do not administer opioid analgesics to patients with burn injuries without considering the co-administration of adjunctive agents, as well as psychological and physical strategies.

Reliance on opioids as the dominant or only analgesic is associated with harms including not only higher opioid requirements and significant side-effects e.g. nausea, constipation, drowsiness, but also dependence, diversion, and overdose. One should implement a multi-modal analgesic strategy including acetaminophen and NSAIDs if there are no contra-indications. One should also consider medications directed at neuropathic pain (e.g. gabapentin, pregabalin, duloxetine, amitriptyline), as well as physical (e.g. positioning) and psychological (e.g. distraction, relaxation, meditation) interventions to optimize mental health, reduce anxiety and promote effective sleep.

6 Do not administer analgesia and sedation (e.g. opioids and benzodiazepines) without regular titration, interruption or dose reassessment of the administered agents.

It is important to regularly review the indication and dosage of analgesia and anxiolytics (including but not limited to opioids and benzodiazepines) in patients mechanically ventilated for their burn injuries. Higher doses of opioids and benzodiazepines are associated with delays in extubation, an increased risk of systemic infections (including ventilator associated pneumonia), deep vein thrombosis, delirium, and longer hospital stays, which in turn result in deconditioning, and long-term psychological effects.

7 Do not undertake medical or surgical procedures if these are inconsistent with the burn patient's expressed goals of care.

All patients should have a goals of care discussion (between the health care team and the patient and/or substitute decision maker) during the first 48 hours of their hospital stay. This is especially relevant for patients with extensive burn injuries, the elderly, and those at high risk of death. Interventions should only be undertaken when they are in keeping with the patient's previously expressed goals of care or best interests, as determined by the patient's substitute decision-maker in conjunction with the clinical team.

8 Do not routinely initiate fluid resuscitation when the burn is less than 15% total body surface area (TBSA).

Partial and full thickness burns affecting less than 15% of the TBSA do not require specific directed fluid resuscitation. Patients with burn injuries under 15% can typically meet their requirements with maintenance intravenous fluid infusions or oral fluid intake alone. There may be other associated indications for fluid replacement, however, such as concomitant trauma, dehydration, alcohol intoxication, or other fluid losses.

9 Do not perform routine investigations such as daily blood tests or chest radiographs unless they will guide decision making with respect to management of the patient with burns.

The medical team should regularly reassess the indications for routine daily bloodwork and chest radiographs as the clinical course proceeds, especially when there has been no significant intervening condition change. Several studies have demonstrated the cost benefits of such a strategy, without compromising the delivery of optimal patient care.

10 Do not excise and autograft partial thickness burns, including scald burns in children, without a period of wound care and observation, unless obvious deep partial thickness.

A significant proportion of partial thickness burn injuries will heal within two to three weeks without surgery. A period of observation of a week or more, especially in smaller burns, will allow the wound to manifest features of healing or the capacity to heal. This is especially true in the context of paediatric scald burns, the most common category of burn injuries globally. A conservative approach to the management of these wounds has the potential to reduce healthcare costs, the need for operative procedures, and the impact of donor site wound care and pain. There is also limited evidence to suggest that a wound that heals within three weeks is more likely to scar prominently when compared to a split thickness skin graft.

11 Do not recommend the administration of hydroxycobalamin (Vitamin B-12A or 'cyanokit') to patients prior to assessment in the burn centre, unless the history and investigations strongly support its use.

Evidence supporting the routine use of hydroxycobalamin is weak and may be associated with the development of renal impairment. Hydroxycobalamin may be administered in the burn centre in the setting of a severe inhalation injury and uncorrected worsening metabolic acidaemia. Patients with a strong clinical picture of severe inhalation injury who require prolonged transport to a burn centre may be the exception to this rule.

How the list was created

This list was created by a working group of burn surgeons and intensivists from across Canada.

A list of 35 themes were developed from initial discussions, and then a modified Delphi process using Survey Monkey enabled the collaborators to systematically stratify statements from 0-5 (strongly disagree, disagree, indifferent, agree and strongly agree). Consensus of expert opinion and evidence from the literature informed the final wording of the statements.

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About Burns Canada

Burns Canada is a working group of burn surgeons and intensivists from across Canada.

About Choosing Wisely Canada

Choosing Wisely Canada is the national voice for reducing unnecessary tests and treatments in health care. One of its important functions is to help clinicians and patients engage in conversations that lead to smart and effective care choices.

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Cardiology

Six Things Clinicians and Patients Should Question

by
Canadian Cardiovascular Society
Last updated: January 2021



1 Don't perform stress cardiac imaging or advanced non-invasive imaging in the initial evaluation of patients without cardiac symptoms unless high-risk markers are present.

Asymptomatic, low-risk patients account for up to 45 percent of unnecessary "screening". Testing should be performed only when the following findings are present: diabetes in patients older than 40-years-old; peripheral arterial disease; or greater than 2 percent yearly risk for coronary heart disease events.

2 Don't perform annual stress cardiac imaging or advanced non-invasive imaging as part of routine follow-up in asymptomatic patients.

Performing stress cardiac imaging or advanced non-invasive imaging in patients without symptoms on a serial or scheduled pattern (e.g., every one to two years or at a heart procedure anniversary) rarely results in any meaningful change in patient management. This practice may, in fact, lead to unnecessary invasive procedures and excess radiation exposure without any proven impact on patients' outcomes. An exception to this rule would be for patients more than five years after a bypass operation.

3 Don't perform stress cardiac imaging or advanced non-invasive imaging as a pre-operative assessment in patients scheduled to undergo low-risk non-cardiac surgery.

Non-invasive testing is not useful for patients undergoing low-risk non-cardiac surgery (e.g., cataract removal). These types of tests do not change the patient's clinical management or outcomes.

4 Don't perform echocardiography as routine follow-up for mild, asymptomatic native valve disease in adult patients with no change in signs or symptoms.

Patients with native valve disease usually have years without symptoms before the onset of deterioration. An echocardiogram is not recommended yearly unless there is a change in clinical status.

5 Don't order annual electrocardiograms (ECGs) for low-risk patients without symptoms.

Don't obtain screening electrocardiogram testing in individuals who are asymptomatic and at low risk for coronary heart disease. In asymptomatic individuals at low risk for coronary heart disease (10-year risk <10%), screening for coronary heart disease with electrocardiography does not improve patient outcomes.

6 Don't offer therapies on the basis of survival benefit without establishing your patient's prognosis, preferences, and goals of care.

It is often the path of least resistance to follow medical care algorithms and escalate care as patient's require it. However, it has been consistently shown that patients value goals of care discussions to better understand prognosis and possible next therapeutic steps. These discussions enhance patient care and help avoid unnecessary interventions.

How the list was created

The Canadian Cardiovascular Society (CCS) established its Choosing Wisely Canada top 5 recommendations by working closely with the American College of Cardiology (ACC). The ACC provided the CCS with the literature review, complete to 2009, that had informed their top 5 recommendations. This provided a strong foundation for the CCS to begin its investigation into relevant top 5 recommendations for cardiac care in the Canadian context. The CCS then conducted an extensive literature review to include all relevant publications since January 1, 2009. Moreover the CCS also included all relevant existing Canadian Guidelines, any Canadian appropriate use criteria and Canadian national or provincial policies that pertained to the five statements. The CCS then performed an extensive dissemination and consultation with its membership via email, Facebook, Twitter, the annual national meeting and webinars to ensure awareness and approval of the top 5 recommendations. The first four items were adapted with permission from the Five Things Physicians and Patients Should Question, ©2012 American College of Cardiology. Item 5 was adapted with permission from the Five Things Physicians and Patients Should Question, ©2012 American College of Family Medicine.

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About the Canadian Cardiovascular Society

The CCS mission is to promote cardiovascular health and care through knowledge translation, including dissemination of research and encouragement of best practices and professional development, as well as leadership in health policy. Its 2,000+ members include academic and community cardiologists, cardiac surgeons, pediatric cardiologists, trainees in those fields, researchers and other health care professionals working in cardiac sciences in all corners of the country.



Canadian Cardiovascular Society
Leadership. Knowledge. Community.

About Choosing Wisely Canada

Choosing Wisely Canada is the national voice for reducing unnecessary tests and treatments in health care. One of its important functions is to help clinicians and patients engage in conversations that lead to smart and effective care choices.

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Critical Care

Five Things Clinicians and Patients Should Question

by

Canadian Critical Care Society

Canadian Association of Critical Care Nurses

Canadian Society of Respiratory Therapists

Last updated: September 2021



1 **Don't start or continue life supporting interventions unless they are consistent with the patient's values and realistic goals of care.**

Patients and their families often value the avoidance of invasive or overly aggressive life-sustaining measures when they are at the end of life. However, many dying patients receive aggressive life-sustaining therapies, in part due to clinicians' failures to elicit patients' preferences and to provide recommendations.

2 **Don't prolong mechanical ventilation by over-use of sedatives and/or analgesics and bed rest.**

Maintaining critically ill patients in an immobile or minimally mobile state during care may potentiate muscle loss and deconditioning. Excessive and/or prolonged use of sedatives is associated with worse outcomes, including increased delirium, excessive use of diagnostic imaging for coma, increased number of tracheostomies, greater duration of mechanical ventilation and ICU length-of-stay.

3 **Don't continue mechanical ventilation without a daily assessment for the patient's ability to breathe spontaneously using coordinated spontaneous breathing and awakening trials.**

Screening for readiness for liberation from mechanical ventilation with spontaneous breathing trials allows clinicians earlier recognition of patients that may be liberated from mechanical ventilation.

4 **Don't order routine investigations including chest radiographs or blood tests in critically ill patients, except to answer a specific clinical question.**

Chest radiographs ("X-rays", CXRs) are not indicated for routine assessment of critically-ill patients except when indicated for specific procedures (e.g., endotracheal tube, naso- or orogastric tube, central vein catheter, pulmonary artery catheter, or other procedure requiring verification after insertion), or to provide information for a specific question related to a change in patient's clinical condition, and if the information will likely impact a specific decision related to diagnosis or treatment.

5 **Don't routinely transfuse red blood cells in hemodynamically stable ICU patients with a hemoglobin concentration greater than 70 g/L (a threshold of 80 g/L may be considered for patients undergoing cardiac or orthopedic surgery and those with active cardiovascular disease).**

Unnecessary transfusion of red blood cells (RBCs) is more harmful than helpful, and wastes a limited resource, which should be reserved for patients with proven indications. Transfusing RBCs at a threshold higher than 70 g/L does not improve survival in ICU patients, and is associated with more complications and higher costs. This has been extensively studied and a restrictive transfusion strategy results in similar or lower mortality compared with higher thresholds, and other complications, including stroke and infections, may also be reduced.

How the list was created

The Choosing Wisely Canada list of recommendations relevant to critical care was assembled by a collaborative task force from Canadian Critical Care Society (CCCS), Canadian Association of Critical Care Nurses, Canadian Society of Respiratory Therapists and representatives from pharmacy, dietitian and physiotherapy. The initial list of items were generated by task force, with support from CCCS Google groups. A modified Delphi method was used to retain 10 items from the initial list. A modified Delphi method was then used to generate domains of interest for ranking items and to select the final list of 5 items. Members of all collaborating societies were surveyed during the 2016 Canadian Critical Care Conference, and for 2 weeks afterwards. Items were modified after review of the survey and feedback from the Choosing Wisely Canada campaign leadership.

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About The Canadian Critical Care Society

CCCS is the national specialty society, representing adult and paediatric critical care medicine physicians in Canada. The practice of critical care medicine in Canada is multidisciplinary and CCCS members hold base specialty certification in anaesthesia, medicine, paediatrics, emergency medicine or surgery and some surgical subspecialties such as cardiac surgery and neurosurgery.

About The Canadian Association of Critical Care Nurses

CACCN is a volunteer organization of critical care nurses. CACCN is the voice for excellence in Canadian critical care nursing. Their shared goal is promote quality patient- and family-centered care for Canadian's experiencing life threatening illness and injury.

About The Canadian Society of Respiratory Therapists

CSRT is the national professional association for respiratory therapists. Founded in 1964 as the Canadian Society of Inhalation Therapy Technicians, the CSRT is dedicated to excellence in cardiorespiratory care.

About Choosing Wisely Canada

Choosing Wisely Canada is the national voice for reducing unnecessary tests and treatments in health care. One of its important functions is to help clinicians and patients engage in conversations that lead to smart and effective care choices.

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Dermatology

Five Things Clinicians and Patients Should Question

by
Canadian Dermatology Association
Last updated: November 2020



1 **Don't routinely prescribe antibiotics for bilateral lower leg redness and swelling.**

Cellulitis is commonly misdiagnosed and may be incorrectly applied as a diagnosis in 1 in 3 cases. There are many causes of 'pseudocellulitis', including: stasis dermatitis, acute lipodermatosclerosis, lymphedema, eczematous dermatitis, contact dermatitis, gout and tinea pedis. The most common among these is stasis dermatitis which generally affects the bilateral lower legs. In the setting of bilateral lower leg skin changes, causes of 'pseudocellulitis' should be considered.

2 **Don't routinely prescribe topical combination corticosteroid/antifungal products.**

Topical corticosteroid/antifungal products in cream or ointment formulations contain high-potency corticosteroids generally considered inappropriate for skin conditions affecting the face and skin folds. These have been prescribed for suspected superficial fungal infections and diaper dermatitis. However, evidence demonstrates inferior clinical efficacy, higher recurrence rates and harmful side effects (skin thinning and systemic absorption) compared to topical antifungals alone. In practice, their use may complicate diagnosis and prolong treatment. Suspicion of fungal infection should be confirmed by skin scraping, and fungal infections with substantial itch may be treated with a short-term topical mild to moderate corticosteroid prescription.

3 **Don't routinely use topical antibiotics on a surgical wound.**

Post-surgical wounds in dermatology may be closed with stitches or allowed to heal in from the base. Most dermatologic procedures result in wounds that are classified as 'non-contaminated' and have low baseline potential for infection. For wounds closed with stitches, the potential harms (allergic contact dermatitis to topical ingredients, antibiotic resistance) outweigh the marginal reduced risk of postoperative infection achieved by use of antibiotics applied to the skin. Only wounds that show symptoms of infection (purulence, swelling, spreading redness, wound breakdown and systemic symptoms) should receive appropriate antibiotic treatment.

4 **Don't prescribe systemic anti-fungals for suspected onychomycosis without mycological confirmation of dermatophyte infection.**

Fungal nail infections account for half of all causes of nail changes (onychodystrophy). The other half can be attributed to conditions such as onychogryphosis (secondary nail thickening), psoriasis and lichen planus. Health care providers vary in their ability to correctly predict fungal toenail infections which can be confirmed by simple microscopy, fungal culture, or histology. Systemic antifungals indicated for moderate to severe nail infection can result in a variety of drug-drug interactions and confer increased risk for heart and liver failure. Confirming a fungal infection can prevent unnecessary treatment with avoidable harms and guide the diagnosis of other possible causes.

5 **Don't use oral antibiotics for acne vulgaris for more than 3 months without assessing efficacy.**

Antibiotics are the most common systemic agent prescribed for the treatment of acne, employed for their antibacterial and anti-inflammatory effect. Prolonged antibiotic courses can lead to disruption of the normal microbiome, increased rates of upper respiratory infection and has been linked to the development of other systemic disorders. There are also rising rates of antibiotic resistance to pathogenic acne bacteria. For moderate or more severe acne warranting systemic treatment, the effect of oral antibiotics should be reassessed after 3 months to gauge progress. If ineffective, treatment should be modified to other systemic medications such as anti-androgens (spironolactone), combined oral contraceptive pills or retinoids. Use of oral antibiotics should always be combined with topical benzoyl peroxide and/or a topical retinoid.

How the list was created

A working group of Canadian Dermatology Association (CDA) members was created based on interest in the topic of resource stewardship in Dermatology. The working group undertook a review of Choosing Wisely Dermatology specialty recommendations in other jurisdictions, followed by a focused review of published literature with the keywords evidence-based medicine, value-based healthcare, and dermatology. From this aggregated list of recommendations, items that were inappropriate for our jurisdiction and disputed by most recent evidence were excluded. Five guidelines were selected for the 'core recommendations' and an additional five guidelines were included in a 'supplemental list'. Reviewers varied in practice type and geography were asked to consider the following criteria in evaluating the recommendations: relevance to dermatology, frequency of occurrence and potential for harm. Reviewers were asked to agree or disagree with the core recommendations and propose a replacement from the supplemental list or another source if there was disagreement. The final consensus list was then approved by the CDA Board of Directors and presented at the CDA 2018 Annual Conference.

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About the Canadian Dermatology Association

The Canadian Dermatology Association (CDA), founded in 1925, represents Canadian certified dermatologists. The association provides easy access to a reliable source of medical knowledge on dermatology. CDA exists to advance the science and art of medicine and surgery related to the care of the skin, hair and nails; provide continuing professional development for its members; support and advance patient care; provide public education on sun protection and other aspects of skin health; and promote a lifetime of healthier skin, hair and nails.



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Emergency Medicine

Ten Things Physicians and Patients Should Question

by
Canadian Association of Emergency Physicians
Last updated: December 2021



1 **Don't order CT head scans in adults and children who have suffered minor head injuries (unless positive for a validated head injury clinical decision rule).**

Head injuries in children and adults are common presentations to the emergency department. Minor head injury is characterized by: Glasgow Coma Scale (GCS) 13–15, an event that is associated with either witnessed loss of consciousness, definite amnesia, or witnessed disorientation. Most adults and children with minor head injuries do not suffer from serious brain injuries that require hospitalization or surgery. CT head scans performed on patients who lack high-risk features can expose patients to unnecessary ionizing radiation that has the potential to increase patients' lifetime risk of cancer. They also increase length of stay and increase the detection of false-positives (incidental, non-clinically relevant findings). There is strong evidence that physicians should not order CT head scans for patients with minor head injury unless validated clinical decision rules are used to make imaging decisions (i.e., Canadian CT head rule for adults, and Canadian Assessment of Tomography for Childhood Head Injury (CATCH) and/or PECARN rules for children). However, CATCH has been shown to be less sensitive than PECARN at detecting any brain injury on CT. While we recommend the use of clinical decision rules (CDRs) for head injuries, these rules are meant to assist and not replace, clinical judgment.

2 **Don't prescribe antibiotics in adults with bronchitis/asthma and children with bronchiolitis.**

Respiratory distress from bronchospasm/wheezing is a common presentation in both children (i.e., bronchiolitis) and adults (i.e., bronchitis/asthma) seen in the emergency department. Most patients with symptoms do not have bacterial infections that require antibiotic treatment or influence outcomes (i.e., hospitalization). Inappropriate administration of antibiotics can expose patients to unnecessary risks (i.e., allergies, rash, diarrhea and other side-effects) and has the potential to increase patients' risk of antibiotic induced diarrhea, including infections with *C. Difficile*. These prescriptions also increase overall antibiotic resistance in the community, and limit the effectiveness of standard antibiotics in the treatment of legitimate bacterial infections. There is strong applied research evidence to recommend that physicians should not prescribe antibiotics in children (i.e., bronchiolitis) and adults (i.e., bronchitis and asthma) with wheezing presentations.

3 **Don't order lumbosacral (low back) spinal imaging in patients with non-traumatic low back pain who have no red flags/pathologic indicators.**

Adults with non-specific lumbosacral (low back) pain, in the absence of significant trauma (i.e., car crash, acute axial loading, acute hyperflexion, etc.), commonly present to the emergency department. The evaluation of patients presenting with non-traumatic low back pain should include a complete focused history and physical examination to identify "red flags" that may indicate significant pathology. These may include, but are not limited to: features of cauda equina syndrome, weight loss, history of cancer, fever, night sweats, chronic use of systemic corticosteroids, chronic use of illicit intravenous drugs, patients with first episode of low back pain over 50 years of age and especially if over 65, abnormal reflexes, loss of motor strength or loss of sensation in the legs. In the absence of red flags, physicians should not order radiological images for patients presenting with non-specific low back pain. Imaging of the lower spine for symptomatic low back pain does not improve outcomes, exposes the patient to unnecessary ionizing radiation and contributes to flow delays without providing additional value.

4 **Don't order neck radiographs in patients who have a negative examination using the Canadian C-spine rules.**

Neck pain resulting from trauma (such as a fall or car crash) is a common reason for people to present to the emergency department. Very few patients have a cervical spinal injury that can be detected on radiographs ("X-rays"). History, physical examination and the application of clinical decision rules (i.e., the Canadian C-spine rule) can identify alert and stable trauma patients who do not have cervical spinal injuries and therefore do not need radiography. The Canadian C-spine rule has been validated and implemented successfully in Canadian centres, and physicians should not order imaging unless this rule suggests otherwise. Unnecessary radiography delays care, may cause increased pain and adverse outcomes (from prolonged spinal board immobilization), and exposes the patient to ionizing radiation without any possible benefit. This strategy will reduce the proportion of alert patients who require imaging.

5 Don't prescribe antibiotics after incision and drainage of uncomplicated skin abscesses unless extensive cellulitis exists.

Justification (revised): Abscesses are walled off collections of pus in soft tissue, with *Staphylococcus aureus* (both sensitive and resistant to methicillin) being the microbe most frequently involved. Most uncomplicated abscesses should undergo incision in an acute care setting such as the emergency department, using local anesthesia or procedural sedation, with complete drainage and appropriate follow-up. Antibiotics may be considered when patients are immunocompromised, systemically ill, or exhibit extensive surrounding cellulitis or lymphangitis. In populations with a high [methicillin-resistant *S. aureus*] MRSA prevalence, there is some evidence to suggest that antibiotics in addition to incision and drainage of uncomplicated abscesses may confer some benefit. However, we encourage physicians to discuss the use of antibiotics in uncomplicated abscesses with patients as the benefits conferred by antibiotics may not outweigh the risks associated with their use (i.e. nausea, diarrhea, and allergic reactions), and the possible benefit to a small percentage of patients may not balance the significant public health and societal effects of antibiotic overuse.

6 Don't order CT head scans in adult patients with simple syncope in the absence of high-risk predictors.

Patients commonly present to the emergency department with syncope. Syncope is a transient loss of consciousness followed by a spontaneous return to baseline neurologic function that does not require resuscitation. The evaluation of syncope should include a thorough history and physical exam to identify high-risk clinical predictors for CT head abnormalities. These high-risk predictors include, but are not limited to: trauma above the clavicles, headache, persistent neurologic deficit, age over 65, patients taking anticoagulants, or known malignancies. Many patients with syncope receive a CT scan of the head; however, in the absence of these predictors, a CT head is unlikely to aid in the management of syncope patients. CT scans can expose patients to unnecessary ionizing radiation that has the potential to increase patients' lifetime risk of cancer. Unwarranted imaging also increases length of stay and misdiagnosis.

7 Don't order CT pulmonary angiograms or VQ scans in patients with suspected pulmonary embolism until risk stratification with decision rule has been applied and when indicated, D-dimer biomarker results are obtained.

Many adults present to the emergency department with chest pain and/or shortness of breath. The majority of adult patients with these symptoms do not have a pulmonary embolism (PE) that requires investigation with a CT pulmonary angiogram (CTPA) or ventilation perfusion (VQ) lung scan. CTPAs or VQ scans expose patients to ionizing radiation that has the potential to increase patients' lifetime risk of cancer. CTPAs also place patients at risk for potential allergic reaction and acute kidney injury from the intravenous contrast required for the CTs. Imaging also increases length of stay and may contribute to misdiagnosis. Evidence demonstrate that physicians should not order CTPAs or VQ scans to diagnose PE until risk stratification with a clinical decision rule (Wells score, PERC rule) has been applied and d-dimer biomarker results are obtained for those patients where it is indicated. For high-risk populations in which the clinical decision rules have not been validated (i.e., pregnancy, hypercoagulability disorders), physicians are urged to exert their clinical judgment.

8 Don't routinely use antibiotics in adults and children with uncomplicated sore throats.

Adults and children frequently present to the emergency department with sore throats (pharyngitis). The vast majority of cases of pharyngitis are caused by self-limiting viral infections that do not respond to antibiotics. The benefit of antibiotics for the approximately 10% of cases in adults (25% in children), caused by bacteria (principally Group A *Streptococcus* [GAS]) is modest at best, although they are associated with fewer complications and a slightly shorter course of illness. Inappropriate administration of antibiotics can expose patients to unnecessary risks (i.e., allergies, rash, and diarrhea) and increase overall antibiotic resistance in the community. Evidence suggests that antibiotics should only be used in patients with intermediate and high clinical prediction scores for GAS (CENTOR or FeverPAIN score) AND confirmatory testing (throat cultures or rapid testing) that is positive for GAS.

9 Don't order ankle and/or foot X-rays in patients who have a negative examination using the Ottawa ankle rules.

Foot and ankle injuries in children and adults are very common presentations to emergency departments. The Ottawa Ankle Rules (OAR) have been validated in both children (greater than 2 years old) and adult populations, and have been shown to reduce the number of X-rays performed without adversely affecting patient care. In alert, cooperative and sensate patients with blunt ankle and/or foot trauma within the previous ten days and who are not distracted by other injuries, only those who fulfill the OAR should undergo ankle and/or foot X-rays. Imaging of the ankle and/or foot in patients who are negative for the OAR does not improve outcomes, exposes the patient to unnecessary ionizing radiation and contributes to flow delays without providing additional value.

10 Don't use antibiotics in adults and children with uncomplicated acute otitis media.

Both adults and children commonly present to the emergency department with symptoms of a middle ear infection, or acute otitis media (AOM). The symptoms of AOM include fever, earache, discharge from ear, and/or decreased hearing. Evidence suggests that adults and children with uncomplicated AOM do not need antibiotics. Treatment should focus on analgesia and the use of antibiotics should be limited to complicated or severe cases. A watch and wait approach (analgesia and observation for 48 to 72 hours) should be considered for healthy, non-toxic appearing children older than six months of age with no craniofacial abnormalities, mild disease (mild otalgia, temperature < 39°C without antipyretics), and who have reliable medical follow-up. Antibiotics should be considered if the child's illness does not improve during the observation period, and for those children who are < 24 months of age with infection in both ears, and in those with AOM and ear discharge. Similarly, antibiotics should not be used for the initial treatment of uncomplicated AOM in adults. Delayed antibiotics are an effective alternative to immediate antibiotics to reduce antibiotic use. Inappropriate administration of antibiotics can expose patients to unnecessary risks (i.e.,

How the list was created

The Canadian Association of Emergency Physicians (CAEP) established its Choosing Wisely Canada top 10 (phase 1 and phase 2) recommendations by forming an Expert Working Group to generate an initial list of potentially overused tests, procedures, and treatments in emergency medicine that do not add value to care. CAEP subcommittee chairs were invited to provide further input to the initial list. The list of potential items was then sent to more than 100 selected emergency physicians to vote on the items based on: action-ability by emergency physicians, effectiveness, safety, economic burden, and frequency of use. The CAEP working group discussed the items with the highest votes, and the ten Choosing Wisely Canada recommendations were generated by consensus. The first five recommendations (items 1-5) were released in June 2015, and the second five recommendations (items 6-10) were released in October 2016.

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About the Canadian Association of Emergency Physicians

CAEP the primary advocacy, educational and medical organization representing the interests of Canadian emergency physicians, their work place issues and their patients. CAEP represents more than 2,000 emergency physicians across Canada. The CAEP head office is located in Ottawa, Ontario and CAEP is a founding member of the International Federation for Emergency Medicine (IFEM). The Association contributes to knowledge translation through the production of the Canadian Journal of Emergency Medicine (CJEM), the CAEP Road Shows and other CME activities, and the Annual CAEP Conference.



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Endocrinology and Metabolism

Five Things Physicians and Patients Should Question

by

Canadian Society of Endocrinology and Metabolism

Last updated: November 2020



1 **Don't recommend routine or multiple daily self-glucose monitoring in adults with stable type 2 diabetes on agents that do not cause hypoglycemia.**

Once target control is achieved and the results of self-monitoring become quite predictable, there is little gained in most individuals from repeatedly confirming this state. There are many exceptions, such as acute illness, when new medications are added, when weight fluctuates significantly, when A1c targets drift off course and in individuals who need monitoring to maintain targets. Self-monitoring is beneficial as long as one is learning and adjusting therapy based on the result of the monitoring.

2 **Don't routinely order a thyroid ultrasound in patients with abnormal thyroid function tests unless there is a palpable abnormality of the thyroid gland.**

Thyroid ultrasound is used to identify and characterize thyroid nodules, and is not part of the routine evaluation of abnormal thyroid function tests (over- or underactive thyroid function) unless the patient also has a large goiter or a lumpy thyroid. Incidentally discovered thyroid nodules are common. Overzealous use of ultrasound will frequently identify nodules, which are unrelated to the abnormal thyroid function, and may divert the clinical evaluation to assess the nodules, rather than the thyroid dysfunction. Imaging may be needed in thyrotoxic patients; when needed, a thyroid scan, not an ultrasound, is used to assess the etiology of the thyrotoxicosis and the possibility of focal autonomy in a thyroid nodule.

3 **Don't use Free T4 or T3 to screen for hypothyroidism or to monitor and adjust levothyroxine (T4) dose in patients with known primary hypothyroidism, unless the patient has suspected or known pituitary or hypothalamic disease.**

T4 is converted into T3 at the cellular level in virtually all organs. Intracellular T3 levels regulate pituitary secretion and blood levels of TSH, as well as the effects of thyroid hormone in multiple organs. Therefore, in most people a normal TSH indicates either normal endogenous thyroid function or an adequate T4 replacement dose. TSH only becomes unreliable in patients with suspected or known pituitary or hypothalamic disease when TSH cannot respond physiologically to altered levels of T4 or T3. Patients should have access to additional testing, as required.

4 **Don't prescribe testosterone therapy unless there is biochemical evidence of testosterone deficiency.**

Many of the symptoms attributed to male hypogonadism are commonly seen in normal male aging or in the presence of comorbid conditions. Testosterone therapy has the potential for serious side effects and represents a significant expense. It is therefore important to confirm the clinical suspicion of hypogonadism with biochemical testing. Current guidelines recommend the use of a total testosterone level obtained in the morning. A low level should be confirmed on a different day, again measuring the total testosterone. In some situations, a free or bioavailable testosterone may be of additional value.

5 **Don't routinely test for Anti-Thyroid Peroxidase Antibodies (anti – TPO).**

Positive anti-TPO titres are not unusual in the 'normal' population. Their presence in the context of thyroid disease only assists in indicating that the pathogenesis is probably autoimmune. As thyroid autoimmunity is a chronic condition, once diagnosed there is rarely a need to re-measure anti-TPO titres. In euthyroid pregnant patients deemed at high risk of developing thyroid disease, anti-TPO antibodies may influence the frequency of surveillance for hypothyroidism during the pregnancy. It is uncommon that measurement of anti-TPO antibodies influences patient management.

How the list was created

In 2013, the Canadian Society of Endocrinology and Metabolism (CSEM) created a Quality Improvement Committee and charged it with the task of collaborating with Choosing Wisely Canada to establish recommendations relevant to the care of endocrine and metabolic disorders. The committee has a membership of 8 practicing endocrinologists from across Canada and whose combined clinical experience is well in excess of 100 practice-years. A survey to solicit suggestions for areas of practice that would fit with CWC's mandate was sent to all members of CSEM. The results were discussed by the committee and grouped and crafted into a short list of recommendations (and examined for alignment with the US Choosing Wisely initiative). The recommendations list was also informed by data about utilization from parts of Canada and an understanding of the frequency with which endocrine disorders occur. The short list was then subjected to a modified Delphi process for ranking and the 5 recommendations selected had the highest mean priority score and the most consistency of opinion for committee members. They were finally agreed upon by consensus. Recommendations 1, 2, and 4 were adopted from the 2013 Five Things Physicians and Patients Should Question list with permission from the Endocrine Society.

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About the Canadian Society of Endocrinology and Metabolism

CSEM is a professional organization bringing together academic and community-based endocrinologists and researchers engaged in providing health care, education and research within the broad domain of endocrinology. The CSEM is a national advocate for excellence in endocrinology research, education, and patient care, and its mandate is to advance the discipline of endocrinology and metabolism in Canada.



About Choosing Wisely Canada

Choosing Wisely Canada is the national voice for reducing unnecessary tests and treatments in health care. One of its important functions is to help clinicians and patients engage in conversations that lead to smart and effective care choices.

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Family Medicine

Thirteen Things Physicians and Patients Should Question

by

College of Family Physicians of Canada

Last updated: July 2020



1 Don't do imaging for lower-back pain 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.

2 Don't use antibiotics for upper respiratory infections that are likely viral in origin, such as influenza-like illness, or self-limiting, such as sinus infections of less than seven days of duration.

Bacterial infections of the respiratory tract, when they do occur, are generally a secondary problem caused by complications from viral infections such as influenza. While it is often difficult to distinguish bacterial from viral sinusitis, nearly all cases are viral. Though cases of bacterial sinusitis can benefit from antibiotics, evidence of such cases does not typically surface until after at least seven days of illness. Not only are antibiotics rarely indicated for upper respiratory illnesses, but some patients experience adverse effects from such medications.

3 Don't order screening chest X-rays and ECGs for asymptomatic or low risk outpatients.

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. Chest X-rays for asymptomatic patients with no specific indications for the imaging have a trivial diagnostic yield, but a significant number of false positive reports. Potential harms of such routine screening exceed the potential benefit.

4 Don't screen with Pap smears if under 21 years of age or over 69 years of age.

- Don't do screening Pap smears annually in those with previously normal results
- Don't do Pap smears in those who have had a hysterectomy for non-malignant disease

The potential harm from screening younger than 21 years of age outweighs the benefits and there is little evidence to suggest the necessity of conducting this test annually when previous test results were normal. Those who have had a full hysterectomy for benign disorders no longer require this screening. Screening should stop at age 70 if three previous test results were normal.

5 Don't do annual screening blood tests unless directly indicated by the risk profile of the patient.

There is little evidence to indicate there is value in routine blood tests in asymptomatic patients; instead, this practice is more likely to produce false positive results that may lead to additional unnecessary testing. The decision to perform screening tests, and the selection of which tests to perform, should be done with careful consideration of the patient's age, sex and any possible risk factors.

6 Don't routinely measure Vitamin D in low risk adults.

Because Canada is located above the 35° North latitude, the average Canadian's exposure to sunlight is insufficient to maintain adequate Vitamin D levels, especially during the winter. Therefore, measuring serum 25-hydroxyvitamin D levels is not necessary because routine supplementation with Vitamin D is appropriate for the general population. An exception is made for measuring Vitamin D levels in patients with significant renal or metabolic disease.

7 Don't routinely do screening mammography for average risk women aged 40 – 49.

Individual assessment of each woman's preferences and risk should guide the discussion and decision regarding mammography screening in this age group.

If, after this careful assessment and discussion, a woman's breast cancer risk is not high, current evidence indicates that the benefit of screening mammography is small. Furthermore, for this age group there is a greater risk of false-positive screening results and consequently of undergoing unnecessary or harmful follow-up procedures. As always, clinicians need to be aware of changes in the balance of evidence on risk and benefit and support women in understanding this evidence. High quality materials to assist these discussions are available through the Canadian Task Force on Preventive Health Care.

8 Don't do annual physical exams on asymptomatic adults with no significant risk factors.

A periodic physical examination has tremendous benefits; it allows physicians to check on their healthy patients while they remain healthy. However, the benefits of this check-up being done on an annual basis are questionable since many chronic illnesses that benefit from early detection take longer than a year to develop. Preventive health checks should instead be done at time intervals recommended by guidelines, such as those noted by the Canadian Task Force on the Periodic Health Examination.

9 Don't order DEXA (Dual-Energy X-ray Absorptiometry) screening for osteoporosis on low risk patients.

While all patients aged 50 years and older should be evaluated for risk factors for osteoporosis using tools such as the osteoporosis self-assessment screening tool (OST), bone mineral density screening via DEXA is not warranted on women under 65 or men under 70 at low risk.

10 Don't advise non-insulin requiring diabetics to routinely self-monitor blood sugars between office visits.

While self-monitoring of blood glucose (SMBG) for patients with diabetes is recommended by certain groups to help monitor glycemic control, for most adults with type II diabetes who are not using insulin, many studies have shown that routine SMBG does little to control blood sugar over time.

11 Don't order thyroid function tests in asymptomatic patients.

The primary rationale for screening asymptomatic patients is that the resulting treatment results in improved health outcomes when compared with patients who are not screened. There is insufficient evidence available indicating that screening for thyroid diseases will have these results.

12 Don't continue opioid analgesia beyond the immediate postoperative period or other episode of acute, severe pain.

The immediate postoperative period or acute episodes of pain typically refers to a time period of three days or less, and rarely more than seven days. Prescribe the lowest effective dose and number of doses required to address the expected pain. This recommendation does not apply to individuals already on long term or chronic opioids or opioid agonist treatment.

13 Don't initiate opioids long-term for chronic pain until there has been a trial of available non-pharmacological treatments and adequate trials of non-opioid medications.

Depending on the pain mechanism and patient co-morbidities, this can include acetaminophen, nonsteroidal anti-inflammatory drugs (NSAIDs), serotonin and norepinephrine reuptake inhibitors (SNRIs), tricyclics and gabapentinoids. Other non-medication modalities for managing acute, subacute and chronic pain may include exercise, weight loss, cognitive-behavioural therapy, massage therapy, physical therapy and/or spinal manipulation therapy. An opioid trial should be guided by clear criteria for monitoring the success of an opioid trial and a plan for stopping opioids if criteria are not met.

How the list was created

Recommendations 1 - 5

The Canadian Medical Association's (CMA) Forum on General and Family Practice Issues (GP Forum) is a collective of leaders of the General Practice sections of the provincial and territorial medical associations. To establish its Choosing Wisely Canada Top 5 recommendations, each GP Forum member consulted with their respective GP Section members to contribute candidate list items. Items from the American Academy of Family Physicians' Choosing Wisely® list were among the candidates. All candidate list items were collated and a literature search was conducted to confirm evidence-based support for the items. GP Forum members discussed which of the thirteen items that resulted should be included. Agreement was found on eight of them. Family physician members of the CMA's e-Panel voted to select five of the eight items. These five items were then approved by the provincial and territorial GP Sections. The College of Family Physicians of Canada is a member observer of the GP Forum and was involved in this list creation process. The first four items on this list are adapted with permission from the Five Things Physicians and Patients Should Question, © 2012 American Academy of Family Physicians.

Recommendations 6 - 11

Items 6 - 11 were selected from ten candidate items that were originally proposed for items 1 - 5. GP Forum members discussed which of these items should be included and agreement was found on eight of them. As was done for the first wave, family physician members of the CMA's e-Panel voted to select five of the eight items; however, subsequent discussions by the GP Forum resulted in six items being chosen. Feedback on these six items was then obtained from the provincial/territorial GP Sections. The College of Family Physicians of Canada is a member observer of the GP Forum and was involved in this list creation process.

The GP Forum was dissolved as of August 2015.

Recommendations 12, 13

In late 2016, Choosing Wisely Canada partners - the College of Family Physicians of Canada and the Canadian Medical Association - formed the Pan-Canadian Collaborative on Education for Improved Opioid Prescribing, with the goal to reduce harm from opioids, decrease the variability in prescribing practices, and improve pain management for patients. The Collaborative formally reached out to Choosing Wisely Canada (CWC) in early 2017, requesting its involvement, citing the important role played by CWC in convening professional societies representing different clinical specialties to tackle unnecessary care. As a result, the 'Opioid Wisely' was launched in March of 2018 and items 12 and 13 were added to the preexisting family medicine list of 11 things patients and clinicians should question.

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About the College of Family Physicians of Canada

The CFPC represents more than 30,000 members across the country. It is the professional organization responsible for establishing standards for the training, certification and lifelong education of family physicians. The College provides quality services and programs, supports family medicine teaching and research, and advocates on behalf of family physicians and the specialty of family medicine. The CFPC accredits postgraduate family medicine training in Canada's 17 medical schools, undergraduate and continuing medical education and encourages the development of research in oncologic surgery.

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About Choosing Wisely Canada

Choosing Wisely Canada is a campaign to help physicians and patients engage in conversations about unnecessary tests, treatments and procedures, and to help physicians and patients make smart and effective choices to ensure high-quality care.

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Fertility and Andrology

Five Things Clinicians and Patients Should Question

by

Canadian Fertility and Andrology Society

Last updated: December 2019



1 **Don't routinely perform preimplantation genetic testing for aneuploidy screening on patients undergoing IVF.**

Preimplantation genetic testing for aneuploidy (PGT-A) was developed to help select the best embryos for transfer in an *in vitro* fertilization (IVF) cycle by screening out aneuploidy. However, there is no clear improvement in cumulative live birth rate compared with IVF alone. PGT-A is expensive, carries a risk of misdiagnosis, and there is no long-term data reported on childhood outcomes. PGT-A should not be performed routinely without an indication and patients should be counselled on the risks and limitations of testing.

2 **Don't prescribe gonadotropins in doses of >450 units daily for controlled ovarian stimulation in IVF.**

Several studies demonstrate that the use of high doses of gonadotropins (approximately 450 units daily or greater) does not result in an increased number of dominant follicles recruited, mature oocytes retrieved, nor good quality embryos produced compared with lower dosing regimens. Furthermore, higher doses of gonadotropins have been associated with an increased risk of ovarian hyperstimulation syndrome (OHSS). Given that there is a greater cost to the patient and potential for harm, with no evidence of an improved outcome, avoidance of high doses of gonadotropins is recommended.

3 **Don't routinely perform laser assisted hatching on fresh embryos prior to transfer.**

Laser assisted hatching (LAH) is a technique where the zona pellucida is disrupted to improve implantation and therefore live birth rates from embryos created through IVF. Although there may be a benefit to performing LAH on fresh embryos in certain patient populations, the routine use of LAH for all patients undergoing a fresh embryo transfer has not been shown to improve live birth rates.

4 **Don't prescribe corticosteroids, IVIG, leukemia inhibitory factor or lymphocyte immunization therapy for patients undergoing IVF, those with a history of recurrent implantation failure or patients with recurrent pregnancy loss.**

Multiple studies have demonstrated no improvement in live birth rate or clinical pregnancy rate with steroids, granulocyte colony-stimulating factor (G-CSF), leukemia inhibitory factor (LIF) or immunoglobulin (IVIG) in those undergoing IVF or those with a history of recurrent implantation failure (RIF). In women with a history of recurrent pregnancy loss (RPL), there is evidence demonstrating no improvement in live birth rate with IVIG or lymphocyte immune therapy.

5 **Don't routinely perform sperm DNA fragmentation testing.**

High-grade evidence to support the routine use of sperm DNA fragmentation testing as part of initial screening investigations for infertility is lacking. Sperm DNA fragmentation tests are poor at predicting outcomes in patients undergoing assisted reproductive technologies, particularly for patients undergoing IVF or intracytoplasmic sperm injection (ICSI), and should not be used to guide treatment decision-making.

How the list was created

The Canadian Fertility and Andrology Society (CFAS) Choosing Wisely National Working Group used a modified Delphi consensus approach, consisting of 5 rounds, to generate item ideas, review supporting evidence, assess clinical relevance, estimate recommendation impact and narrow the items. The Working Group was comprised of 11 diverse clinicians with experience in the field. Round 4 of the Delphi process consisted of a National CFAS Membership Survey to rank the remaining 13 items. The top 5 items were selected based on 4 qualities: prevalence, cost, potential for harm and impact on clinical practice (round 5). The CFAS Board of Directors provided feedback which was incorporated into the composition of the final list approved by the Board.

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About the Canadian Fertility and Andrology Society

The Canadian Fertility and Andrology Society (CFAS) is a multidisciplinary national non-profit society that serves as the voice of reproductive specialists, scientists, and allied health professionals working in the field of Assisted Reproduction in Canada. The mission of the CFAS is to responsibly advance reproductive science and medicine in Canada through leadership, research and guidance.



About Choosing Wisely Canada

Choosing Wisely Canada is the national voice for reducing unnecessary tests and treatments in health care. One of its important functions is to help clinicians and patients engage in conversations that lead to smart and effective care choices.

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Gastroenterology

Eleven Things Clinicians and Patients Should Question

by

Canadian Association of Gastroenterology

Canadian IBD Network for Research and Growth in Quality Improvement

Crohn's and Colitis Canada

Last updated: November 2021



1 **Don't maintain long term Proton Pump Inhibitor (PPI) therapy for gastrointestinal symptoms without an attempt to stop/reduce PPI at least once per year in most patients.**

PPIs are effective drugs for the treatment of gastro-esophageal reflux disease (GERD). Patients should always be prescribed the lowest dose of drug that manages their symptoms. Even though GERD is often a chronic condition, over time the disease may not require acid suppression and it is important that patients do not take drugs that are no longer necessary. For this reason patients should try stopping their acid suppressive therapy at least once per year. Patients with Barrett's esophagus, Los Angeles Grade D esophagitis, and gastrointestinal bleeding would be exempt from this.

2 **Avoid using an upper GI series to investigate dyspepsia.**

Upper GI series are often requested for the investigation of upper gastrointestinal symptoms. This investigation has a significant proportion of false positive and false negative results compared with endoscopy, and studies have consistently found that this is not a cost-effective approach compared to other strategies of managing dyspepsia.

3 **Avoid performing an endoscopy for dyspepsia without alarm symptoms for patients under the age of 60 years.**

Endoscopy is an accurate test for diagnosing dyspepsia, but organic pathology that does not respond to acid suppression or Helicobacter pylori eradication therapy is rare under the age of 60. Most guidelines therefore recommend as the first line approach for managing dyspepsia either empirical proton pump inhibitor therapy or a non-invasive test for Helicobacter pylori and then offering therapy if the patient is positive. If the patient has alarm features such as progressive dysphagia, anemia or weight loss, endoscopy may be appropriate.

4 **Avoid performing a colonoscopy for constipation in those under the age of 50 years without family history of colon cancer or alarm features.**

Constipation is a common problem and systematic review data suggests this is not an accurate symptom in diagnosing organic disease. If the patient is also under the age of 50 and does not have a family history of colon cancer and there are no alarm features such as anemia or weight loss, then the risk of colorectal cancer is very low and the risks of colonoscopy usually outweigh the benefits in these patients.

5 **Don't routinely perform colonoscopy in IBS patients <50 years of age without alarm features.**

Data is conflicting, and while some evidence suggested that IBS patients are at increased risk for organic disease over the long-term compared with individuals in the general population, absolute rates remain low. With respect to CRC, the risk is low in the general population <50 years of age, and IBS is not a recognized risk factor for CRC. There appears to be little or no evidence that IBS increases the risk of CRC over the short-term compared with the general population, with the exception of a study from Taiwan that suggested a 3.6 times higher 10-year risk in the IBS group compared with the non-IBS group. Finally, data do not support the idea that patients may be reassured by a normal colonoscopy. Therefore, the consensus group concluded that routine colonoscopy is generally not warranted in IBS patients <50 years of age, and alarm symptoms do not appear to increase the risk of CRC sufficiently to warrant routine colonoscopy. Alarm features that warrant investigation include, but are not limited to, rectal bleeding, weight loss and anemia.

GRADE: Strong recommendation, very low-quality evidence

6 Don't prescribe oral corticosteroids in adults with Crohn's disease of any severity in order to maintain complete remission.

The adverse effects of long-term corticosteroid use are well-known and well-documented. In the TREAT registry, prednisone therapy was independently associated with serious infections (hazard ratio [HR], 1.57; 95% CI, 1.17–2.10; $P = .002$). No safe lower limit of dosing has been identified in which patients are spared from the adverse effects. The risks of long-term corticosteroid therapy and the lack of evidence supporting efficacy over placebo in this setting led the consensus group to recommend against the use of maintenance corticosteroid therapy.

GRADE: Strong recommendation, low-quality evidence

7 Don't prescribe oral corticosteroids in children with CD of any severity in order to maintain clinical remission.

There is a lack of demonstrated efficacy of steroids in preventing relapse and concerns around the adverse events associated with long-term use, particularly in children.

GRADE: Strong recommendation, low-quality evidence.

8 Don't use opioids long-term to manage abdominal pain in inflammatory bowel disease (IBD).

While opioids may be used to manage abdominal pain in select acute settings in IBD patients, their prolonged use may mask the symptoms of active IBD or its complications (e.g., bowel perforation or megacolon). Chronic opioid use has been proven ineffective for non-malignancy associated chronic pain and is associated with excess mortality. Moreover, because of their potential risk for dependence, their long-term use for managing IBD-related abdominal pain should be avoided especially in the context of the opioid crisis in North America.

9 Don't unnecessarily prolong the course of intravenous corticosteroids in patients with acute severe ulcerative colitis (UC) in the absence of clinical response.

Non-response to intravenous corticosteroids for acute severe UC can be predicted after the first 72 hours of treatment. However, about a third of non-responders receive systemic steroid monotherapy beyond 7 days. This prolonged use of ineffective systemic steroids may unnecessarily lengthen hospitalization days and increase risk of postoperative complications in those who eventually require colectomy.

10 Don't initiate or escalate long-term medical therapies for the treatment of inflammatory bowel disease (IBD) based only on symptoms.

Clinical symptoms often prompt initiation or escalation of medical treatments for inflammatory bowel disease (IBD). However, functional bowel disorders (e.g., irritable bowel syndrome) coexist in 20% of IBD patients and can mimic symptoms of the latter. Clinical symptoms, in fact, do not correlate well with IBD disease activity. Consequently, relying on only clinical symptoms without confirming active disease may commit patients to long-term treatments that have potentially significant adverse effects and resource implications.

11 Don't use abdominal computed tomography (CT) scan to assess inflammatory bowel disease (IBD) in the acute setting unless there is suspicion of a complication (obstruction, perforation, abscess) or a non-IBD etiology for abdominal symptoms.

Abdominal CT scanning is effective for the time-sensitive diagnosis of IBD complications such as obstruction, perforation, or non-IBD related causes of abdominal pain when these are suspected. The effective ionizing radiation dose from a single conventional abdominal CT scan (10-20mSv) is within acceptable safety limits (<50mSv). However, minimizing inappropriate utilization of CT is a priority because repeated exposure to ionizing radiation over a lifetime, particularly among younger IBD patients, may potentially increase the risk of malignancy. In the acute setting (e.g., emergency department), abdominal CT scan should only be used when there is suspicion of a complication of IBD and should not be used for the assessment of disease activity.

How the list was created

This list was created by polling the Canadian Association of Gastroenterology (CAG) Quality Leads on items that were felt to meet the goals of Choosing Wisely Canada. The five items were selected for being the most frequently identified and reflected common GI disorders managed by health care professionals. This list was then voted on by the CAG Quality Leads and the statements were further modified for language by the group.

The recommendations related to IBD were developed by the Canadian IBD Network for Research and Growth in Quality Improvement (CINERGI) in collaboration with Crohn's and Colitis Canada (CCC) and the Canadian Association of Gastroenterology (CAG). The CINERGI group comprises 14 gastroenterologists specialized in the care of inflammatory bowel disease representing 12 academic centres across Canada. A preliminary survey was sent to the CINERGI working group to solicit candidate recommendations. The top ten recommendations were selected by the working group members through an online voting platform. During a face-to-face consensus meeting in Toronto on November 4, 2016 that included CINERGI working group members, two radiologists, representatives from CCC and CAG, and two patient representatives, a modified Delphi process was used to select the top five recommendations. This list was submitted to the CAG Quality Affairs Committee, the Executive Board, and the CAG general membership for feedback and approval.

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About the Canadian Association of Gastroenterology

The CAG represents more than 1,100 members across Canada, including physicians, basic scientists, and affiliated health care providers who work in the field of gastroenterology. The CAG is a memberfocused organization with a mission to support and engage in the study of the organs of the digestive tract in health and disease, as well as to promote and advance gastroenterology by providing leadership in patient care, research, teaching and continuing professional development.



About the Canadian IBD Network for Research and Growth in Quality Improvement

CINERGI is a research network of 14 inflammatory bowel disease (IBD) specialists representing 12 Canadian academic institutions spanning 7 provinces. Collectively, we have research expertise in epidemiology, clinical trials, health services research, economic analysis, and quality improvement. We are committed to a diverse array of initiatives to improve healthcare delivery in IBD.

About the Crohn's and Colitis Canada

Crohn's and Colitis Canada is the only national, volunteer-based charity focused on finding the cures for Crohn's disease and ulcerative colitis and improving the lives of children and adults affected by these diseases. Crohn's and Colitis Canada focuses on transforming the lives of people affected by Crohn's and colitis (the two main forms of inflammatory bowel disease) through research, patient programs, advocacy, and awareness.

About Choosing Wisely Canada

Choosing Wisely Canada is a campaign to help physicians and patients engage in conversations about unnecessary tests, treatments and procedures, and to help physicians and patients make smart and effective choices to ensure high-quality care.

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General Surgery

Seven Things Physicians and Patients Should Question

by

Canadian Association of General Surgeons

Last updated: August 2020



1 **Don't use ultrasound routinely to evaluate clinically evident inguinal hernias.**

The diagnosis of most inguinal hernias can be made with a focused patient history and physical examination. Routine ultrasounds add little value to the diagnosis and management of clinically evident inguinal hernias and can result in treatment delay. These investigations should therefore not be performed where there is a clearly palpable abdominal wall defect and should instead be limited to use in the evaluation of occult inguinal hernias.

2 **Consider a watchful waiting approach in patients with asymptomatic or minimally symptomatic inguinal hernias.**

For minimally symptomatic hernias, surgical repair can prevent potential complications of hernia incarceration and strangulation, but the risk of post-operative complications from infection, hernia recurrence, and chronic inguinal pain approaches the overall risks of incarceration. Watchful waiting for asymptomatic or minimally symptomatic inguinal hernias is a safe option for carefully selected patients and does not preclude patients from undergoing elective repair should discomfort worsen.

3 **Don't use computed tomography (CT) for the evaluation of suspected appendicitis in pediatric patients until an ultrasound has been considered as an option.**

Ultrasound is an accurate and cost-effective imaging modality for initial evaluation of suspected appendicitis in the pediatric population. Evidence shows that the sensitivity and specificity of ultrasound is high with reports of up to 95%, though this may vary based on center experience and capabilities. Where findings on ultrasound exam are equivocal, CT can be considered as part of a step-up investigative approach after discussion with the patient and caregivers about risks of childhood radiation exposure.

4 **Routine preoperative chest x-rays and baseline laboratory studies, such as complete blood count, metabolic panel, or coagulation studies, should not be obtained in patients undergoing low-risk surgery with no significant systemic disease (ASA I or II) and the absence of symptoms.**

Obtaining routine preoperative radiological and laboratory testing offers little value to the perioperative care of asymptomatic patients undergoing low-risk surgery. Evidence suggests that abnormal results within this setting rarely affect management or change clinical outcomes. Instead, a focused history and physical examination should be performed to identify which preoperative investigations are required. Where preoperative testing may add value is in the setting of symptomatic patients or higher risk surgery where significant blood loss and fluid shifts may be expected. A discussion with the patient, anesthesiologists, and surgical team would help guide decision-making in these circumstances.

5 **Avoid colorectal cancer screening tests in asymptomatic patients with a life expectancy of less than 10 years and with no personal or family history of colorectal neoplasia.**

The aim of screening investigations for colorectal cancer, such as fecal immunochemical test (FIT) and colonoscopy, is to reduce deaths through early detection and removal of polyps (a precursor to colon cancer) and early stage colorectal cancers. While colonoscopy is a safe screening modality, increased risks have been associated with advanced age and comorbidities. Life expectancy, presence of symptoms, personal and family history, previous investigations, and patient preference must all be considered in order to determine the safety and appropriateness of screening investigations and surveillance colonoscopy. If colonoscopy is determined to be unsafe or inappropriate, FIT should not be offered as an alternative.

6 Contralateral prophylactic mastectomy (CPM) is not recommended for average risk women with early stage unilateral breast cancer.

CPM for early stage breast cancer lacks evidence for survival benefit in average risk women with unilateral breast cancer. CPM can be associated with chronic pain, poor cosmetic outcome, and doubles the risk of post-operative infection and bleeding. Recommended surgical options for treatment for a unilateral early breast cancer in average risk women include lumpectomy and nodal staging or unilateral mastectomy and nodal staging. CPM is recommended for women with unilateral breast cancer and previous Mantle field radiation or a BRCA 1/2 gene mutation. CPM can also be considered by the surgeon on an individual basis for women with unilateral breast cancer and a genetic mutation in the CHEK2/PTEN/p53/PALB2/CDH1 genes, and in women who may have difficulty achieving symmetry after unilateral mastectomy. In all cases, the rationale, risks, and benefits of CPM should be discussed with patients and carefully considered based on each individual patient's particular situation. managed with watchful waiting for up to 2 years after assessment, a choice that should be offered to appropriately selected persons.

7 Prolonged use of opioid analgesia beyond the immediate postoperative period or other acute pain episode is not recommended.

Opioid use poses considerable health risks to patients including opioid use disorder, overdose, and side-effects such as psychomotor impairment. While opioid analgesia may be appropriate in select circumstances, prolonged use of opioids beyond the immediate postoperative period and for chronic non-cancer pain is not recommended. Instead, clinicians and patients should consider alternative therapies, such as non-opioid pharmacologic therapy or non-pharmacologic therapies. If opioid analgesia is required, the lowest effective dose, potency, and number of doses required to address the acute pain episode should be prescribed.

How the list was created

Practicing general surgeons in Canada were invited to join the Choosing Wisely General Surgery working group. A review of previous Choosing Wisely recommendations was performed, in addition to practice guidelines previously approved by the Canadian Association of General Surgeons (CAGS) Clinical Practice Committee and the American College of Surgeons (ACS). New topics were identified through focus group sessions. These were subjected to a review of the literature and those that were not evidence-based were excluded. A nominal group technique was used to reach consensus. The top 7 recommendations were put forward and has been endorsed by CAGS. These will be submitted for publication to the Canadian Journal of Surgery for distribution to general surgeons in Canada.

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About the Canadian Association of General Surgeons

With 2500 members, CAGS is the voice of the specialty of general surgery across Canada. CAGS supports the quality education, evidence-based research, and steadfast advocacy of general surgery so that its members can provide the best surgical care possible to Canadians.

About Choosing Wisely Canada

Choosing Wisely Canada is the national voice for reducing unnecessary tests and treatments in health care. One of its important functions is to help clinicians and patients engage in conversations that lead to smart and effective care choices.

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Geriatrics

Five Things Clinicians and Patients Should Question

by
Canadian Geriatrics Society
Last updated: November 2020



1 **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.

2 **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. The number needed to treat with a sedative-hypnotic for improved sleep is 13, whereas the number needed to harm is only 6. Older patients, their caregivers and their health care 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. Prescribing or discontinuing sedative-hypnotics in hospital can have substantial impact on long-term use. Cognitive behavioural therapy, brief behavioural interventions and benzodiazepine-tapering protocols have proven benefit in sedative-hypnotic discontinuation. These non-pharmacologic interventions are also beneficial in improving sleep.

3 **Don't recommend percutaneous feeding tubes in patients with advanced dementia; instead offer oral 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. Use of oral nutritional supplements may be beneficial. Tube-feeding is associated with agitation, increased use of physical and chemical restraints and worsening pressure ulcers.

4 **Don't use antipsychotics as first choice to treat behavioural and psychological symptoms of dementia.**

People with dementia often exhibit aggression, resistance to care and other challenging or disruptive behaviours. In such instances, antipsychotic medicines are often prescribed, but they provide limited benefit and can cause serious harm, including premature death. Use of these drugs 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 behaviour change can make drug treatment unnecessary.

5 **Avoid using medications known to cause hypoglycemia to achieve hemoglobin A1c <7.5% in many adults age 65 and older; moderate control is generally better.**

There is no evidence that using medications to achieve intense glycemic control in older adults with type 2 diabetes is beneficial (A1c under 7.0%). Among non-older adults, except for long-term reductions in myocardial infarction and mortality with metformin, using medications to achieve glycated haemoglobin levels less than 6 % is associated with harms, including higher mortality rates. Intense control has been consistently shown to produce higher rates of hypoglycemia in older adults. Given the long timeframe (approximately 8 years) to achieve theorized benefits of intense 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 – 8.5% in those with multiple morbidities and shorter life expectancy.

How the list was created

The Canadian Geriatrics Society (CGS) established its Choosing Wisely Canada Top 5 recommendations by first establishing a small group of its Council members and Committee chairs to evaluate the American Geriatrics Society (AGS) Choosing Wisely® list. Feeling confident that the AGS recommendations reflected geriatric care in Canada, the list was presented to the CGS executive. After initial review by the CGS executive, each topic was reviewed in detail by selected Canadian geriatricians and other specialists with the relevant research and clinical expertise. This process was undertaken to ensure the recommendations and background information for each topic were valid and relevant for Canadian patients and our health care system. Ultimately, all five items were adopted with permission from the Five Things Physicians and Patients Should Question, © 2012 American Geriatrics Society.

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About the Canadian Geriatrics Society

The CGS has 375 members who have an interest in the health care of the elderly. This includes specialists in geriatrics and care of the elderly, family physicians and allied health professionals. The objectives of the CGS are to promote excellence in the medical care of older Canadians, promote a high standard of research in the field of geriatrics/gerontology and improve the education provided to Canadian physicians on aging and its clinical challenges.



About Choosing Wisely Canada

Choosing Wisely Canada is the national voice for reducing unnecessary tests and treatments in health care. One of its important functions is to help clinicians and patients engage in conversations that lead to smart and effective care choices.

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Headache

Four Things Physicians and Patients Should Question

by
Canadian Headache Society
Last updated: July 2020



1 Don't order neuroimaging or sinus imaging in patients who have a normal clinical examination, who meet diagnostic criteria for episodic migraine, and have no "red flags" for a secondary headache disorder.

Red flags for a secondary headache include thunderclap onset, fever and meningismus, papilloedema, unexplained focal neurological signs, unusual headache attack precipitants, and headache onset after age 50. The yield of neuroimaging in patients with typical recurrent migraine attacks is very low. Any imaging study, particularly MRI, can identify incidental findings of no clinical significance which may lead to patient anxiety and further unnecessary investigation. For patients with typical migraine and a normal clinical examination who desire reassurance, careful explanation of the diagnosis and patient education may be more advisable.

2 Don't prescribe opioid analgesics or combination analgesics containing opioids or barbiturates as first line therapy for the treatment of migraine.

Non-steroidal anti-inflammatory drugs and triptans are recommended first line treatments for acute migraine therapy. Opioids may produce increased sensitivity to pain and increase the risk that intermittent headache attacks will become more frequent and escalate to a chronic daily headache syndrome (medication overuse headache), particularly when opioids are used on 10 days a month or more. Opioids may impair alertness and produce dependence or addiction syndromes.

3 Don't prescribe acute medications or recommend an over-the-counter analgesic for patients with frequent migraine attacks without monitoring frequency of acute medication use with a headache diary.

All acute medications used for migraine attacks, when used too frequently, increase the risk of medication overuse headache with progression to a chronic daily headache syndrome. Use of opioids, triptans, ergotamines, or combination analgesics of any kind on 10 days a month or more, and use of NSAIDs or acetaminophen on 15 days a month or more places patients at risk for medication overuse headache. Patients with migraine should be educated with regard to these risks.

4 Don't forget to consider the behavioural components of migraine treatment, including lifestyle issues like regular and adequate meals and sleep, and management of specific triggers including stress.

Lifestyle issues and specific trigger management can contribute considerably to successful migraine control. Patient education regarding these factors may reduce the need for expensive medications and reduce indirect costs related to disability. Training in relaxation and other stress management techniques should be considered. Training in other skills like pacing activities to help patients manage their schedules and stress levels well, and how to take acute medications appropriately are also important.

How the list was created

The Canadian Headache Society (CHS) executive agreed to participate in the Choosing Wisely Canada campaign. A list of potential statements for Choosing Wisely Canada was created through email discussion among the executive, and input was then sought from other CHS directors. The refined statement list was then brought to the June 2015 Annual General Meeting of the Society where they were discussed and further input was obtained. Following this, draft versions were circulated and refined among the CHS executive and directors, and a final version was produced with the assistance of individuals from the Choosing Wisely Canada campaign.

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About the Canadian Headache Society

The CHS is an incorporated non-profit organization of health professionals which has as its objectives the promotion of education, research and excellence in patient care in the field of headache medicine in Canada.



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Hematology

Five Things Physicians and Patients Should Question

by
Canadian Hematology Society
Last updated: June 2020



1 **Don't give IVIG as first line treatment for patients with asymptomatic immune thrombocytopenia (ITP).**

Treatment for ITP is recommended for a platelet count less than $30 \times 10^9/L$. Corticosteroids are considered first-line treatment, with the addition of IVIgG reserved for severe ITP and bleeding, when a rapid rise in platelets is required, or when corticosteroids are contraindicated. There is no evidence of benefit of IVIgG in combination with corticosteroids for first-line treatment of asymptomatic ITP. Unnecessary IVIgG infusions can result in multiple adverse effects, including acute hemolytic or anaphylactic reactions, infections, thromboembolic events, and aseptic meningitis.

2 **During interruption of warfarin anticoagulation for procedures, don't 'bridge' with full-dose low molecular weight heparin (LMWH) or unfractionated heparin (UFH) unless the risk of thrombosis is high.**

Patients on warfarin with a low-risk for thrombotic events do not require bridging anticoagulation. If interruption is necessary, warfarin can be stopped 5 days prior to a planned procedure and resumed when it is felt to be safe to do so afterwards. Bridging with LMWH or UFH has been shown to cause excess bleeding when compared with no bridging and may ultimately delay resumption of warfarin. High-risk patients (e.g. mechanical mitral valve, venous thromboembolism within the last 3 months or atrial fibrillation with recent stroke/TIA) should be considered for bridging if the risk of thrombosis is higher than the risk of peri-procedural bleeding.

3 **Don't order thrombophilia testing in women with early pregnancy loss.**

Early pregnancy losses are common amongst healthy women. Current guidelines do not support the routine screening of women with pregnancy loss for inherited thrombophilias. Moreover, there are recommendations against instituting thromboprophylaxis in women with inherited thrombophilias wishing to achieve a successful term pregnancy. By performing testing for inherited thrombophilias, patients may be unnecessarily exposed to the harms of thromboprophylaxis, inappropriately labeled with a disease-state, and may unnecessarily modify future plans for travel, pregnancy or surgery based on detection of an "asymptomatic" thrombophilia. Further, patients with negative testing may receive false reassurance.

4 **Don't request a fine-needle aspirate (FNA) for the evaluation of suspected lymphoma.**

The diagnosis of lymphoma requires specimens with intact cellular architecture for accurate histopathologic and immunophenotypic classification. FNA is associated with a low sensitivity and potentially results in delays in lymphoma diagnosis. Although excisional biopsy is the gold standard for lymphoma diagnosis, depending on the lymph node location, excisional biopsy may be associated with complications and the need for general anesthesia. At a minimum, an imaging-guided core biopsy should be obtained to improve the accuracy and timeliness of lymphoma diagnosis.

5 **Don't transfuse patients based solely on an arbitrary hemoglobin threshold.**

Decisions to transfuse should be based on assessment of an individual patient including their underlying cause of anemia. There is high quality evidence that demonstrates a lack of benefit and, in some cases, harm to patients transfused to achieve an arbitrary transfusion threshold. If necessary, transfuse only the minimum number of units required instead of a liberal transfusion strategy. Risks of red blood cell transfusions include allergy, fever, infections, volume overload and hemolysis.

How the list was created

The entire membership of the Canadian Hematology Society (CHS) was asked to submit potential Choosing Wisely Canada list items. A steering committee consisting of 8 self-nominated CHS members was then formed. Next, the committee identified items for potential inclusion in the final list based on principles from the American Society of Hematology Choosing Wisely campaign and Choosing Wisely Canada. These principles included that the recommendations should aim to reduce harm, be evidence-based, reduce strain on the health care system, focus on common tests, procedures or treatments and be within the clinical domain of members of the CHS. Items that were felt by at least 5 of the 7 committee members (the chairperson remained neutral) for potential inclusion were selected for evidence review. Members could opt out of voting on a particular item if they felt it was outside of their scope of practice. Thirty-eight items were suggested by the membership-at-large and 12 items were selected for evidence review. Health Quality Ontario and the Canadian Agency for Drugs and Technologies in Health performed the literature searches. It was determined that expert recommendations could be a suitable evidence-base if the other principles were maintained. If a relevant clinical practice guideline was identified, it was reviewed to ensure congruence with the final recommendations. If disagreements were found, the input of relevant Canadian experts was sought. The agencies performing the literature reviews generated an evidence summary for each potential list item. Using the evidence summaries, a review of clinical practice guidelines and application of our principles, the 12-item list was then narrowed to the final 5-item list based on the committee's ranking.

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About the Canadian Hematology Society

CHS is a professional association founded in 1971, whose membership includes most of the hematologists in Canada. The main goals of CHS are to maintain the integrity and vitality of the specialty of hematology, by participating with the Royal College of Physicians and Surgeons of Canada in designing training programs for our successors, encouraging and rewarding scholarly research, and providing a forum for communication and mutual support for all of our colleagues in both community and academic settings.



About Choosing Wisely Canada

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Hepatology

Five Things Physicians and Patients Should Question

by

Canadian Association for the Study of Liver Disease

Last updated: July 2020



1 Don't order serum ammonia to diagnose or manage hepatic encephalopathy (HE).

High blood-ammonia levels alone do not add any diagnostic, staging, or prognostic value in HE patients known to have chronic liver disease.

2 Don't routinely transfuse fresh frozen plasma, vitamin K, or platelets to reverse abnormal tests of coagulation in patients with cirrhosis prior to abdominal paracentesis, endoscopic variceal band ligation, or any other minor invasive procedures.

Routine tests of coagulation do not reflect bleeding risk in patients with cirrhosis and bleeding complications of these procedures are rare.

3 Don't order HFE genotyping based on serum ferritin values alone to diagnose hereditary hemochromatosis.

Serum ferritin values reflect an increase in hepatic iron content and have a significant false positive rate because of elevations due to inflammation. Thus, in patients with evidence of liver disease, hemochromatosis genotyping should only be performed among individuals with an elevated ferritin and fasting transferrin saturation >45% (TSat) or a known family history of HFE-associated hereditary hemochromatosis.

4 Don't perform computed tomography (CT) or magnetic resonance imaging (MRI) routinely to monitor benign focal liver lesions (e.g., focal nodal hyperplasia, hemangioma).

Patients with benign focal liver lesions who do not have underlying liver disease and have demonstrated clinical (asymptomatic) and radiologic stability do not need repeated imaging as the likelihood of evolving into neoplastic lesions is very low. In contrast, patients with radiologic evidence of hepatocellular adenoma may have an increased risk of complications and/or neoplasia thus warranting closer observation.

5 Don't repeat hepatitis C viral load testing in an individual who has established chronic infection, outside of antiviral treatment.

Highly sensitive quantitative assays of hepatitis C RNA are appropriate at the time of diagnosis (to confirm infection) and as part of antiviral therapy, which is typically at the beginning and after therapy is completed to confirm sustained virological response at week 12 (SVR 12). Outside of these circumstances the results of virologic testing do not change clinical management or outcomes.

How the list was created

The Canadian Association for the Study of Liver Disease (CASL) established a Choosing Wisely Task force in November 2015 to develop its list of recommendations felt to meet the goals of Choosing Wisely Canada. Members of this group were selected from the CASL Education Committee to broadly represent varying practice settings and subspecialty expertise within the field of Hepatology. Hepatologists with methodological experience in evidence-based medicine were also included. The working group solicited recommendations from CASL membership that should be considered for inclusion in the list of "Five Things Physicians and Patients Should Question". Fifteen recommendations were then rated based upon judgments related to harm, benefit and excess resource utilization. Based on working group voting and literature review, a total of eight suggestions were identified with subsequent voting by CASL membership to generate the final top five recommendations. These recommendations were submitted and approved by CASL Governing Board and Choosing Wisely Canada.

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About the Canadian Association for the Study of Liver Diseases

CASL is a non-profit organization that seeks to eliminate liver disease through research, education and advocacy. The membership includes hepatologists, gastroenterologists, pathologists, pediatricians, radiologists, scientists, surgeons, trainees and other interested people.



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Hospital Dentistry

Eight Things Dentists and Patients Should Question

by

The Canadian Association of Hospital Dentists

Last updated: October 2021



1 Don't use opioids for post-operative dental pain until non-opioid analgesics have been optimized.

For post-operative dental pain, the dose and frequency of a non-opioid (ibuprofen and/or acetaminophen) analgesic should be optimized. If this is not sufficient for managing pain, an opioid may be considered. If an opioid analgesic is appropriate, consider limiting the number of tablets dispensed and discuss the proper use and disposal of opioid drugs. Daily dispensing and/or delayed prescriptions may be useful strategies for appropriate use of opioids.

2 Don't prescribe antibiotics for toothache or localized dental abscess.

Irreversible pulpitis or toothache occurs when the soft tissue and nerve inside the tooth (the dental pulp) becomes damaged because of decay, trauma, or large fillings. The intense pain is caused by inflammation of the dental pulp and the tissue surrounding the root – not by infection. Because this is not an infection, antibiotics do not relieve the pain and should not be used. Treatment for this condition is the removal of the damaged or diseased dental pulp, either through root canal therapy or extraction of the tooth. Inflammatory dental pain is best managed by NSAIDs.

An acute dental abscess is a localized infection that occurs due to an untreated infection of the dental pulp. Root canal therapy or extraction of the tooth, along with drainage of the abscess, is required to remove the infected tissue. Antibiotics are of no additional benefit. In the event of systemic complications (e.g., fever, lymph node involvement, or spreading infection), or for an immunocompromised patient, antibiotics may be prescribed in addition to drainage of the abscess.

3 Don't give prophylactic antibiotics prior to dental procedures to patients with total joint replacement or nonvalvular cardiac and other indwelling devices.

Infections of orthopedic implants are uncommon events and are rarely caused by bacteria found in the mouth. Although dental procedures such as extractions cause transient bacteremia, most bacteremia of oral origin occurs with activities of daily living, including brushing, flossing, and chewing. There is no reliable evidence that antibiotics before dental procedures prevent prosthetic joint infections. Patients should not be exposed to the adverse effects of antibiotics when there is no evidence of benefit.

There is no convincing evidence that oral bacteria from dental procedures cause infections of the following devices at any time after implantation: pacemakers; implantable defibrillators; ventriculoatrial/ventriculoperitoneal shunts; devices for patent ductus arteriosus, atrial septal defect, and ventricular septal defect occlusion; peripheral vascular stents; prosthetic vascular grafts; hemodialysis shunts; coronary artery stents; dacron parotid patches; and chronic indwelling central venous catheters.

4 Don't prescribe dental x-rays or other diagnostic imaging without indication.

Dental x-rays and other imaging modalities are important and necessary tools to diagnose and monitor oro-facial disorders and dental diseases. Determine the need for diagnostic imaging on an individual basis for each patient based on medical and dental history, clinical findings, and risk assessment, rather than on a routine basis.

5 Don't replace fillings unless they have failed.

Dental restorations (fillings) fail due to excessive wear, fracture of material or tooth, loss of retention, or recurrent decay. The larger the size of the restoration and/or the greater the number of surfaces filled increases the likelihood of failure. Restorative materials have different survival rates and fail for different reasons, but age should not be used as criteria for failure. Drilling to remove and replace fillings can weaken teeth. If feasible, repair of small defects, rather than replacement of a filling, can save tooth structure and increase the lifespan of restorations at a lower cost.

Amalgam dental restorations release small amounts of mercury. Judicious management of mercury waste in dentistry is mandated in Canada. Randomized clinical trials demonstrate that the mercury present in amalgams does not produce illness. Removal of such amalgams if the restoration is otherwise sound is unnecessary, expensive, and subjects the individual to absorption of greater doses of mercury than if left in place. Furthermore, placement of composite resin restorations is known to cause a transient increase in urinary Bisphenol-A levels, for which there are unknown health effects. High-quality evidence suggests higher failure rates in composite resins versus amalgam restorations.

6 Don't delay or postpone urgent or essential dental care unless prohibited by public health directives.

Dentists are required to provide services within the context of provincial directives from the provincial health authority. When directives prohibit non-essential dental visits, urgent care must be provided to relieve pain and treat infections. Critical dental services should be prioritized to minimize harm to patients from delaying care and be provided in a way that protects patients and dental personnel. The latter includes interim stabilization of the dental problem; minimization of aerosol-generating procedures; and use of appropriate PPE and other IPAC measures as advised by provincial health authorities/regulators. Strategies should be developed to monitor patients whose care has been cancelled or delayed.

7 Don't require in-person care when a virtual care visit may be more appropriate.

Virtual care minimizes exposure of patients and staff to COVID-19 and its variants. It allows patients to avoid crowds and unnecessary travel and supports physical distancing measures in clinics, hospitals, and other facilities. In addition, virtual care allows more timely and accessible care, especially when challenges such as distance, disability, or frailty exist.

Virtual care cannot replace the need for in-person physical examination and assessment of many oral disorders. In-person care may be required for patients whose condition is not stable or is deteriorating. Virtual care may not be appropriate for patients with low digital health literacy or the inability to access a digital device.

For effective virtual care, appropriate infrastructure, provider funding, protection of privacy, and thorough preparation of the patient are needed.

8 Don't prescribe antibiotics or opioid analgesics without an examination.

Antibiotic resistance has increased because of the widespread use of antibiotics over many years. It is a significant global threat to health. Opioid misuse has also become a serious problem in recent years. During a pandemic phase where only "essential" dental care is permitted or advised, it may be necessary to prescribe antibiotics or analgesics without examining the patient in person. When managing new dental infections and/or dental pain on an emergency basis, if the concern has not resolved after the preliminary course of therapy, the patient should be re-examined to determine the next steps.

How the list was created

A working group of CAHD member dentists with both hospital-based and private practice experience, representing geographic, gender and years in practice diversity was created. The American Dental Association Choosing Wisely list was reviewed to determine if items were relevant and addressed issues that the group considered to be of high importance. A list of 25 recommendations was generated and using an iterative process, the recommendations were discussed, duplicates (there was significant duplication and overlap) were removed, and consensus was obtained to create the final list of eight items. The draft list was sent to all individual CAHD members and 17 national dental organizations and specialty groups for feedback. The final list was reviewed and endorsed by the CAHD Board of Directors in 2018.

The list was updated by the CAHD Working Group in 2021 with feedback from the CAHD members and approved by the CAHD Board. COVID-19 related recommendations were added to reflect the changed nature of dental practice as a result of the pandemic.

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About the Canadian Association of Hospital Dentists

The Canadian Association of Hospital Dentists (CAHD) is a proud partner of the Choosing Wisely Canada campaign. As the national voice of Canadian hospital-affiliated dentists, CAHD's mission is to promote the highest standards of evidence-based oral health care, advance dental education in academic health sciences centres, encourage collaborative research and advocate for access to care for Canadians with complex needs who require dental care in hospital settings.



**Canadian Association
of Hospital Dentists** 

About Choosing Wisely Canada

Choosing Wisely Canada is the national voice for reducing unnecessary tests and treatments in health care. One of its important functions is to help clinicians and patients engage in conversations that lead to smart and effective care choices.

Hospital Medicine

Five Things Physicians and Patients Should Question

by
Canadian Society for Hospital Medicine
Last updated: June 2021



1 **Don't place or leave in place a urinary catheter without reassessment.**

The use of urinary catheters among hospitalized patients is common. Urinary catheter use is associated with preventable harm such as, catheter-associated urinary tract infection, sepsis, and delirium. Guidelines support routine assessment of the indications for urinary catheters and minimizing their duration of use. Appropriate indications include acute urinary obstruction, critical illness and end-of-life care. Strategies that reduce inappropriate use of urinary catheters have been shown to reduce health care associated infections.

2 **Don't prescribe antibiotics for asymptomatic bacteriuria (ASB) in non-pregnant patients.**

The inappropriate treatment of ASB represents a leading misuse of antimicrobial therapeutics. Clinicians should avoid the use of antibiotics given the lack of treatment benefits, risk of potential harm such as *Clostridium difficile* infections and the emergence of antimicrobial resistant organisms. The majority of hospitalized patients with ASB do not require antibiotics with the exception of pregnant women, and patients undergoing invasive urologic surgical procedures. In all other situations, antimicrobial therapy should be targeted to those who have symptoms of urinary tract infections in the presence of bacteriuria.

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

Insomnia, agitation, and delirium commonly occur among elderly inpatients, and hospital providers frequently prescribe pharmacological sleep aids or sedatives. However, studies in older adults have shown that benzodiazepines and other sedative-hypnotics significantly increase the risk of morbidity (such as falls, delirium and hip fractures) and mortality. Use of these drugs should be avoided as first line treatment for the indications of insomnia, agitation, or delirium. Instead, other non-pharmacological alternatives should be considered first.

4 **Don't routinely obtain neuro-imaging studies (CT, MRI scans, or carotid Doppler ultrasonography) in the evaluation of simple syncope in patients with a normal neurological examination.**

Syncope is common and has been defined as transient loss of consciousness, associated with inability to maintain postural tone and with immediate, spontaneous and complete recovery. Patients presenting with transient loss of consciousness due to neurological causes (such as seizures and stroke) are infrequent and must be differentiated from true syncope. While neurological disorders can occasionally result in transient loss of consciousness, the utility of neuro-imaging studies are of limited benefit in the absence of signs or symptoms concerning for neurological pathologies.

5 **Don't routinely obtain head computed tomography (CT) scans, in hospitalized patients with delirium in the absence of risk factors.**

Delirium is a common problem among hospitalized patients. In the absence of risk factors for intracranial causes of delirium (such as recent head trauma or fall, new focal neurological findings, and sudden or unexplained prolonged decreased level of consciousness), routine head CT scans are of low diagnostic yield. Guidelines suggest a step-wise approach to the management of new delirium in hospitalized patients and consideration of head CT only in patients with select risk factors.

How the list was created

The Canadian Society for Hospital Medicine (CSHM) established its Choosing Wisely Canada (CWC) Top 5 recommendations by creating a CWC subcommittee within its Quality Improvement (QI) Committee. The subcommittee members represent a diverse group of hospitalists from across Canada, practicing in a variety of settings. A draft list of 16 recommendations was solicited from the broader CSHM membership via email and society website. Members were asked to consider relevance to hospital medicine, frequency of occurrence and potential for harm. The QI Committee vetted each recommendation and conducted a literature review to determine the strength of the supporting evidence. Recommendations lacking in evidence were removed from the list. All CSHM members were invited to rank the remaining 12 items using an anonymous electronic web-based survey tool. The top 9 recommendations with the highest scores were selected for a second round of voting in which the scores from the first round of voting were revealed to participants. The top 5 recommendations with the highest degree of agreement were selected and submitted to the Board of Directors for approval as the final list.

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About the Canadian Society of Hospital Medicine

CSHM was founded in 2001 as the Canadian chapter of the US based Society of Hospital Medicine. The CSHM is committed to promoting the highest quality of care for all hospitalized patients. The CSHM supports Canadian hospitalists promoting excellence in the practice of hospital medicine through education, advocacy and research.



About Choosing Wisely Canada

Choosing Wisely Canada is a campaign to help physicians and patients engage in conversations about unnecessary tests, treatments and procedures, and to help physicians and patients make smart and effective choices to ensure high-quality care.

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Hospital Pharmacy

Six Things Clinicians and Patients Should Question

by
Canadian Society of Hospital Pharmacists
Last updated: July 2021



1 **Don't continue medications that are no longer indicated or where the risks outweigh the benefits.**

Polypharmacy, often defined as taking five or more medications at the same time, has been associated with a variety of adverse health outcomes. Therapy with a medication is initiated when the patient and care team conclude that the benefits of taking the medication outweigh the risks of not starting therapy. However, over time, patients and their conditions or goals of care change, new evidence is discovered, and other factors can tip the balance, such that the benefits no longer outweigh the risks or burdens of continued treatment. Few, if any, medications should be continued on a lifelong basis. Patients and caregivers should be made aware of the planned duration of therapy and the outcomes desired, and should feel empowered to follow up with providers to ensure that the benefits of therapy continue to outweigh the risks. The performance of medication reconciliation and transitions of care—such as admission to or discharge from a hospital—may serve as critical activities for deciding whether to continue therapy or create a plan to safely stop a medication.

2 **Don't use a medication for long-term risk reduction if life expectancy is shorter than the time to benefit of the medication.**

The “time to benefit” is the period between initiation of an intervention (in this case, a medication) and the point when the patient begins to experience a benefit. This period varies from one medication to another. Treatment with a medication is usually not indicated unless the “time to benefit” is clearly shorter than the patient's life expectancy and any potential adverse effects are deemed manageable. These factors are particularly relevant for older adults and those receiving palliative care.

3 **Don't continue a proton pump inhibitor at discharge unless there is a compelling reason to continue therapy.**

In many cases, a proton pump inhibitor (PPI) is initiated for a valid indication, in cases where the benefits outweigh the risks. During a hospital stay, PPIs may be started for stress ulcer prophylaxis or for patients who will receive certain treatments that increase the likelihood of high-risk gastrointestinal conditions. After the patient's risk for stress ulcer returns to baseline the PPI should be stopped. In addition, patients who did not require a PPI before their hospital admission typically will not need to continue taking one of these drugs after the underlying reason for PPI therapy has been addressed. Long-term adverse effects associated with the acid inhibition caused by PPIs are now emerging. Patients should talk to their healthcare team and only continue taking PPIs if the benefits truly outweigh the risks and to obtain advice on how to taper the dose towards discontinuation if warranted.

4 **Don't start or prolong broad-spectrum antibiotic treatment unless clinically indicated.**

Broad-spectrum antibiotics are effective in treating bacterial infections, particularly life-threatening infections such as sepsis or febrile neutropenia. In certain high-risk situations, these drugs may be clinically indicated and started at the first signs or symptoms of an infection. Broad-spectrum antibiotics should be stopped as soon as the causative pathogen is known or suspected. Targeted antibiotic therapy should begin as soon as possible. When a broad-spectrum antibiotic is deemed necessary, it should be used for the shortest possible duration, according to guideline recommendations and the patient's clinical response.

5 **Don't routinely prescribe benzodiazepines or other sedative-hypnotics for promotion of sleep without first a trial of non-pharmacologic interventions.**

Non-pharmacologic options to treat insomnia, such as sleep hygiene and cognitive behavioural therapy, are less harmful than drugs, and should be first line therapy.

6 **Don't initiate or escalate opioid doses for chronic non-cancer pain before optimizing non-opioid pharmacotherapy and non-pharmacologic therapy.**

Evidence shows that opioids are not more effective than other analgesics for certain chronic pain conditions. Furthermore, evidence is mounting that the risks of opioid treatment, including opioid use disorder, overdose, and other previously under-recognized side effects (e.g., hyperalgesia, psychomotor impairment [which can increase the risk of fractures], myocardial infarction, sexual dysfunction) support the use of non-opioid therapy. Thorough patient-centred discussion about risks, benefits, and expectations is essential.

How the list was created

The Canadian Society of Hospital Pharmacists (CSHP) formed a working group of pharmacists who practice in a variety of settings (e.g., hospital, primary care). Members of CSHP were invited to contribute recommendations to CSHP, via email, an online survey, and paper forms distributed at national and regional conferences. The suggested recommendations were reviewed by the working group: duplicate and similar recommendations were combined and recommendations that did not meet criteria (i.e., those that could not be written as a "don't" statement) were removed. Two lists of recommendations resulted: "medication-based" (consisting of 17 items) and "practice-based" (consisting of 14 items). CSHP members were asked to identify their "top 5" recommendations in each of those two categories. The results of the survey were reviewed by the working group. A shortened set of recommendations was created by identifying the recommendations that had support from at least 40% of the respondents.

Evidence supporting each of CSHP's proposed recommendations was gathered, and Choosing Wisely Canada's recommendations from other organizations were reviewed to identify if similar recommendations already exist. The proposed recommendations were compared to each other to remove any obvious duplication. CSHP's Board voted on the draft set of recommendations in October 2018. After the recommendations were approved by Choosing Wisely Canada, CSHP's Board approved the final set of recommendations in January 2019.

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About the Canadian Society of Hospital Pharmacists

The Canadian Society of Hospital Pharmacists is the national voluntary organization of pharmacists committed to patient care through the advancement of safe, effective medication use in hospitals and other collaborative healthcare settings.

Canadian Society of
Hospital Pharmacists



Société canadienne des
pharmaciens d'hôpitaux

About Choosing Wisely Canada

Choosing Wisely Canada is the national voice for reducing unnecessary tests and treatments in health care. One of its important functions is to help clinicians and patients engage in conversations that lead to smart and effective care choices.

Infectious Disease

Five Things Physicians and Patients Should Question

by

Association of Medical Microbiology and Infectious Disease

Last updated: June 2021



1 **Don't routinely prescribe intravenous forms of highly bioavailable antimicrobial agents for patients who can reliably take and absorb oral medications.**

Antimicrobials such as fluoroquinolones, trimethoprim-sulfamethoxazole, clindamycin, linezolid, metronidazole and fluconazole have excellent bioavailability and only rarely need to be administered intravenously. Use of oral formulations of these medications reduces the need for placement and maintenance of venous access devices and their associated complications.

2 **Don't prescribe alternate second-line antimicrobials to patients reporting non-severe reactions to penicillin when beta-lactams are the recommended first-line therapy.**

Reported penicillin reactions frequently result in the use of alternate second-line agents that may be clinically inferior or may pose increased risks to patients resulting in longer lengths of stay and increased costs of care. Alternate broad-spectrum agents may also result in increased rates of adverse events and selection for antimicrobial resistance. Therefore, it is important to obtain a detailed history of a patient's reported prior reaction to penicillin to determine whether beta-lactam therapy can be safely administered.

3 **Don't routinely repeat CD4 measurements in patients with HIV infection with HIV-1 RNA suppression for >2 years and CD4 counts >500/ μ L, unless virologic failure occurs or intercurrent opportunistic infection develops.**

The 2014 recommendations of the International Antiviral Society – US Panel state that measurement of CD4 count is optional among patients with suppressed viral loads for >2 years and CD4 counts >500/ μ L. CD4 measurement in these patients is of low-value and may create unnecessary patient concern in response to normal variation of CD4 counts. In prospective studies of patients who have responded to antiretroviral therapy with HIV-1 RNA suppression and rises in CD4 cell count >200 cells/ μ L, there was little clinical benefit from continued routine measurement of CD4 counts.

4 **Don't routinely repeat radiologic imaging in patients with osteomyelitis demonstrating clinical improvement following adequate antimicrobial therapy.**

There is poor correlation between clinical response and resolution of findings on magnetic resonance imaging (MRI), computed tomography (CT), and nuclear studies in patients with osteomyelitis. Because radiologic resolution may lag behind clinical improvement, repeat imaging may lead to unnecessary prolongation of antimicrobial therapy. Repeat imaging is indicated in cases where there is a lack of clinical response, progression of clinical findings, or the presence of an undrained abscess on the initial scan.

5 **Don't prescribe aminoglycosides for synergy to patients with bacteremia or native valve infective endocarditis caused by *Staphylococcus aureus*.**

The addition of an aminoglycoside such as gentamicin to beta-lactam therapy or vancomycin for treatment of bacteremia or native valve infective endocarditis caused by *Staphylococcus aureus* has not been demonstrated to improve clinical outcomes. This practice may result in adverse effects including acute kidney injury and ototoxicity. The addition of gentamicin is still recommended in cases of prosthetic valve endocarditis caused by *Staphylococcus aureus*.

How the list was created

The Association of Medical Microbiology and Infectious Disease (AMMI) Canada established its Choosing Wisely Canada list of “Five Things that Physicians and Patients Should Question” by convening a Working Group of 14 members representing a diverse group of Infectious Diseases specialists from multiple geographical regions, practice settings and institution types, with varying years in practice. Following a survey of AMMI Canada membership to identify low-value practices within Infectious Diseases, the Working Group developed a list of 23 declarative statements. In an iterative process, Working Group members were invited to rank and comment on all recommendations online. Practices that met the following four criteria received highest ranking: (i) within the purview of Infectious Diseases practice; (ii) frequently encountered in practice; (iii) significant potential for uptake by other physicians and societies; and (iv) likely to have significant overall impact on the value of care provided by the members of our profession. The Top Five list was shared with AMMI Canada membership electronically and during a national open forum at the AMMI Canada – CACMID Annual Conference held on April 18, 2015, in Charlottetown, PEI, to obtain feedback. Following minor refinements, the AMMI Canada Executive Council and Guidelines Committee provided full endorsement and support for the final list.

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About the Association of Medical Microbiology and Infectious Disease Canada

AMMI Canada is the national association that represents physicians, clinical microbiologists and researchers specializing in the fields of medical microbiology and infectious diseases. Through promotion of the diagnosis, prevention and treatment of human infectious diseases and by our involvement in education, research, clinical practice and advocacy, AMMI Canada aims to serve and educate the public and also to enhance the career opportunities of its members through professional development and advocacy initiatives.



About Choosing Wisely Canada

Choosing Wisely Canada is a campaign to help physicians and patients engage in conversations about unnecessary tests, treatments and procedures, and to help physicians and patients make smart and effective choices to ensure high-quality care.

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Internal Medicine

Eleven Things Physicians and Patients Should Question

by
Canadian Society of Internal Medicine
Last updated: July 2021



1 **Don't routinely obtain neuro-imaging studies (CT, MRI, or carotid dopplers) in the evaluation of simple syncope in patients with a normal neurological examination.**

Although an uncommon cause for syncope, providers must consider a neurological cause in every patient presenting with transient loss of consciousness. In the absence of signs or symptoms concerning for neurological causes of syncope (such as but not limited to focal neurological deficits), the utility of neuro-imaging studies are of limited benefit. Despite a lack of evidence for the diagnostic utility of neuroimaging in patients presenting with true syncope, providers continue to perform brain computed tomographic (CT) scans. Thus, inappropriate use of this diagnostic imaging modality carries high costs and subject patients to the risks of radiation exposure.

2 **Don't place, or leave in place, urinary catheters without an acceptable indication (such as critical illness, obstruction, palliative care).**

Use of urinary catheters without an acceptable indication of use increases the likelihood of infection leading to greater morbidity and health care costs. Catheter-associated bacteriuria often leads to inappropriate antimicrobial use and secondary complications including emergence of antimicrobial-resistant organisms and infection with *Clostridium difficile*. A previous study showed that physicians are often unaware of urinary catheterization among their patients. Use of urinary catheters has found to be inappropriate in up to 50% of cases, with urinary incontinence listed as the most common reason for inappropriate and continued placement of urinary catheters. Clinical practice guidelines support the removal or avoidance of unnecessary urinary catheters in order to reduce the risk of catheter-associated urinary tract infections (CAUTIs).

3 **Don't transfuse red blood cells for arbitrary hemoglobin or hematocrit thresholds in the absence of symptoms, active coronary disease, heart failure or stroke.**

Indications for blood transfusion depend on clinical assessment and are also guided by the etiology of the anemia. No single laboratory measurement or physiologic parameter can predict the need for blood transfusion. Transfusions are associated with increased morbidity and mortality in high-risk hospitalized inpatients. Adverse events range from mild to severe, including allergic reactions, acute hemolytic reactions, anaphylaxis, transfusion related acute lung injury, transfusion associated circulatory overload, and sepsis. Studies of transfusion strategies among multiple patient populations suggest that a restrictive approach is associated with improved outcomes.

4 **In the inpatient setting, don't order repeated CBC and chemistry testing in the face of clinical and lab stability.**

Repetitive inpatient blood testing occurs frequently and is associated with adverse consequences for the hospitalized patient such as iatrogenic anemia, and pain. A Canadian study showed significant hemoglobin reductions as a result of phlebotomy. Given that anemia in hospital patients is associated with increased length of stay, readmission rates and transfusion requirements, reducing unnecessary testing may improve outcomes. Studies support the safe reduction of repetitive laboratory testing without negative effects on adverse events, readmission rates, critical care utilization or mortality. Laboratory reduction interventions have also reported significant cost savings.

5 **Don't routinely perform preoperative testing (such as chest X-rays, echocardiograms, or cardiac stress tests) for patients undergoing low risk surgeries.**

Routine preoperative tests for low risk surgeries results in unnecessary delays, potential distress for patients and significant cost for the health care system. Numerous studies and guidelines outline lack of evidence for benefit in routine preoperative testing (e.g., chest X-ray, echocardiogram) in low risk surgical patients. Economic analyses suggest significant potential cost savings from implementation of guidelines.

6 **Don't initiate therapy with opioids for patients with chronic non-cancer pain unless non-opioid pharmacotherapy and other non-pharmacological options have been optimized.**

Several non-opioid therapies (including both drug and non-drug alternatives) may achieve a similar magnitude of improvement in pain and function more safely without the potentially serious side effects of opioid therapy (e.g. harms related to dependence, addiction and overdose).

7 Don't do a workup for clotting disorders (hypercoagulability testing) for patients who develop first episode of DVT in the setting of a known precipitant.

Thrombophilia testing is costly and can result in harm to patients if the duration of anticoagulation is inappropriately prolonged or if patients are incorrectly labeled as thrombophilic. Thrombophilia testing does not change the management of VTEs occurring in the setting of major transient VTE risk factors. When VTE occurs in the setting of pregnancy or hormonal therapy, or when there is a strong family history plus a major transient risk factor, the role of thrombophilia testing is complex and patients and clinicians are advised to seek guidance from an expert in VTE.

8 Don't undertake prolonged life-sustaining treatments or escalate to intensive care without establishing prognosis, preferences and goals of care.

Patients and their families often prefer to avoid invasive or overly aggressive life-sustaining measures at the end of life. However, many dying patients receive non-beneficial life-sustaining treatments, in part due to clinicians' failures to elicit patients' preferences, provide appropriate recommendations, and participate in shared decision-making.

9 Don't order or refer for percutaneous coronary intervention in patients with stable coronary artery disease that do not have high risk features, and are asymptomatic or have not been on optimal medical therapy.

Performing percutaneous coronary intervention in the absence of a clear indication is costly and exposes patients to procedural risks, radiation, contrast exposure, and possible stent-related complications. Patients whose symptoms are controlled on optimal medical therapy, and who do not have any high-risk findings* on non-invasive testing (e.g., exercise treadmill test, myocardial perfusion imaging, stress echocardiography, or coronary computed tomographic angiography), should not be referred for percutaneous coronary intervention.

*This [table](#) outlines high-risk features of non-invasive test results associated with >3% annual rate of death or MI

10 Don't order continuous telemetry monitoring outside of ICU without using a protocol that governs discontinuation.

Published guidelines provide clear indications for the use of telemetric monitoring which are contingent upon frequency, severity, duration and conditions under which the symptoms occur. Inappropriate use of telemetric monitoring is likely to increase the cost of care and restrict patient mobility. False positive alarms increase workload and interruptions for front-line clinicians and can create unnecessary anxiety for patients.

11 Don't initiate long-term maintenance treatments (e.g. bronchodilators, inhaled corticosteroids, leukotriene receptor antagonists, or other) in adult patients with suspected COPD/asthma without confirming a diagnosis with objective testing such as spirometry/methacholine challenge.

Many individuals are erroneously assigned a diagnosis of COPD/asthma without objective diagnostic testing. It is recommended that confirmatory testing be used to make the diagnosis of airflow obstruction in patients with respiratory symptoms. Starting long-term maintenance treatments without first objectively diagnosing COPD/asthma results in unnecessary treatment in those patients who do not actually have the disease. This exposes these patients to both the side-effects and the cost of these medications, and might delay the appropriate diagnosis.

How the list was created

The Canadian Society of Internal Medicine (CSIM) established its Choosing Wisely Canada Top 5 recommendations by convening a Committee of 20 members that represent a diverse group of general internists from across Canada, reflecting a broad range of geographical regions, practice settings, institution types and experience. The Committee chose to adopt pre-existing recommendations that have already undergone rigorous evidence review from the Five Things Physicians and Patients Should Question (© 2013 American College of Physicians; © 2012 Society of Hospital Medicine; © 2013 Society of General Internal Medicine), the American College of Physicians High Value Cost Conscious Care recommendations, and the “do not do” recommendations from the National Institute for Health and Care Excellence (NICE) in the United Kingdom. In addition, members brought forward recommendations based on experience and relevance to practice. Each Committee member was invited to anonymously rank all recommendations online. The Committee discussed the highest ranked recommendations and reached a consensus on a list of Top 5 items. The list of recommendations was presented at an open forum CSIM meeting and to the Executive Council at the 2013 CSIM Annual Meeting in Toronto, Canada. CSIM members who attended the Council meeting and the Choosing Wisely Update session were also given an opportunity to provide feedback. Minor refinements to the list were made and subsequently approved by the Committee. In 2018, recommendations 6-11 were added, following the same process. The CSIM Executive Council provides full endorsement and support for the final list of CSIM Choosing Wisely Canada recommendations.

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About the Canadian Society of Internal Medicine

The CSIM is a national medical society of physicians who are specialists in the broad discipline of general internal medicine. CSIM members provide expert medical care for adults with complex multi-system diseases at community and academic hospitals across Canada. CSIM members are teachers of medical students and residents and are leaders in health research and quality improvement. The CSIM has over 1,100 members and associates.



About Choosing Wisely Canada

Choosing Wisely Canada is the national voice for reducing unnecessary tests and treatments in health care. One of its important functions is to help clinicians and patients engage in conversations that lead to smart and effective care choices.

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Long Term Care

Seven Things Physicians and Residents/Patients Should Question

by

Canadian Society for Long Term Care Medicine

Last updated: February 2021



1 **Don't send the frail resident of a nursing home to the hospital, unless their urgent comfort and medical needs cannot be met in their care home.**

Transfers to hospital for assessment and treatment of a change in condition have become customary. However, they are often of uncertain benefit, and may result in increased morbidity. In one Canadian study, 47% of hospitalizations were considered avoidable, while a recent US study found 39% to be 'potentially avoidable'. Transfer often results in long periods in an unfamiliar and stressful environment for the patient. Other hazards include delirium, hospital acquired infections, medication side effects, lack of sleep, and rapid loss of muscle strength while bedridden. Harms often outweigh benefits. Residents assessed and treated at their care home will receive more individualized care, better comfort and end of life care. If a transfer is unavoidable, give clear prior instructions to the hospital of the patient's needs. Respect for patient choice is a fundamental consideration in all decisions to transfer to a hospital. A clear understanding of the patient's goals must be established taking into account current health status, values and preferences. This will reduce the likelihood of inappropriate transfer. These goals should be discussed earlier and often with the patient and family, including whether comfort, function and quality of life are their most important goals.

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

People with dementia can sometimes be disruptive, behaving aggressively and resisting personal care. There is often a reason for the behaviour (pain, for example) and identifying and addressing the causes can make drug treatment unnecessary. When drug treatment is chosen, antipsychotic medicines are often prescribed, but they provide limited benefit and can cause serious harm, including premature death. These medications should be limited to cases where non-drug measures have already been tried and failed and the patients are a threat to themselves or others. When an antipsychotic has been prescribed, frequent review and attempts at reduction or discontinuation must be done to reduce harm.

3 **Don't do a urine dip or urine culture unless there are clear signs and symptoms of a urinary tract infection (UTI).**

Unless there are UTI symptoms such as urinary discomfort, abdominal/back pain, frequency, urgency or fever, testing should not be done. Testing often shows bacteria in the urine, with as many as 50% of those tested showing bacteria present in the absence of localizing symptoms to the genitourinary tract. Over-testing and treating asymptomatic bacteriuria with antibiotics leads to increased risk of diarrhea and infection with *Clostridium difficile*. It also increases the risk of failure to consider other causes of change in condition such as SARS-CoV-2. Overuse of antibiotics contributes to increasing antibiotic-resistant organisms.

4 **Don't insert a feeding tube in individuals with advanced dementia. Instead, assist the resident to eat.**

Inserting a feeding tube does not prolong or improve quality of life in patients with advanced dementia. If the resident has been declining in health with recurrent and progressive illnesses, they may be nearing the end of their life and will not benefit from feeding tube placement. Feeding tubes are often placed because of fears that patients may aspirate food or become malnourished. Studies show that tube feeding does not make the patient more comfortable or reduce suffering. Tube feeding may cause fluid overload, diarrhea, abdominal pain and discomfort/injury (from the tube itself). A tube can actually increase the risk of aspiration and aspiration pneumonia. Helping people eat, rather than tube feeding, is a better way to feed patients who have advanced dementia and feeding difficulties.

5 Don't continue or add long-term medications unless there is an appropriate indication and a reasonable expectation of benefit in the individual patient.

Long-term medications should be discontinued if they are no longer needed (e.g., heartburn drugs, antihypertensives) as they can reduce the resident's quality of life while having little value for a frail elder with limited life expectancy (e.g., statins, osteoporosis drugs). The use of multiple medications may also affect patient safety. Prescribing medications to meet lab test "targets" that apply to adults living in the community (e.g., blood sugar, blood pressure) may instead have dangerous effects on mobility, function, mortality and quality of life when applied to a frail elder in care.

6 Don't order screening or routine chronic disease testing just because a blood draw is being done.

Unless you are sure treatment can be given that would add to quality of life, don't do these tests. "Routine" testing may lead to harmful over-treatment in frail residents nearing the end of their life and lead to misusing healthcare resources that would do more good used wisely.

7 Don't hesitate to use virtual care to complement in-person visits in order to meet the needs of residents in long-term care during the COVID-19 pandemic.

To reduce the potential of serious outbreaks in long-term care during COVID-19, physicians are encouraged to practice virtual medicine, where appropriate. To be effective, physicians and senior leadership, must strive for excellent communications and timely access to physicians. Studies have shown that the use of telemedicine in caring for nursing home residents can facilitate better patient care and overall cost savings through reducing unnecessary hospital transfers to the emergency department and subsequent hospitalizations.

If the home needs to be physically attended to, physicians are encouraged to do targeted on-site visits and consider charting remotely. Telemedicine in long-term care can contribute to the delivery of high-quality medical care reducing avoidable hospitalizations. Utilizing virtual care where appropriate can ensure protection of health care workers while still maintaining effective communication with staff and residents' families. Appropriate systems level optimization can be created so that physicians can effectively advocate for older residents who are especially vulnerable to contracting COVID-19. The pandemic has further illustrated the need to provide timely access to care to assess acute change in status including respiratory complaints and hypoactive delirium.

How the list was created

The Canadian Society for Long Term Care Medicine (formerly the Long Term Care Medical Directors Association of Canada) established its Top 6 recommendations under the leadership of their Director. CSLTCM members were invited to participate in the list development by email. Two physician volunteers came forward to join the Director and form the Choosing Wisely Canada working group. To represent the patient voice, an articulate patient leader and Patients for Patient Safety Canada "champion" joined the working group. The American Medical Directors Association and Canadian Geriatric Society lists were reviewed as a starting point. None of these lists was specific to the frail elderly in residential care. The process aimed for recommendations that were valid and relevant for Canadian patients and our health care system. By small group discussion amongst the working group, the 6 recommendations were proposed. The document was then circulated to the members of the Board of the CSLTCM for feedback and approval.

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About the Canadian Society for Long Term Care Medicine

CSLTCM's vision is to increase physician leadership capacity in the nursing home, to improve the quality of care and, more importantly, the quality of life for patients.



About Choosing Wisely Canada

Choosing Wisely Canada is the national voice for reducing unnecessary tests and treatments in health care. One of its important functions is to help clinicians and patients engage in conversations that lead to smart and effective care choices.

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Medical Biochemistry

Five Things Clinicians and Patients Should Question

by

Canadian Association of Medical Biochemists

Last updated: February 2020



1 **Don't order serum folate testing in the absence of the following: anemia with red blood cell macrocytes or hypersegmented polynuclear neutrophils and a reasonable clinical suspicion of a nutritional deficiency such as an unsupplemented restrictive diet, severe Alcohol Use Disorder, or malabsorption.**

Since 1998, all wheat white flours for food use sold in Canada and United States are enriched with folic acid as a mandatory legal requirement. The main reason for this supplementation is to prevent neural tube defects in newborns. Folates are found in processed food that contains white flour and in green leafy vegetables, legumes, some fruits and beans. Folate deficiency is therefore now encountered very rarely in Canada.

For most patients at risk for folate deficiency, like those with malabsorption, it is more practical and economical to treat with multivitamin supplements including folic acid, than to test for deficiency.

The Society of Obstetricians and Gynecologists of Canada recommends universal supplementation for women in the reproductive age group. Investigations are not required prior to initiating folic acid in women considering pregnancy.

2 **Don't order an erythrocyte sedimentation rate (ESR) to screen asymptomatic patients or as a general test to look for inflammation in patients with undiagnosed conditions.**

ESR is a non-specific inflammation marker influenced by various factors including anemia, pregnancy, and smoking. C-reactive protein (CRP) is a less expensive and more sensitive and specific reflection of the acute phase of inflammation, hence should be used for this purpose. In the first 24 hours of a disease process, the CRP will be elevated, while the ESR may be normal. If the source of inflammation is removed, CRP will normalize within a day or so, while ESR will remain elevated for days. Only CRP should be used as a measure of systemic inflammation.

3 **Don't order amylase in addition to lipase to detect pancreatitis.**

In pancreatitis, levels of amylase and lipase have been found to correlate very well. However, multiple studies have shown that lipase is a more sensitive and specific marker of acute pancreatitis than amylase. Moreover, lipase stays elevated longer than amylase, which is useful in cases of delayed presentation. However, false negative results may still be observed after many days, but amylase is not helpful in those cases. For children, pediatric specific reference ranges should be adapted.

4 **Don't request a serum protein electrophoresis in asymptomatic patients in the absence of otherwise unexplained hypercalcemia, renal insufficiency, anemia or lytic bone lesions.**

Serum protein electrophoresis (SPE) is mainly indicated to detect monoclonal gammopathy in patients who have clinical symptoms and signs related to multiple myeloma, amyloidosis, or Waldenstrom macroglobulinemia. It may also be performed in certain uncommon diseases associated with a monoclonal protein like POEMS syndrome and some forms of polyneuropathy.

About 3% of the population above the age of 50, have a monoclonal gammopathy of undetermined significance (MGUS).

Current practice guidelines do not recommend routine screening for MGUS in the general population because of the lack of proven benefit, absence of actionable preventive therapy and creation of unnecessary anxiety for some patients.

SPE is not a sensitive test to detect inflammation, C-reactive protein is a better and less costly alternative that is more responsive to changes in the patient status.

Don't request uric acid as part of the routine evaluation of cardiovascular risk, obesity or diabetes.

Although evidence of a causative link between hyperuricemia and cardiometabolic risk is mounting, it still does not support the use of pharmacotherapy and its concentration is not used in equations for estimating vascular risk. Asymptomatic hyperuricemia is a frequent, coincidental, biochemical finding that does not require any treatment.

Uric acid should not be measured routinely, but its measurement may be considered mainly in the following situations:

- Investigation of acute joint pain
- Follow-up of hypouricemic treatment
- Follow-up of patients with kidney disease and kidney stone disease
- Preeclampsia
- Tumor lysis syndrome

How the list was created

The list was developed under the guidance of a committee formed with the specific intent of producing a list of 5 recommendations. All CAMB members were invited to participate and members were nominated by the CAMB board executive. The committee members reviewed the CWC guidance on producing recommendations and put forward a number of topics that were refined in discussion during committee meetings. A preliminary list of 22 topics was produced by the committee. A survey of all the membership was conducted by an electronic survey with options to add more suggestions. The ranked result of the survey was discussed with the committee and duplicate results were not considered. Weighting of each topic was reviewed and a list of 5 topics was agreed upon.

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About the Canadian Association of Medical Biochemists

The CAMB is the national association that represents physicians specialized in medical biochemistry, a specialty recognized by the Royal College of Physicians and Surgeons of Canada. Medical Biochemists direct clinical laboratories, consults, diagnoses and treat patients with a variety of metabolic disorders and biochemical abnormalities. The CAMB promotes quality and security in laboratory medicine and in the clinical use of laboratory information through education, research, and clinical practice. The CAMB aims to serve and educate the public and also to enhance career opportunities of its members through continuous professional development and advocacy initiatives.



About Choosing Wisely Canada

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Medical Education: Residents

Five Things Residents and Patients Should Question

by

Resident Doctors of Canada

Last updated: January 2020



1 Don't order investigations that will not change your patient's management plan.

Investigations may not change your patient's management plan for several reasons. In some cases, the patient's pre-test probability for a condition is low, and further testing is not necessary (e.g., screening for breast cancer in younger women with low risk of breast cancer). Another example is unnecessary preoperative testing before a low-risk surgical procedure where the risk of complications is low. On the other hand, high-risk patients may warrant treatment irrespective of the test result; thus, testing in these patients would not influence the ultimate decision to treat (e.g., thrombophilia testing in patients with an unprovoked pulmonary embolism at high risk for recurrence is not helpful, since these patients should receive indefinite anticoagulation). Where possible, residents can refer to evidence-based clinical decision rules to guide appropriate testing or treatment – examples include the Well's criteria or pulmonary embolism rule-out criteria (PERC) for pulmonary embolism, the Canadian CT Head Rule for CT scan of the head in a trauma patient, or the Centor criteria for likelihood of bacterial infection in adult patients with a sore throat.

2 Don't order repeat laboratory investigations on inpatients who are clinically stable.

Daily laboratory investigations can persist despite clinical stability for a variety of reasons (e.g., daily order without a stop date, not reassessing whether investigations are still needed). Observational studies suggest that resident physicians order routine daily CBC (complete blood count) and electrolyte panels more frequently than attending physicians. Daily phlebotomy contributes to patient discomfort and iatrogenic anemia. Studies support the safe reduction of repetitive laboratory investigations when patients are clinically stable without a negative impact on patient outcomes, including readmission rates, critical care utilization, adverse events, or mortality. Laboratory investigations should be ordered with a specific purpose which directly links to a specific management plan for patients.

3 Don't order intravenous (IV) when an oral (PO) option is appropriate and tolerated.

Patients are often ordered intravenous (IV) medications when oral (PO) options are available, appropriate, and equally bioavailable. Common examples include antibiotics that are highly orally bioavailable (e.g., fluoroquinolones), oral potassium replacement (which is more effective than IV replacement), proton pump inhibitors (PPI) including in the setting of many cases of acute gastrointestinal bleeding, and oral vitamin B12 replacement (as opposed to intramuscular injections, including in the context of pernicious anemia). Peripheral catheters increase the risk of complications, including extravasation, infections, and thrombophlebitis. Furthermore, IV medication administration is often significantly costlier, decreases patient mobility, and increases length of hospital stay and pharmacist and nursing workload.

4 Don't order non-urgent investigations or procedures that will delay discharge of hospital inpatients.

Discharges are commonly delayed for investigations that will not change acute management. Examples include biopsies, imaging to further investigate incidental findings, assessment by a specialist that is non-urgent, waiting for bloodwork results as part of a non-urgent diagnostic work-up, or echocardiography for patients with mild heart failure. Delayed discharges contribute to hospital over-crowding and negatively impact care efficiency. Crucially, longer lengths of stay is a risk factor for nosocomial infections, venous thromboembolism, pressure injuries, immobility, malnutrition, and deconditioning. Consider outpatient investigations when possible, if good follow-up can be assured.

5 Don't order invasive studies if less invasive options are available and as effective.

When considering diagnosis or screening investigations, consider all available tests. It is prudent to consider the least invasive option that will have similar sensitivity and specificity to guide clinical decision making to minimize the potential for harm to the patient. For example, when diagnosing acute appendicitis in children, ultrasound should be considered before computed tomography (CT) scanning. Not only is ultrasound radiation- and contrast-free, but it has been shown to be equivalent to CT scanning in the diagnosis and management of acute appendicitis across several clinically-relevant endpoints, including time to antibiotic delivery, time to appendectomy, negative appendectomy rate, perforation rate, or length of stay. Another example is conducting a non-invasive urea breath test rather than invasive endoscopy to prove *H. pylori* eradication. The sensitivity and specificity of the urea breath test are superior compared to other diagnostic tests and the risk of patient harm is minimal compared to endoscopy.

How the list was created

Resident Doctors of Canada (RDoC) established its Choosing Wisely Canada Top 5 recommendations by forming a resident taskforce comprised of 5 residents representing geographic and specialty diversity. The taskforce established six principles of development: 1) arise frequently in residency training, 2) have relevance to residents, 3) play a role in shaping future behaviours, 4) be one that residents may feasibly address during their training, 5) focus on residents' use of tests, treatments, or procedures, and 6) contribute to building a more economically sustainable, cost-conscious healthcare system. The task force generated a list of 20 candidate recommendations along with supporting evidence that were reviewed by the RDoC Practice Committee, and then narrowed the list to 12 recommendations to move forward for national consultation. The candidate recommendations were distributed to residents across Canada through an online questionnaire. Residents were asked to rank the recommendations keeping in mind the above principles for development. Over 750 residents from all provincial housestaff organizations provided feedback and weighted aggregate scores for each recommendation were calculated. The taskforce discussed the results and used the information to inform the final list of five recommendations. The RDoC Board approved and officially endorses the list of resident recommendations.

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About Resident Doctors of Canada

Resident Doctors of Canada (RDoC) is a proud partner of the Choosing Wisely Canada campaign. RDoc represents over 9,000 resident doctors across Canada. Established in 1972, it is a not-for-profit organization providing a unified, national voice for our members. RDoC collaborates with other national health organizations to foster excellence in training, wellness, and patient care in patient care through research, education and advocacy.



About Choosing Wisely Canada

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Medical Education: Students

Six Things Medical Students and Trainees Should Question

by

Canadian Federation of Medical Students

Fédération médicale étudiante du Québec

Last updated: September 2021



1 **Don't suggest ordering the most invasive test or treatment before considering other less invasive options.**

There are often diagnostic approaches and treatment options that result in the same clinical outcome but are less invasive. Examples include the use of ultrasound instead of computed tomography (CT) scanning to diagnose acute appendicitis in children, or the use of an oral antibiotic that has similar oral bioavailability as its intravenous counterpart. Taking time to consider the diagnostic sensitivity and specificity of less invasive tests or the therapeutic effectiveness of less invasive treatments can minimize unnecessary patient exposure to harmful side effects of more invasive tests or treatments.

2 **Don't suggest a test, treatment, or procedure that will not change the patient's clinical course.**

When ordering tests, it is important to always consider the diagnostic characteristics such as sensitivity, specificity and predictive value in light of the patient's pre-test probability. Patients who are at very low baseline risk often do not require an additional test to rule out the diagnosis. Furthermore, evidence suggests that in such low-risk patients, diagnostic tests do not reassure patients, decrease their anxiety, or resolve their symptoms. Examples include the use of computed tomography (CT) scanning in low-risk patients to rule out pulmonary embolism, or pre-operative cardiac testing for patients prior to low risk surgery. Evaluation of baseline risk and the use of decision tools wherever possible, along with a 'how will this change my management' approach, can help to avoid unnecessary 'rule out' testing in patients.

3 **Don't miss the opportunity to initiate conversations with patients about whether a test, treatment or procedure is necessary.**

Patient requests sometimes drive overuse. For example, a parent might request antibiotics for his or her child who likely has viral sinusitis, or a patient might request magnetic resonance imaging (MRI) for low-back pain. Often patients are unaware of the benefits, side-effects and risks of tests and treatments. Taking time to explore a patient's concerns, and counseling them about the relative benefits and risks of tests or treatments represents a patient-centered approach to ensuring the appropriate use of resources.

4 **Don't hesitate to ask for clarification on tests, treatments, or procedures that you believe are unnecessary.**

Unfortunately, in some learning environments, a hierarchy exists between supervisors and students that makes it difficult for students to feel comfortable speaking up. As a result, students might observe unnecessary care, but avoid saying anything for fear of potential consequences. Supervisors need to encourage students to feel free to question whether tests or treatments are truly necessary without fear of repercussion. The clinical training environment should be one where students feel safe to ask questions.

5 **Don't suggest ordering tests or performing procedures for the sole purpose of gaining personal clinical experience.**

The clinical training years in medical school represent an important opportunity for students to translate what was learned in the classroom to the bedside. This can be a challenging time of great uncertainty for students. Students may order tests excessively due to a lack of clinical experience, or recommend investigations in order to build upon their personal experience.

6 **Don't suggest ordering tests or treatments pre-emptively for the sole purpose of anticipating what your supervisor would want.**

A "hidden curriculum" pervasive in the academic environment encourages medical students to search for zebras through extensive (and often unnecessary) diagnostic workups. Because restraint is often discouraged, students adopt the belief that faculty expect an exhaustive diagnostic approach, and feel that they need to demonstrate their knowledge, thoroughness and curiosity through test ordering. Students can overcome this practice by articulating why they chose not to order a specific test. This, combined with a shift towards 'celebrating restraint' by faculty can help to combat this pervasive practice in medical training.

How the list was created

The list of "Six Things Medical Students and Trainees Should Question" was developed in partnership with the Canadian Federation of Medical Students (CFMS), and the Fédération médicale étudiante du Québec (FMEQ), which together represent all medical students in Canada. A student-led taskforce, including 3 medical students and 3 Choosing Wisely Canada leads, convened to develop recommendations that target behaviors medical students should question during their training. The task force generated a list of 10 candidate recommendations with input from a key informant group that included student, resident, and faculty representatives. The candidate recommendations were distributed to medical students across Canada through an online questionnaire. Students were asked to rate recommendations while keeping the following criteria in mind: the issue should (i) arise frequently in medical school training, (ii) have relevance to medical students, (iii) play a role in shaping future behaviors, and (iv) be one that medical students could feasibly address during their training. Nearly 2,000 students from all 17 Canadian medical schools provided feedback, which the taskforce used to inform the final list of six recommendations. Both the CFMS and the FMEQ executives approved and officially endorse the list of medical student recommendations.

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About The Canadian Federation of Medical Students

The Canadian Federation of Medical Students (CFMS) is a proud partner of the Choosing Wisely Canada campaign. The CFMS is the organization representing over 8,000 medical students from 14 Canadian medical student societies from coast to coast. The CFMS represents medical students to the public, to the federal government, and to national and international medical organizations.



About The Fédération médicale étudiante du Québec

The Fédération médicale étudiante du Québec (FMEQ) is a proud partner of the Choosing Wisely Canada campaign. The FMEQ is the body that represents the voice of the four Quebec medical associations and promotes their interests, serving more than 3900 medical students in Quebec.



About Choosing Wisely Canada

Choosing Wisely Canada is the national voice for reducing unnecessary tests and treatments in health care. One of its important functions is to help clinicians and patients engage in conversations that lead to smart and effective care choices.

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Medical Genetics

Five Things Physicians and Patients Should Question

by
Canadian College of Medical Geneticists
Last updated: August 2021



1 **Don't use non-invasive prenatal detection of fetal aneuploidies by cell-free DNA as a diagnostic test.**

Non-invasive prenatal detection of fetal aneuploidies by cell-free DNA, also called non-invasive prenatal testing (NIPT) and non-invasive prenatal screening (NIPS), is a method of non-invasive fetal DNA testing done through a maternal blood sample. NIPT testing for common aneuploidies, microdeletions and sex chromosome disorders is clinically available to patients in Canada. NIPT is a highly sensitive and specific screening test, but is not diagnostic. Even in high-risk populations, there can be false positive NIPT results. Genetic counselling, along with confirmatory testing via amniocentesis or chorionic villus sampling, should be done prior to using the result to impact management of a pregnancy.

2 **Don't make medical decisions based on results of direct to consumer genetic testing (DTC-GT) without a clear understanding of the limitations and validity of the test.**

Three types of potentially medically-relevant DTC-GT are available: (1) assessment of risk for common multifactorial diseases (e.g., diabetes, etc.); (2) targeted mutation analysis for single gene disorders; and, (3) sequencing. Some DTC-GT companies state that they do not guarantee the accuracy or reliability of their tests. Many of the significant genetic risk and protective factors for multifactorial conditions have not been identified. This leads to greatly divergent risk interpretations between companies, even when performed on the same individual. For targeted mutation analysis and sequencing, the specific test may not include all clinically relevant genes or mutations; resulting in false reassurance. Genetic changes that are only weakly associated with disease may be reported, leading to anxiety or inappropriate additional testing. When making medical decisions based on results of genetic testing, the test should meet the recommendations made by the Canadian College of Medical Geneticists in 2012. Not all DTC-GT meet these recommendations.

3 **Don't order a chromosome analysis by doing a karyotype for individuals with intellectual disability/developmental delay of unknown etiology.**

Microarray is the first line test for individuals with intellectual disability/developmental delay without a recognizable syndrome. Indeed, a microarray has a much higher detection rate (15 - 20%) compared to a karyotype (3 - 4%) in individuals presenting for this clinical indication. A karyotype remains important in limited clinical situations where a specific numerical or structural chromosomal syndrome, such as Down syndrome, is suspected.

4 **Don't order whole exome sequencing prior to genetic counselling.**

Whole exome sequencing (WES) is a powerful test for individuals suspected of having an underlying genetic diagnosis. However, WES increases the likelihood of unexpected findings, which may or may not be clinically significant. Further, due to methodological limitations, WES may not always be the correct test to order as WES will not detect all genetic causes of disease (for example, it will not detect chromosomal structural differences). Both informative and uninformative results can lead to complex patient and family psychosocial repercussions, and could impair future insurability. Genetic counselling facilitates informed decision-making. Given complexity of results, WES should only be ordered after counselling by a qualified health care provider.

5 **Don't order carrier testing in children.**

Carrier testing is primarily useful in the reproductive period to determine the risk of an individual having a child affected by the condition for which testing is being considered. Knowing that a child is a carrier of an X-linked or autosomal recessive condition usually does not alter medical care in the pediatric years since most carriers are unaffected. Thus, in most situations, there is not a medical indication for carrier testing in a child. Undertaking carrier testing of a child violates the right of the child to make his or her own decision about testing and could potentially impair future insurability. An exception could be made for a mature adolescent who may be able to understand the reproductive implications of carrier testing after appropriate genetic counselling.

How the list was created

The medical genetics Choosing Wisely Canada recommendations were generated by the Ethics, Education and Public Policy (E2P2) committee of the Canadian College of Medical Geneticists (CCMG) in consultation with the entire membership of the CCMG. In the summer of 2015, the E2P2 committee generated a first list of potential statements and a pilot survey was distributed during the CCMG annual conference in September 2015. Based on the feedback received, the E2P2 committee modified the statements and generated new ones. An electronic survey (via Survey Monkey) was distributed to the entire CCMG membership in March 2016; members were asked to rank their 5 favourite statements. The answers were weighted and the 5 top statements were selected. Members of the E2P2 committee reviewed the literature and generated a rationale for each of the 5 statements. The 5 statements and their rationale were orally presented during the general assembly of the CCMG annual meeting in June 2016. Comments received at that time led to a slight revision of the wording of the rationale of some statements by the members of the E2P2 committee. The statements and their rationale were then posted online for comments in the members-only section of the CCMG website for one month during the summer of 2016. Members of the CCMG all received an email prompting them to review these statements. The E2P2 committee reviewed all comments received and slightly altered the wording of some statements. The list was then circulated to all medical professional society leads engaged in Choosing Wisely Canada for review. Comments received were considered by the E2P2 committee and the list was finalized.

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About the Canadian College of Medical Geneticists

Medical genetics is the branch of medicine concerned with the effect of genetic variation on human development and health and also with the study, diagnosis, management, and prevention of genetic and related disorders in individuals, families, and communities. The Canadian College of Medical Geneticists is the national specialty society that represents genetic specialists (MDs and PhDs) who see patients with genetic conditions and/or direct laboratories that perform diagnostic testing for genetic conditions.



About Choosing Wisely Canada

Choosing Wisely Canada is the national voice for reducing unnecessary tests and treatments in health care. One of its important functions is to help clinicians and patients engage in conversations that lead to smart and effective care choices.

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Medical Laboratory Science

Seven Things Clinicians and Patients Should Question

by

Canadian Society for Medical Laboratory Science

Last updated: July 2020



1 **Don't collect more blood than what is needed. Use short draw tubes, consider add-on testing, and reduce or combine duplicate orders.**

Phlebotomy is not a risk-free event for the patient or the healthcare worker. While rare, injury from needlestick and/or pathogen exposure can occur. Cumulative blood loss due to multiple phlebotomy episodes can result in iatrogenic anemia, particularly in the elderly, children, or those with medical conditions. This anemia can lead to worsened patient outcomes. Employing mechanisms that limit the amount of blood taken has been shown to lessen the severity of iatrogenic anemia. This can range from using smaller-volume collection tubes, consulting about the possibility of add-on testing to previously drawn samples, or adopting a maximum blood volume policy. Addressing duplicate requisitions can limit a patient from being phlebotomized twice.

2 **Don't proceed with testing or reporting when sample quality or identification is suspect.**

The quality of specimens received in the laboratory is paramount to obtaining accurate results. Proceeding with testing in the presence of poor sample quality may give misleading results. This contributes to delays and unnecessary repeat examinations. Any level of error should be avoided to decrease negative impact on clinical decisions and patient care. Laboratory professionals should be proactive in ensuring that all types of specimens are collected in a high quality manner with correct identification, regardless of which health professional group is performing the act.

3 **Don't collect extra blood tubes in anticipation of test orders.**

Frequently called 'just-in-case', 'rainbow draws' or simply 'extra tubes', blood collected before tests are ordered is frequently unused and ultimately discarded. This represents a waste of laboratory resources and a challenge for specimen management. Excessive phlebotomy is a recognized contributor to iatrogenic anemia, which is linked to worsened patient outcomes.

4 **Don't support repeat test ordering (re-testing) at a frequency that is not backed by evidence.**

Many analytes have known stability profiles or minimum retesting intervals. In most cases, values will not change during this time. These intervals may be longer than traditional or historical test repeat ordering frequency. Ordering tests more frequently is unlikely to provide clinically meaningful results, and may contribute to iatrogenic anemia. Iatrogenic anemia can worsen patient outcomes. Laboratorians can play an active role in drawing awareness to and/or acting to reduce these types of orders.

5 **Don't routinely repeat critical results for most common analytes before reporting.**

With modern instrumentation, analytical precision is very high when the result is within the reportable range and no delta checks have failed. Providing that sample integrity and performance validity has been confirmed, repeating critical values rarely changes the result. However, turnaround time is significantly increased. This can delay clinical action, negatively impact patient care, and increase the likelihood of unnecessary investigations.

6

Don't support ordering system mechanisms that contribute to over-testing. Encourage the development of an evidence-based utilization management program that may include interventions such as unbundling order sets, reflex testing algorithms, and decision-support technology.

Over-testing is a recognized problem, and evidence supports multi-faceted interventions that capitalize on advances in computer-based ordering technology. Bundling of tests may provide results that are not necessary for the ordering professional and may lead to duplication of testing or unnecessary follow-up. Order sets should be regularly reviewed. Research supports increased collaboration of all healthcare providers, including laboratory personnel, in combating over-testing. Laboratory professionals can be involved at all stages of interventions from problem recognition, feedback provision, to participation in the creation of supportive education materials and ordering guidelines.

7

Don't allow standing orders for repeat testing without a stop or review date.

Standing orders without an expiry or review date allow testing to be performed repetitively for extended periods of time. This type of testing is rarely clinically necessary without regularly reviewing the validity of the order. This contributes to overutilization of laboratory tests, and may exacerbate the development of iatrogenic anemia.

How the list was created

Project leadership was established as a team of individuals from the Canadian Society of Medical Laboratory Science (CSMLS) and the Medical Laboratory Science program at the University of Alberta. A working group (herein referred to as the "Expert Panel") of experienced medical laboratory professionals (MLPs) from across Canada were recruited through advertisement by the CSMLS. Expert Panel members were selected based on maximal representation of geography, years and variety of working experience, and professional designation. All traditional disciplines of medical laboratory science (chemistry, hematology, blood bank, microbiology, and histology) were represented by at least 2 members. There were five virtual synchronous meetings as well as asynchronous technology-enabled discussions over approximately one year. Potential CWC list items were generated through Expert Panel members, a national CSMLS survey, and a meeting at the 2019 CSMLS annual convention. A modified Delphi process was used to reduce a long list to a short list of items. We used scoping reviews to generate evidence for items on the short list. Items with the strongest evidence were sent to the CSMLS Board of Directors for approval.

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About the Canadian Society for Medical Laboratory Science

The Canadian Society for Medical Laboratory Science (CSMLS) is the national certifying body for medical laboratory technologists and medical laboratory assistants, and the national professional society for Canada's medical laboratory professionals. Our purpose is to: 1) promote and maintain a nationally accepted standard of medical laboratory technology by which other health professionals and the public are assured of effective and economical laboratory services, and 2) promote, maintain and protect the professional identity and interests of the medical laboratory professional and of the profession.

Our members practice in hospital laboratories, private medical laboratories, public health laboratories, government laboratories, research and educational institutions. Incorporated in 1937 as the Canadian Society of Laboratory Technologists, the society has over 14,500 members in Canada and in countries around the world.



About Choosing Wisely Canada

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Medical Microbiology

Five Things Physicians and Patients Should Question

by

Association of Medical Microbiology and Infectious Diseases Canada

Last updated: June 2021



1 **Don't collect urine specimens for culture from adults who lack symptoms localizing to the urinary tract or fever unless they are pregnant or undergoing genitourinary instrumentation where mucosal bleeding is expected.**

Urine cultures are the most frequently ordered microbiologic test, with the majority of specimens submitted from asymptomatic patients. Urine cultures should only be ordered if patients have symptoms localizing to the urinary tract such as acute dysuria, urgency, frequency, suprapubic or flank pain or fever without an obvious alternate source. Outside of these specific symptoms, positive cultures indicate asymptomatic bacteriuria and frequently result in antimicrobial therapy that is of no benefit and is potentially harmful. Cloudy or malodorous urine are not specific findings of urinary tract infection and should not prompt culture unless acute urinary tract symptoms are present. Delirium is not considered a symptom of cystitis in non-catheterized patients. In catheterized patients with fever or delirium, a positive urine culture may still represent asymptomatic bacteriuria unless alternate sources have been excluded. Laboratories should consider supplementing educational efforts to reduce collection of urine cultures from asymptomatic patients with analytical interventions that reduce processing of low-value specimens.

2 **Don't routinely collect or process specimens for *Clostridium difficile* testing when stool is non-liquid (i.e., does not take the shape of the specimen container) or when the patient has had a prior nucleic acid amplification test result within the past 7 days.**

Only liquid stool specimens should be collected or processed for *C. difficile* detection, as a positive test in the absence of diarrhea likely represents *C. difficile* colonization. Diagnostic gains are minimal with repeat *C. difficile* nucleic acid amplification testing within 7 days of a negative test. Repeat *C. difficile* toxin testing by enzyme immunoassay within 7 days of a prior negative test is also of little incremental diagnostic yield but may be warranted in select cases. Test of cure in patients with recent *C. difficile* infection is also not recommended. Prior investigations have shown that the use of hospital information systems to restrict ordering of repeat tests for these reasons resulted in a 91% reduction in repeat testing.

3 **Don't obtain swabs from superficial ulcers for culture as they are prone to both false positive and false negative results with respect to the cause of the infection.**

All wounds are colonized with microorganisms. Cultures should not be obtained from wounds that are not clinically infected (i.e., absence of classical signs of inflammation or purulence or increasing pain). For wounds that are clinically infected, the ideal specimens for culture are deep specimens that are obtained through biopsy or deep curettage following cleansing/debridement of the wound. Laboratories should consider use of screening criteria to reject such swabs without proceeding to culture. For superficial swab specimens that are processed/cultured, interpretation of the results should be correlated with the Gram stain.

4 **Don't routinely order nucleic acid amplification testing on cerebrospinal fluid (e.g., herpes simplex virus, varicella zoster virus, enteroviruses) in patients without a compatible clinical syndrome.**

Although nucleic acid amplification testing is the modality of choice for determining the viral etiology of meningitis/encephalitis, it should not be requested routinely on all cerebrospinal fluid specimens. The routine use of these tests in patients without compatible clinical syndromes can result in unnecessary empiric antiviral treatment, additional care, and prolonged length of hospitalization for patients awaiting testing results. Additionally, routine testing may result in depletion of cerebrospinal fluid needed for other diagnostic purposes. In cases where nucleic acid testing is requested for adults, laboratories should have policies for when testing will be performed if the cerebrospinal fluid cell count and protein are normal.

5 **Don't routinely obtain swabs during surgical procedures when fluid and/or tissue samples can be collected.**

Fluids and tissue specimens can usually be obtained in the controlled setting of the operating room and represent higher quality specimens than swabs. Culture of swab specimens is associated with increased false negative results, as they are inferior in recovering anaerobic bacteria, mycobacteria and fungi, and provide inadequate volumes to perform all necessary diagnostic tests. To encourage collection of fluid and/or tissue samples, consideration should be given to making swabs unavailable in the operating room without specific request.

How the list was created

A Choosing Wisely Canada top five list in medical microbiology was developed by the Association of Medical Microbiology and Infectious Diseases Canada (AMMI Canada) through broad consultation of its members. Following an electronic survey requesting members to identify low-value practices within microbiology, AMMI Canada convened a Working Group which developed a list of draft recommendations that were discussed and ranked during a national open forum using the modified Delphi method. The top five list was revised based on feedback received from AMMI Canada members through an online forum. The AMMI Canada Executive Council and Guidelines Committee endorsed the final list, which was disseminated online.

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About the Association of Medical Microbiology and Infectious Disease

AMMI Canada is the national association that represents physicians, clinical microbiologists and researchers specializing in the fields of medical microbiology and infectious diseases. Through promotion of the diagnosis, prevention and treatment of human infectious diseases and by our involvement in education, research, clinical practice and advocacy, AMMI Canada aims to serve and educate the public and also to enhance the career opportunities of its members through professional development and advocacy initiatives.



About Choosing Wisely Canada

Choosing Wisely Canada is the national voice for reducing unnecessary tests and treatments in health care. One of its important functions is to help clinicians and patients engage in conversations that lead to smart and effective care choices.

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Medical Radiation Technology

Five Things Medical Radiation Technologists and Patients Should Question

by

Canadian Association of Medical Radiation Technologists

Last updated: July 2021



1 **Don't image a patient without a relevant clinical history and a complete requisition in order to prevent unnecessary or redundant studies.**

An accurate and comprehensive clinical history ensures patient safety and reduces unnecessary repeat examinations. Medical Radiation Technologists (MRTs) are encouraged to engage patients in conversation to fill in any gaps in the clinical information available. MRTs should speak with other members of the healthcare team to address any discrepancies with an imaging request.

2 **Don't perform medical imaging/radiation therapy procedures before assessing patient preparedness in order to prevent repeat procedures.**

Proper patient preparation reduces the need for repeat procedures and is an important quality and safety consideration for both medical imaging and radiation therapy. A multidisciplinary approach to pre-procedural care emphasizes the importance of advanced planning to achieve the desired outcomes for the procedure and ensures that the procedures do not need to be cancelled or repeated. This includes necessary laboratory results, adherence to dietary requirements and administration of pre-procedure medications. It is the Medical Radiation Technologist's (MRT) responsibility to ensure patients have completed all necessary pre-procedural instructions.

3 **Don't perform medical imaging or radiation procedures prior to assessing the patient's ability to tolerate the procedure in order to prevent repeat or poor quality studies.**

Many patients have difficulty tolerating medical imaging and radiation therapy procedures that often cause repeat examinations and/or poor-quality outcomes. Medical Radiation Technologists (MRTs) must communicate with patients, their families and other healthcare providers to ensure patients are physically, mentally and emotionally able to perform the procedure requested.

4 **Don't perform medical imaging or radiation therapy without using appropriate and/or available radiation dose reduction strategies and technologies.**

Stopping patients from receiving unnecessary radiation dose is a primary consideration for Medical Radiation Technologists (MRTs). MRTs should use all available hardware, software, accessory devices, and patient instructions (pre and post procedure) to minimize dose to patients during medical imaging and radiation therapy planning and treatment alignment. All imaging should be performed using the As Low as Reasonably Achievable (ALARA) principle to optimize the appropriate dose for each clinical situation.

5 **Don't start peripheral venous lines when an appropriate central access is available.**

All available central venous access lines should be assessed for compatibility with contrast injections before a new peripheral venous line is started. This prevents starting unnecessary lines which are uncomfortable for patients.

How the list was created

The Canadian Association of Medical Radiation Technologists (CAMRT) established its Choosing Wisely Top 5 recommendations by creating a subject matter expert Choosing Wisely Core Committee representing all four Medical Radiation Technology (MRT) disciplines: radiological technology, nuclear medicine, magnetic resonance and radiation therapy. This committee created and sent outlines for 10 recommendations to key professional stakeholders including the CAMRT Board of Directors, the MRT Alliance of Regulators and Provincial MRT Associations. This consultation used a Delphi survey to establish the top 5 recommendations. Individual recommendation committees were then created for each to perform an extensive literature review and participate in a rigorous critical appraisal process. All recommendations were then reviewed by the Core Committee for consistency in language, by the Choosing Wisely Physician Committee, and finally by Choosing Wisely stakeholders.

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About the Canadian Association of Medical Radiation Technologists

The Canadian Association of Medical Radiation Technologists (CAMRT) is a proud partner of the Choosing Wisely Canada campaign. The CAMRT is the national professional association and certifying body for radiological, nuclear medicine and magnetic resonance imaging technologists and radiation therapists. As the authoritative national voice for medical radiation technology, the CAMRT works on behalf of its more than 12,000 members to address critical issues affecting all areas of their practice.



About Choosing Wisely Canada

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Nephrology

Five Things Physicians and Patients Should Question

by
Canadian Society of Nephrology
Last updated: September 2021



1 **Don't initiate erythropoiesis-stimulating agents (ESAs) in chronic kidney disease (CKD) patients with hemoglobin levels greater than or equal to 100 g/L without symptoms of anemia.**

Administering ESAs to CKD patients with the goal of normalizing hemoglobin levels has not demonstrated survival or cardiovascular disease benefit, and may be harmful in comparison to a treatment regimen that delays ESA administration or sets relatively conservative targets (90–110 g/L).

2 **Don't prescribe nonsteroidal anti-inflammatory drugs (NSAIDs) in individuals with hypertension or heart failure or CKD of all causes, including diabetes.**

The use of NSAIDs, including cyclo-oxygenase type 2 (COX-2) inhibitors, for the pharmacological treatment of musculoskeletal pain can elevate blood pressure, make antihypertensive drugs less effective, cause fluid retention and worsen kidney function in these individuals. Other medication prescribed by a healthcare professional may be safer than and as effective as NSAIDs.

3 **Don't prescribe angiotensin converting enzyme (ACE) inhibitors in combination with angiotensin II receptor blockers (ARBs) for the treatment of hypertension, diabetic nephropathy and heart failure.**

When used in combination ACE inhibitors and ARBs are associated with an increased risk of symptomatic hypotension, acute renal failure and hyperkalemia and may increase mortality.

4 **Don't initiate chronic dialysis without ensuring a shared decision-making process between patients, their families, and their nephrology health care team.**

The decision to initiate chronic dialysis should be part of an individualized, shared decision-making process between patients, their families, and their nephrology health care team. This process includes eliciting individual patient goals and preferences and providing information on prognosis and expected benefits and harms of dialysis within the context of these goals and preferences. Limited observational data suggest that survival may not differ substantially for older adults with a high burden of comorbidity who initiate chronic dialysis versus those managed conservatively.

5 **Don't initiate dialysis in outpatients with Stage 5 CKD in the absence of clinical indications.**

Initiating chronic dialysis before the appearance of uremic symptoms or other clinical indication is associated with significant burden and inconvenience for the patient without any clinical benefit. Recent guidelines from the Canadian Society of Nephrology recommend that patients with an estimated glomerular filtration rate (eGFR) less than 15 mL/min should be closely followed by their nephrologist and dialysis deferred until symptoms of uremia, volume overload, hyperkalemia or acidosis become an issue or the eGFR drops below 6 mL/min.

How the list was created

The Canadian Society of Nephrology (CSN) established its Choosing Wisely Canada recommendations by striking a Choosing Wisely Working Group from its Clinical Practice Guidelines Committee. The working group created a survey to poll the members of the society, who were asked to vote for 5 tests, 5 investigations and 5 treatments that they felt were overused, misused or had potential to cause harm. Over 400 members were surveyed with a 22% response rate. These responses were collated into themes, and ordered by their frequency of occurrence. Three members of the working group reviewed the list independently; each of whom proposed a top 10 list of recommendations derived from the survey responses. These 3 lists were then reviewed by the working group and a draft top ten list was generated based on the following criteria: strength of evidence; potential for harm; cost saving; frequency of occurrence in clinical practice and pertinence to nephrology. The draft list of ten items was presented at the CSN annual general meeting and members were asked to vote electronically on their agreement with each recommendation. In addition to the membership votes, the working group then considered the strength of evidence and potential for meaningful impact of the recommendations, and a final list of five items was agreed upon. Recommendations 1, 2, and 4 were adapted with permission from the Five Things Physicians and Patients Should Question, © 2012 American Society of Nephrology.

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About the Canadian Society of Nephrology

CSN is a society of physicians and scientists specializing in the care of people with kidney disease, and in research related to the kidney and kidney disease. The mission of CSN is focused on setting high standards for medical training and education; encouraging research related to the kidney, kidney disorders and renal replacement therapies; improving the delivery of health care related to nephrology; and, promoting the continuing professional competence of nephrologists.



Canadian Society of Nephrology/
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Neurology

Seven Things Clinicians and Patients Should Question

by
Canadian Neurological Society
Last updated: September 2021



1 **Don't routinely perform brain imaging after acute seizure in patients with established epilepsy.**

Typically, epilepsy patients have brain imaging at the time of diagnosis to investigate for a structural cause for seizures. Seizures in these patients are unlikely a result of new structural changes. Neuroimaging can be considered in patients with longstanding epilepsy without prior imaging studies, or in patients who are candidates for neurosurgery with seizures refractory to medical management.

2 **Don't treat women of childbearing potential with Valproic acid if other effective treatments are available.**

Valproic acid is teratogenic for a developing fetus and should be avoided. Valproic acid increases the risk of diminished IQ as well as major congenital malformations including neural tube defects and cardiovascular abnormalities for a developing fetus. If valproic acid treatment is deemed necessary, patients should be counselled regarding contraception and the risks of conception. In this case, the lowest effective dose should be used.

3 **Don't choose opioids or cannabinoids as the first choice of treatment for neuropathic pain.**

Opioids and cannabinoids have weak or inconclusive evidence in effective treatment of neuropathic pain. The well documented risks of opioid and cannabinoids include nausea, sleepiness, impairment, dependence, and development of substance use disorders. With impairment comes further risks to oneself and others in altered judgement in the workplace or while operating a vehicle. Opioids come with an additional risk of decreased respiratory drive and fatality with overdose. Neuropathic pain can be treated effectively using agents with demonstrated efficacy and significantly less risks compared to opioids and cannabinoids.

4 **Don't order neuroimaging or EEG in asymptomatic patients in the emergency department with syncope and a normal neurological evaluation.**

Syncope, and pre-syncope with observed convulsions are very common and frequently investigated in the emergency department. Typical syncope with a normal examination requires minimal investigation. Neuroimaging and EEG will not help in determining the etiology or management of patients with typical syncope in the absence of focal neurologic symptoms or findings on examination.

5 **Don't order CT head scans in adults and children who have suffered minor head injuries (unless positive for a validated head injury clinical decision rule).**

Head injuries in children and adults are common presentations to the emergency department. Minor head injury is characterized by: Glasgow Coma Scale (GCS) 13-15, associated with either witnessed loss of consciousness, definite amnesia, or witnessed disorientation. Most adults and children with minor head injuries do not suffer from serious brain injuries that require hospitalization or surgery. CT head scans performed on patients without signs of significant injuries can expose patients to unnecessary ionizing radiation that has the potential to increase patients' lifetime risk of cancer. They also increase length of stay and misdiagnosis. There is strong evidence that physicians should not order CT head scans for patients with minor head injury unless validated clinical decision rules suggest otherwise (i.e., Canadian CT head rule for adults, and CATCH or PECARN rules for children). Despite their validity, these rules are never 100% sensitive and are meant to assist and not replace, clinical judgement.

6**Don't use opioids for treatment of migraines.**

Opioids are not adequate for pain control for patients with migraines. The risk for harm, including impairment, dependence, tolerance, medication overuse headaches, and opioid use disorder with opioids is greater than the documented benefit. Additionally, opioids may worsen nausea and vomiting associated with the migraine. Prescription opioids for migraines would have minimal to no benefit with the excess of risk, and contribute to the opioid crisis.

7**Don't use butalbital, butorphanol, or ergotamine as treatment for migraines except as a last resort.**

Butalbital, butorphanol, and ergotamine are not adequate abortive or preventative treatments for patients who suffer with migraines. Butalbital and butorphanol are barbiturate containing medications which carry the risks of sedation, intoxication, dependence, abuse potential, severe withdrawal, and substance use disorders. The risk of medication overuse headache with these medications is also significant. These medications are only helpful in refractory cases of migraines as a last resort. There are more effective and less harmful first line agents available for prophylactic and abortive treatment of migraine headaches.

How the list was created

The Canadian Neurological Society (CNS) formed a Choosing Wisely task force in August 2018. The American Board of Internal Medicine Choosing Wisely Neuroscience recommendations were reviewed for their relevance to Canadian neurology as well as recommendations from the American Epilepsy Society, American Association of Neuromuscular and Electrodiagnostic Medicine, American Academy of Nursing, American College of Emergency Physicians, American Geriatrics Society, American Academy of Neurology, and American Academy of Pediatrics. Ten potential recommendations were initially selected and were sent to CNS members in a ranking survey from which a top five list was chosen. These recommendations were presented at the Canadian Neurosciences Federation National Congress in June 2019 which were well received. The list was then sent to Choosing Wisely Canada for review and finalization.

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About the Canadian Neurological Society

The Canadian Neurological Society was established in 1948 and represented both neurologists and neurosurgeons. In 1965, the original CNS was dissolved and two new societies were created to represent the two distinct groups.

Today, the Canadian Neurological Society has approximately 540 members and represents neurologists and neurology residents in Canada. The CNS Board of Directors manages the business, initiatives and finances of the CNS. The board also appoints CNS member representatives to sit on various CNSF committees, including the Professional Development Committee and the Scientific Program Committee. The CNS President and Vice-President also serve on the Board of Directors of the Canadian Neurological Sciences Federation (CNSF).



About Choosing Wisely Canada

Choosing Wisely Canada is the national voice for reducing unnecessary tests and treatments in health care. One of its important functions is to help clinicians and patients engage in conversations that lead to smart and effective care choices.

Nuclear Medicine

Five Things Physicians and Patients Should Question

by

Canadian Association of Nuclear Medicine

Last updated: September 2021



1 **Don't perform stress cardiac imaging or coronary angiography in patients without cardiac symptoms unless high-risk markers are present.**

Asymptomatic, low-risk patients account for up to 45% of inappropriate stress testing. Testing in these asymptomatic patients should be performed only when the following findings are present: diabetes in patients older than 40 years of age, peripheral arterial disease, and greater than 2% yearly coronary heart disease event rate.

2 **Don't use nuclear medicine thyroid scans to evaluate thyroid nodules in patients with normal thyroid gland function.**

Nuclear medicine thyroid scanning does not conclusively determine whether thyroid nodules are benign or malignant; cold nodules on thyroid scans will still require biopsy. Nuclear medicine thyroid scans are useful to evaluate the functional status of thyroid nodules in patients who are hyperthyroid.

3 **Don't use a computed tomography angiogram (CTA) to diagnose pulmonary embolism in young patients, particularly women, with a normal chest radiograph; consider a radionuclide lung study ("V/Q study") instead.**

When the clinical question is whether or not pulmonary emboli are present, a V/Q study can provide the answer with lower overall radiation dose than can CTA. The dose to the breast in women from a nuclear medicine lung scan is much less than the dose from CT performed with a breast shield. Imaging may not be required in patients with a low clinical likelihood of pulmonary emboli and a negative high-sensitivity D-Dimer.

4 **Don't do routine bone scans in men with low-risk prostate cancer.**

Patients who are at low risk of metastatic disease, defined by criteria based on prostate-specific antigen (PSA) and Gleason score, do not need a bone scan for staging. Bone scans may be useful if there are findings in the patient's history or physical examination, which raise the suspicion of bony involvement.

5 **Don't repeat DEXA scans more often than every two years in the absence of high risk or new risk factors.**

Various factors limit the utility of repeat DEXA scans more often than every two years, particularly in stable patients. These include the expected rate of bone loss, which is unlikely to be detected at smaller intervals, and measurement error, which may make repeat measures unreliable. This may be compounded if different DEXA machines are used. In stable patients, the interval between scans may be prolonged, or a repeat may not be necessary.

How the list was created

The Canadian Association of Nuclear Medicine (CANM) established its Choosing Wisely Canada Top 5 recommendations by first having its newly created Choosing Wisely Campaign Working Group review the Society of Nuclear Medicine and Molecular Imaging (SNMMI) and the American Society of Nuclear Cardiology (ASNC) Choosing Wisely® lists. As the American lists reflected the same issues encountered in Canada, the CANM Working Group approved the lists in principle, selected the most appropriate procedures to be questioned and added two recommendations of its own. The list created was then circulated to the CANM Board of Directors and to the general membership for feedback. Item 1 was adopted with permission from the Five Things Physicians and Patients Should Question, ©2012 American Society of Nuclear Cardiology. Items 2 and 4 were adopted with permission from the Five Things Physicians and Patients Should Question, ©2013 Society of Nuclear Medicine and Molecular Imaging.

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The Canadian Association of Nuclear Medicine

The Canadian Association of Nuclear Medicine (CANM) is a proud partner of the Choosing Wisely Canada campaign. The CANM strives for excellence in the practice of diagnostic and therapeutic nuclear medicine by promoting the continued professional competence of nuclear medicine specialists, establishing guidelines of clinical practice, and encouraging biomedical research. We work with all professionals in nuclear medicine to ensure that Canadians have access to the highest quality nuclear medicine services.



About Choosing Wisely Canada

Choosing Wisely Canada is the national voice for reducing unnecessary tests and treatments in health care. One of its important functions is to help clinicians and patients engage in conversations that lead to smart and effective care choices.

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Nurse Practitioner

Nine Things Nurse Practitioners and Patients Should Question

by
Nurse Practitioner Association of Canada
Last updated: July 2021



1 **Don't prescribe any medication to patients over the age of 65 without conducting a thorough medication review.**

Patients over the age of 65 have an increased risk of drug interactions, adverse drug reactions and falls. Although it can sometimes be appropriate to prescribe new medications, a thorough medication review should be done concurrently. The review should ensure that the medications are having the desired effect, that the lowest effective doses are being used, that the patient has been involved in the decision to use them and that they align with the patient's goals of care. There is a paucity of research on clinical outcomes associated with medication review tools however, the STOPP/START, Beers criteria and the McLeod criteria have been reviewed in a Cochrane analysis. Another useful resource is www.Medstopper.com.

2 **Don't prescribe vitamin B12 injections to clients with low vitamin B12 levels as first line therapy.**

Vitamin B12 deficiency affects approximately 5% of Canadian adults. Deficiencies are primarily the result of a lack of intrinsic factor (pernicious anemia). Vitamin B12 absorption can also be affected by the regular use of proton pump inhibitors. There is a large body of evidence supporting the efficacy of oral B12 administration in most cases related to pernicious anemia, malabsorption or malnutrition. The use of oral vitamin B12 is cost effective. Furthermore, using the oral formulation will decrease the need for unnecessary clinic visits for vitamin B12 injection, improve efficiency and decrease costs without compromising patient care. After the initiation of therapy, serum vitamin B12 concentrations should be monitored to assess for efficacy. Given the lack of conclusive evidence, vitamin B12 injections should still be considered for patients with severe neurological involvement, ileectomy and significant malabsorption syndromes.

3 **Don't routinely measure Vitamin D levels in low risk adults.**

Clinical evidence shows that screening for vitamin D deficiency in healthy individuals is generally not necessary. Vitamin D deficiency is common in many populations, particularly in patients at higher latitudes, during winter months and in those with limited sun exposure. Therefore, Canadians have inadequate exposure to sunlight, which puts them at risk for vitamin D deficiency. Over the counter vitamin D supplements and increased summer sun exposure are sufficient interventions for most otherwise healthy patients. Laboratory testing is appropriate in higher risk patients when results will be used to institute more aggressive therapy (e.g., osteoporosis, chronic kidney disease, malabsorption, some infections, obese individuals).

4 **Don't do annual complete physical examinations on asymptomatic adults with no significant risk factors.**

Instead, nurse practitioners should counsel their well, asymptomatic patients regarding the importance of screening and focused health assessments performed according to their risk factors. These visits may include specific physical examination maneuvers and screening tests that should occur at intervals informed by the available evidence such as the Canadian Task Force on Preventive Health Care and provincial cancer care organizations. Following evidence based recommendations, including relevant physical examination and screening test guidelines (pap smears, colorectal cancer screening, etc.) has been shown to be effective at helping nurse practitioners and their patients to find disease before symptoms arise.

5 **Don't order screening chest X-rays in asymptomatic patients.**

This includes periodic health exams, pre-employment health assessments, tuberculosis screening, preoperative and pre-admission screening and cancer screening. There is little evidence to indicate that patient outcomes are improved with screening in these populations. Furthermore, exposure to unnecessary radiation may exceed any potential benefits. Chest X-rays on asymptomatic patients may also result in false positive reporting, which may cause undue stress. The decision to order a chest X-ray should be considered on careful evaluation of any patient presentation indicative of respiratory disease or illness.

6 Don't order chest X-rays in patients with acute upper respiratory tract infections.

There is no evidence that a chest X-ray improves patient outcomes or decreases recovery time for those with upper respiratory infections. Chest X-rays should be reserved for those patients with clinical suspicion of pneumonia, acute upper airway infection with comorbid conditions and those with symptoms persisting beyond three weeks. Pneumonia presents with at least two of: fever, rigors, new cough with or without sputum production or chronic cough with change in colour of sputum, pleuritic chest pain, shortness of breath and localized crackles. Nurse practitioners should be mindful of the risks associated with cumulative radiation exposure such as that from chest X-rays.

7 Don't order thyroid function tests as screening for asymptomatic, low risk patients.

The primary rationale for screening asymptomatic patients is that the resulting treatment leads to improved health outcomes when compared with patients who are not screened. There is insufficient evidence available indicating that screening for thyroid diseases will have these results.

8 Don't prescribe prophylactic antibiotics to prevent travellers' diarrhea.

Travellers' diarrhea is the most predictable travel related illness affecting up to 70% of travellers to developing countries. The vast majority of cases clear on their own in a few days without treatment. Antibiotic prophylaxis for travellers' diarrhea is not recommended as these treatments disrupt the normal gut flora and allow resistant bacteria such as extended-spectrum beta lactamase (ESBL) producing bacteria to flourish. Those taking antibiotics are more likely to become colonized with ESBL producing bacteria. These individuals can shed the bacteria upon return home for several months and close contacts and family members may become colonized with the organism. As a safer alternative, travellers should consider prophylaxis with bismuth salicylate given the good evidence for its use. Clinicians may consider prescribing a three-day supply of antibiotics to carry with patients with clear instructions to only take them for severe diarrhea, given the benefit of reduced symptom duration.

9 Don't screen women with Pap smears if under 25 years of age or over 69 years of age.

Screening pap tests should not be done on asymptomatic patients outside of screening intervals and age groups specified in relevant provincial and national guidelines. Cervical cancer is very rare in women younger than 25 years of age even if they are sexually active. Cervical cancer is very rare in women over 65 years of age who have had normal pap smears at regular recommended screening intervals. Screening pap smears done outside of recommended populations could result in false positive findings and lead to unnecessary follow up and treatment. This could result in stress for the patient and expose them to the risks associated with additional investigations and treatments.

How the list was created

The Nurse Practitioner Association of Canada's (NPAC) Executive Board approved the development of Choosing Wisely Canada's NP recommendations. NPAC created a small working group to review existing Choosing Wisely Canada recommendations and develop potential ideas for an NP list. The working group created a list of suggested recommendations based on existing research, experience and common practice patterns. The Choosing Wisely Canada NP list was posted on the NPAC website discussion board for review and comments by NPAC members. The nine recommendations selected to be part of the Choosing Wisely Canada NP campaign were presented to the NPAC executive board for review and final approval prior to being submitted to Choosing Wisely Canada.

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About the Nurse Practitioner Association of Canada

NPAC-AIIPC is the national voice for Nurse Practitioners, with the goal of advocating for, and reducing barriers to NP practice. This Canadian organization consists of over 1300 members, encompassing a number of nurse practitioner specialties.



Nurse Practitioner
Association of Canada

About Choosing Wisely Canada

Choosing Wisely Canada is a campaign to help physicians and patients engage in conversations about unnecessary tests, treatments and procedures, and to help physicians and patients make smart and effective choices to ensure high-quality care.

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Nursing: Critical Care

Five Things Nurses and Patients Should Question

by

Canadian Nurses Association

Canadian Association of Critical Care Nurses

Last updated: July 2020



1 **Don't insert or leave in place a urinary catheter without an acceptable indication.**

While it's common to insert indwelling urinary catheters for critical care patients, prolonged use can lead to catheter-associated urinary tract infections (CAUTI), urosepsis, increased hospital stays and other complications. Although critical illness can be a legitimate indication for urinary catheter use, daily assessment of urinary catheters is recommended. Some evidence indicates that reminder systems or stop orders in critical care settings can reduce the incidence of CAUTI and catheter duration.

2 **Don't administer benzodiazepines to treat symptoms of delirium.**

The treatment of delirium is multifactorial, including environmental stimulation, ongoing mobilization and family presence. Guidelines recommend against using benzodiazepines for sedation, unless otherwise indicated (e.g., withdrawal related to alcohol or benzodiazepine use). The inappropriate administration of benzodiazepines may harm a critically ill patient by inadvertently increasing the incidence of delirium or the length of stay in an ICU. Nonpharmacologic strategies should be used, along with monitoring, assessing and treating pain. Preliminary research has shown that implementing nurse-driven daily awakening protocols and best practice bundles such as ABCDE may improve outcomes, including decreases in length of overall hospital stay, ventilator days and risk of ICU-acquired delirium.

3 **Don't use physical restraints with critically ill patients as the first choice to prevent self-extubation or removal of lines or tubes.**

The intention to use physical restraints to prevent self-extubation or accidental removal of lines or tubes is often misguided. In fact, some research has found restraints have the potential to cause harm to critically ill patients, including complications but not limited to unplanned extubation, increased risk for delirium, and prolonged recovery. The use of physical restraints in ICU patients in Canada is common and significantly higher comparable to some European countries. Guidelines recognize the paucity of evidence to substantiate the use of physical restraints as an effective strategy. The use of physical restraints can be minimized by maintaining direct visual observation of patients, permitting the presence of family care partners, initiating spontaneous awakening and breathing trials (to support removal of endotracheal tube and thus reduce need for restraints), and assessing delirium and the need for mobilization. Decreased use of physical restraints is an important indicator of quality nursing care.

4 **Don't repeatedly attempt intravenous access during a life-threatening event when intraosseous access is available.**

In emergency situations, intravenous (IV) access can be difficult to obtain. Nurses often lose time trying to insert peripheral IVs, and insertion of central venous catheters may be initiated. However, intraosseous (IO) access is a faster and safer option, with less chance of complications, when inserted by trained personnel.

5 **Don't prolong use of central venous or peripherally inserted central catheters without daily reassessment.**

Central venous or peripherally inserted central catheters require close monitoring for signs of central line-associated bloodstream infections (CLABSI) and should be reviewed daily during multidisciplinary rounds to ensure the appropriateness of the catheter and its intended use. Peripheral intravenous catheters should be assessed daily and removed if they are not part of the continued plan of care or the lumen remains dormant for greater than 24 hours. Unless medically necessary for parenteral nutrition or vasoactive support, the strategies to mitigate CLABSI in central venous access should include considering an access device that is the least invasive with the greatest likelihood of reaching the end of the planned therapy with the lowest rate of replacements and complications.

How the list was created

The Canadian Nurses Association (CNA) and the Canadian Association of Critical Care Nurses (CACCN) established its Choosing Wisely Canada nursing list by convening an 11-member nursing working group (NWG). The group consisted of critical care nursing experts from across Canada, representing a broad range of geographical regions and practice settings. The NWG began considering its list by reviewing existing recommendations, including items from Choosing Wisely Canada's specialty societies and the American Academy of Nursing (AAN) Choosing Wisely list, both of which had already undergone rigorous evidence reviews. In addition, members brought forward recommendations on new evidence-based items. The NWG appraised 331 items for their relevance to critical care nursing using a structured process developed for this work. Each of these items (302 Choosing Wisely Canada items, 25 AAN Choosing Wisely items and 4 independently submitted items) was appraised by two working group members and then validated by the group. Using a modified Delphi process for the next two rounds of revision, the group refined and adapted 14 items until it reached consensus on a final six-item list. A literature review was conducted to confirm the evidence for these items, with support from the Canadian Agency of Drugs & Technologies (CADTH) and supporting nursing research was added where appropriate. The list subsequently underwent extensive consultation, with input from nursing experts in patient safety, members of the Canadian Network of Nursing Specialties, patient advocates, CNA jurisdictional members, CNA nurses, principal nurse advisors, CADTH and Choosing Wisely Canada's internal clinician reviewers. In March of 2020, the Choosing Wisely Canada critical care nursing list was presented to the CNA Board of Directors, who gave it their full endorsement and support.

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About the Canadian Nurses Association

CNA represents registered nurses from ten provincial and territorial nursing associations and colleges, independent registered nurse members from Ontario and Quebec and retired registered nurses from across the country. CNA advances the practice and profession of nursing to improve health outcomes and strengthen Canada's publicly funded, not-for-profit health system.



About the Canadian Association of Critical Care Nurses

The Canadian Association of Critical Care Nurses (CACCN) is a volunteer organization of Critical Care Nurses. CACCN is the voice for excellence in Canadian critical care nursing. Our shared goal is promote quality patient- and family-centered care for Canadian's experiencing life threatening illness and injury.



About Choosing Wisely Canada

Choosing Wisely Canada is a campaign to help physicians and patients engage in conversations about unnecessary tests, treatments and procedures, and to help physicians and patients make smart and effective choices to ensure high-quality care.

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Nursing: Gerontology

Six Things Nurses and Patients Should Question

by

Canadian Nurses Association

Canadian Gerontological Nursing Association

Last updated: October 2020



1 **Don't routinely suggest antimicrobial treatment for older persons unless they are consistent with their goals of care.**

While antimicrobial treatments can be lifesaving, they are not without side-effects, particularly for an older person. Antimicrobial use is only appropriate if it aligns with the older person's wishes and goals of care. Life-prolonging use of antimicrobials may be inconsistent with a patient's wishes or a palliative approach to care. Talk with the older person and their family to ensure they understand the impact of antimicrobial treatment.

2 **Don't routinely use intravenous antimicrobials for older persons who can take and absorb oral medications.**

When antimicrobials are indicated and consistent with an older person's plan of care, intravenous formulations should not be the first choice unless there is no other safe and effective route of administration. Many antimicrobials have excellent bioavailability and only in rare instances need to be administered intravenously. Use of oral formulations of these medications reduces the need for placement and maintenance of venous access devices and their associated complications. In addition, reduced need for venous access can prevent transfer of an older person away from their current setting to accommodate a higher level of care.

3 **Don't send frail older persons to the hospital unless their urgent needs and goals of care cannot be met in their current setting.**

Transfers to hospital for assessment and treatment of a change in condition have become customary. However, harms can outweigh benefit and may result in increased morbidity. In one Canadian study, approximately half of hospitalizations were considered avoidable. Transfer often results in long periods in an unfamiliar and stressful environment for the older person. Other hazards include delirium, hospital-acquired infections, medication side effects, lack of sleep, and rapid loss of muscle strength while bedridden. Frail older persons assessed and treated in their current settings have the opportunity to receive more individualized care and better comfort and end-of-life care. If a transfer is unavoidable, a person-centred collaborative approach is necessary to communicate the older person's functionality and plan of care to ensure their needs are met. Much consideration should be given to the older person's goals of care, including integrating a palliative approach to care.

4 **Don't encourage bed rest for older persons during a hospital stay unless medically indicated.**

Continuous bed rest or limited ambulation during a hospital stay causes deconditioning and loss of muscle mass and is one of the primary factors for loss of walking independence in hospitalized older adults. Up to 65% of older persons who can walk independently will lose this ability during a hospital stay. Walking during the hospital stay is critical for maintaining this functional ability. Loss of walking independence increases the length of hospital stay, the need for rehabilitation services, the possibility of placement in a nursing home, and the risk for falls both during and after discharge from the hospital. It also places higher demands on caregivers and increases the risk of death. Compared with older persons who don't walk during their hospital stay, those that do are able to walk farther by discharge, are discharged from the hospital sooner, have improved ability to perform basic daily living tasks independently, and have a faster recovery rate after surgery.

5**Don't use restraints with older persons unless all other alternatives have been explored.**

Restraints are most often applied when an older person is distressed or has a change in medical status. These situations require immediate assessment and attention, not restraint. Restraints can be mechanical, physical, chemical or environmental in nature — for example, devices or medications that can be used to restrict a person's movement. Perceived benefits of restraints are often outweighed by their significant potential for harm, including serious complications and even death. Safe, quality care can be achieved using a least-restraint approach.

6**Don't use a q2h turning routine unless it meets the older person's plan of care.**

Individualized turning plans should be developed to align with the older person's care needs. Turning an older person q2h is often considered the gold standard implemented in many areas of health care to aid in the avoidance of skin breakdown and pressure injuries. However, there is little evidence to support this particular frequency of repositioning. In some cases, it is far too frequent; in others, it is not frequent enough. For older persons at low risk for skin breakdown, this practice may severely impact their quality of life due to sleep deprivation and disruption, leading to delirium, depression and other psychiatric impairments. Excessive repositioning of an older adult may also result in shearing forces that can lead to pressure injuries. Conversely, q2h turning may be inadequate for persons at higher risk for skin breakdown, including those with decreased tissue tolerance and limited mobility. To facilitate an appropriate turning schedule for older adults of all risk levels, it is crucial to use a validated tool to assess each client's risk for skin breakdown and develop an individualized turning plan.

How the list was created

The Canadian Nurses Association (CNA) and the Canadian Gerontological Nursing Association (CGNA) established its Choosing Wisely Canada nursing list by convening an 11 member nursing working group (NWG). The group consisted of gerontological nursing experts from across Canada, representing a broad range of geographical regions and practice settings. The NWG began considering its list by reviewing existing recommendations, including items from Choosing Wisely Canada's specialty societies and the American Academy of Nursing (AAN) Choosing Wisely list, both of which had already undergone rigorous evidence reviews. In addition, members brought forward recommendations on new evidence-based items. The NWG appraised 260 items for their relevance to gerontological nursing using a structured process developed for this work. Each of these items (227 Choosing Wisely Canada items, 20 AAN Choosing Wisely items and 13 independently-submitted items) was appraised by two independent reviewers and then validated by the group. Using a modified Delphi process for the next two rounds of revision, the group refined and adapted 17 items until it reached consensus on a final six-item list. A literature review was conducted to confirm the evidence for these items, and supporting nursing research was added where appropriate. The list subsequently underwent extensive consultation, with input from nursing experts in patient safety, members of the Canadian Network of Nursing Specialties, patient advocates, CNA jurisdictional members, CNA nurses, principal nurse advisors, the Canadian Agency for Drugs and Technologies in Health (CADTH) and Choosing Wisely Canada's internal clinician reviewers. In March of 2018, the Choosing Wisely Canada gerontological nursing list was presented to the CGNA executive and CNA board, both of whom gave it their full endorsement and support.

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About the Canadian Nurses Association

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About the Canadian Gerontological Nursing Association

The Canadian Gerontological Nursing Association is an organization that represents gerontological nurses and promotes gerontological nursing practice across national and international boundaries. The vision of CGNA is to promote excellence in gerontological nursing through leadership, knowledge, and scholarship. CGNA's mission is to address the health concerns of older Canadians and the nurses who participate with them in health care.



About Choosing Wisely Canada

Choosing Wisely Canada is the national voice for reducing unnecessary tests and treatments in health care. One of its important functions is to help clinicians and patients engage in conversations that lead to smart and effective care choices.

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Nursing: Infection Prevention and Control

Seven Things Nurses and Patients Should Question

by

Canadian Nurses Association

Infection Prevention and Control Canada

Last updated: August 2019



1 **Don't do a urine dip or send urine specimens for culture unless urinary tract symptoms are present.**

Don't do a urine dip or send urine specimens for culture when patients/clients/residents (including the elderly or persons with diabetes) do not have urinary tract symptoms or when following up to confirm effective treatment. Testing should only be done when there are urinary tract infection (UTI) symptoms such as urinary discomfort, frequency, urgency, supra-pubic pain, flank pain or fever. Dark, cloudy and/or foul-smelling urine may not be suggestive of UTI but rather of inadequate fluid intake. Delirium by itself is not considered a symptom of cystitis in non-catheterized patients. Testing often shows bacteria in the urine, with as many as 50% of those tested showing bacteria without localizing symptoms to the genitourinary tract. Over-testing and treating asymptomatic bacteriuria with antibiotics lead to an increased risk of diarrhea and infection with *Clostridium difficile*. Overuse of antibiotics contributes to increasing antimicrobial resistance. The only exceptions to such overuse are screening in early pregnancy, for which there are clear guidelines, and screening for asymptomatic bacteriuria before urologic procedures in which mucosal bleeding is anticipated.

2 **Don't recommend antibiotics for infections that are likely viral in origin, such as an influenza-like illness.**

Since the vast majority of upper respiratory infections are viral, antibiotics are rarely indicated and may lead to adverse effects. Overuse or misuse of antibiotics can lead to increased antibiotic resistance in the individual and the larger society. Antiviral drugs are authorized for influenza treatment and prophylaxis in Canada. Their use will depend on a number of factors such as patient risk, relevant history and the duration and severity of symptoms. If a nurse caring for a patient feels that medication is not the appropriate intervention, the nurse has a responsibility to discuss these concerns with the prescribers.

3 **Don't overuse gloves.**

Gloves should only be worn: (1) when a point-of-care risk assessment indicates a risk of contact with broken skin, blood or body fluids, mucous membranes or contaminated surfaces (as per routine practices); (2) for situations where additional (contact) precautions are indicated; or (3) for contact with chemicals (e.g., during environmental cleaning, preparing chemotherapy, etc.). When a task requires gloves, they should be put on immediately beforehand and removed immediately after, at which point hands should be cleaned. Gloves are not necessary for social touch (e.g., shaking hands) or when contact is limited to intact skin (e.g., taking blood pressure, dressing a client) or clean surfaces. Don't wear multiple layers of gloves and don't substitute gloves for hand hygiene. Hand hygiene is the single most important way to prevent transmission of infection, and alcohol-based hand rub (ABHR) is the preferred method. If gloves must be worn, after cleaning hands, allow them to dry before putting on gloves to reduce the risk of chronic irritant contact dermatitis (ICD) and colonization of hands. If hands are not visibly soiled, this risk could be reduced by avoiding handwashing and using ABHR instead.*

4 **Don't send unnecessary or improperly collected specimens for testing.**

Don't routinely send specimens for testing or screening (e.g., for methicillin-resistant *Staphylococcus aureus* [MRSA]) unless clinical evidence of infection is present (e.g., for incisions or eyes). If the highest quality specimen that can be obtained is through a swab of infected skin, tissue or wound, cleanse the area with sterile saline beforehand to reduce surface contaminants. Do not take a specimen of the discharge unless it is specifically ordered. Improperly collected or poor-quality specimens (including swabs) can reduce patient safety by prompting antimicrobial therapy (in cases of colonization) and increase laboratory and pharmacy expenses. To promote sensible antimicrobial use and optimize the treatment of infected patients, while reducing unnecessary microbiology lab workup, attention should be paid to appropriate specimen collection.

5**Don't collect stool that is not diarrhea for *Clostridioides difficile* infection testing or test of cure.**

Don't routinely collect or process specimens for *Clostridioides* (formerly *Clostridium*) *difficile* testing when stool is not diarrhea (i.e., does not take the shape of the specimen container), the patient has had a prior nucleic acid amplification test result within the past seven days (e.g., polymerase chain reaction) or as a test of cure. A positive test in the absence of diarrhea likely represents *C. difficile* colonization. Repeated *C. difficile* testing within seven days of a negative test generally adds little diagnostic value. A test of cure in patients with recent *C. difficile* infection is also not recommended, as colonization may continue indefinitely. Contact precautions are required until symptoms (i.e., diarrhea) resolve.

6**Don't prolong the use of invasive devices.**

Invasive devices (such as central venous catheters and endotracheal tubes) should not be used without specific indication (determined by appropriate clinical assessment) and should not be left in place without daily re-assessment. If required, invasive devices should not be used longer than necessary, as they breach skin and body integrity and are portals of entry for infection.

7**Don't shave hair for medical procedures. Use clippers if hair removal is required.**

Shaving hair (e.g., preoperatively, for vascular access device insertion or electrode application) can result in microscopic cuts and abrasions to the underlying skin surface. According to World Health Organization guidelines, hair should not be removed unless it interferes with a surgical procedure. The use of razors (shaving) prior to surgery increases incidents of wound infection when compared to clipping, depilatory use or the non-removal of hair. If hair must be removed, clipper use is sufficient for any body part (razor use is not appropriate for any operative site). Clippers should be used as close to the time of surgery as possible. To facilitate better contact for electrodes or vascular access device dressings, disposable (or cleaned and disinfected reusable-head) surgical clippers should be used.

How the list was created

The Canadian Nurses Association (CNA) and Infection Prevention and Control (IPAC) Canada established its Choosing Wisely Canada nursing list by convening an eight-member nursing working group (NWG). The group consisted of infection prevention and control nursing experts from across Canada, representing a broad range of geographical regions and practice settings. The NWG began considering its list by reviewing existing recommendations, including items from Choosing Wisely Canada's specialty societies and the American Academy of Nursing (AAN) Choosing Wisely list, both of which had already undergone rigorous evidence reviews. In addition, members brought forward recommendations on new evidence-based items. The NWG appraised 298 items for their relevance to nursing using a structured process developed for this work. Each of these items (217 from Choosing Wisely Canada, 15 from AAN Choosing Wisely and 66 that were independently submitted) was appraised by two independent reviewers then validated by the group. Using a modified Delphi process for the next two rounds of revision, the group refined and adapted 30 items until it reached consensus on a final seven-item list. A literature review was conducted to confirm the evidence for these items, and supporting nursing research was added where appropriate. The list subsequently underwent extensive consultation, with input from nursing experts in patient safety, members of the Canadian Network of Nursing Specialties, patient advocates, CNA jurisdictional members, CNA nurses, the Canadian Association for Drugs and Technologies in Health (CADTH) and Choosing Wisely Canada's internal clinician reviewers. In September 2017, the Choosing Wisely Canada nursing list was presented to the IPAC Canada and CNA boards, who gave it their full endorsement and support.

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About the Canadian Nurses Association

CNA represents registered nurses from ten provincial and territorial nursing associations and colleges, independent registered nurse members from Ontario and Quebec and retired registered nurses from across the country. CNA advances the practice and profession of nursing to improve health outcomes and strengthen Canada's publicly funded, not-for-profit health system.



About Infection Prevention and Control Canada

IPAC Canada is a multidisciplinary, professional organization for those engaged in the prevention and control of infections. IPAC Canada was incorporated under the Canadian Corporation Act in 1976 and is a registered non-profit organization. IPAC Canada has over 1600 members.



About Choosing Wisely Canada

Choosing Wisely Canada is the national voice for reducing unnecessary tests and treatments in health care. One of its important functions is to help clinicians and patients engage in conversations that lead to smart and effective care choices.

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Nursing

Nine Things Nurses and Patients Should Question

by

Canadian Nurses Association

Last updated: October 2020



1 **Don't insert an indwelling urinary catheter or leave it in place without daily assessment.**

The use of indwelling urinary catheters among hospital patients is common. Yet it can also lead to preventable harms such as urinary tract infection, sepsis and delirium. Guidelines support routine assessment of appropriate urinary catheter indications—including acute urinary obstruction, critical illness and end-of-life care—and minimizing their duration of use. Strategies consistent with CAUTI (catheter-associated urinary tract infection) guidelines regarding inappropriate urinary catheter use have been shown to reduce health care-associated infections.

2 **Don't advise routine self-monitoring of blood glucose between appointments for clients with type 2 diabetes who are not taking insulin or other medications that could increase risk for hypoglycemia.**

Many studies show that, once target control is achieved, routine self-monitoring of blood glucose (SMBG) does little to control blood sugar for most adults with type 2 diabetes who don't use insulin or other medications that could increase risk for hypoglycemia. It should be noted that SMBG may be indicated during acute illness, medication change or pregnancy; when a history or risk of hypoglycemia exists (e.g., if using a sulfonylurea), and when individuals need monitoring to maintain targets — considerations that should be part of assessment and client education.

3 **Don't add extra layers of bedding (sheets, pads) beneath patients on therapeutic surfaces.**

Additional layers of bedding can limit the pressure-dispersing capacities of therapeutic surfaces (such as therapeutic mattresses or cushions). As a result, extra sheets and pads can contribute to skin breakdown and impede the healing of existing pressure wounds.

4 **Don't use oxygen therapy to treat non-hypoxic dyspnea.**

Oxygen is frequently used to relieve shortness of breath. However, supplemental oxygen does not benefit patients who are short of breath but not hypoxic. Supplemental flow of air is as effective as oxygen for non-hypoxic dyspnea.

5 **Don't routinely use incontinence containment products (including briefs or pads) for older adults.**

Adult incontinence containment products are frequently used for continent patients (especially women) with low mobility. Yet the literature associates their use with multiple adverse outcomes including diminished self-esteem and perceived quality of life, and higher incidence rates of dermatitis, pressure wounds and urinary tract infections. Among older adults, nurses should conduct a thorough assessment to determine the risk of such outcomes before initiating or continuing the use of incontinence containment products. The development of a continence care plan should be a shared decision-making process that includes the known wishes of clients regarding care needs and the perspectives of carers and the health care team.

6 **Don't recommend tube feeding for clients with advanced dementia without ensuring a shared decision-making process that includes the known wishes of clients regarding future care needs and the perspectives of carers and the health care team.**

Tube feeding for older adults with advanced dementia offers no benefit over careful feeding assistance related to the outcomes of aspiration pneumonia and the extension of life. While food is the preferred form of obtaining nutrition, oral supplements may be beneficial if this intervention meets the person's known goals of care. Tube feeding may contribute to client discomfort and result in agitation, the use of physical and/or chemical restraint and worsening pressure wounds.

7 Don't recommend antipsychotic medicines as the first choice to treat symptoms of dementia.

People with dementia frequently exhibit responsive behaviors, which are often misinterpreted as aggression, resistance to care and challenging or disruptive behaviours. In such instances antipsychotic medicines are regularly prescribed. The benefit of these drugs is limited, however, and they can also cause serious harm including premature death. Their use should be limited to cases where non-pharmacologic measures have failed and where patients pose an imminent threat to themselves or others. Identifying and addressing the causes of behaviour change can render drug treatment unnecessary. If a nurse caring for a patient feels that medication is not the appropriate intervention, the nurse has a responsibility to discuss these concerns with the prescriber.

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

Signs and symptoms suggestive of urinary tract infection (UTI) are increased frequency, urgency, pain or burning on urination, supra-pubic pain, flank pain and fever. Dark, cloudy and/or foul-smelling urine may not be suggestive of UTI but rather of inadequate fluid intake. Cohort studies have found no adverse outcomes associated with asymptomatic bacteriuria for older adults. Not only does antimicrobial treatment for such bacteriuria in older adults show no benefits, it increases adverse antimicrobial effects. Consensus criteria have been developed for the specific clinical symptoms that (when associated with bacteriuria) define UTI. Exceptions to these criteria include recommended screening for and treatment of asymptomatic bacteriuria before urologic procedures where mucosal bleeding is anticipated. If a nurse caring for a patient feels that medication is not the appropriate intervention, the nurse has a responsibility to discuss these concerns with the prescribers.

9 Don't routinely recommend antidepressants as a first-line treatment for mild depressive symptoms in adults.

Antidepressant response rates are higher for moderate or severe adult depression. For mild depressive symptoms a complete assessment, ongoing support and monitoring, psychosocial interventions and lifestyle modifications should be the first lines of treatment. This approach can avoid the side-effects of medication and establish etiological factors important to future assessment and management. Antidepressants are appropriate in cases of persistent mild depression where a past history of more severe depression exists or where other interventions have failed. If a nurse caring for a patient feels that medication is not the appropriate intervention, the nurse has a responsibility to discuss these concerns with the prescriber.

How the list was created

The Canadian Nurses Association (CNA) established its Choosing Wisely Canada nursing list by convening a 12-member nursing working group (NWG) of diverse nurse experts from across Canada representing a broad range of geographical regions, practice settings and experience. The NWG began considering its potential list by reviewing existing recommendations, including items from Choosing Wisely Canada's specialty societies and the American Academy of Nursing (AAN) Choosing Wisely® list, which had already undergone rigorous evidence reviews. In addition, members brought forward recommendations on new evidence-based items. The NWG appraised 195 items for relevance to nursing using a structured process developed for this work. Each of these (171 Choosing Wisely Canada physician-related items, 15 AAN Choosing Wisely items and nine independently submitted items) was appraised by two independent reviewers. Using a modified Delphi process for the next two rounds of revision, the group then refined and adapted 36 items until reaching consensus on a final nine-item list. A literature review was conducted to confirm the evidence for these items, and supporting nursing research was added where appropriate. Subsequently, the final list underwent extensive consultation, in which further input was obtained from nursing experts in patient safety, various members of the Canadian Network of Nursing Specialties, CNA, its jurisdictional members and patient advocates. In November 2016, the Choosing Wisely Canada nursing list was presented to CNA's board of directors, who gave it their full endorsement and support.

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About the Canadian Nurses Association

CNA represents registered nurses from ten provincial and territorial nursing associations and colleges, independent registered nurse members from Ontario and Quebec and retired registered nurses from across the country. CNA advances the practice and profession of nursing to improve health outcomes and strengthen Canada's publicly funded, not-for-profit health system.



About Choosing Wisely Canada

Choosing Wisely Canada is the national voice for reducing unnecessary tests and treatments in health care. One of its important functions is to help clinicians and patients engage in conversations that lead to smart and effective care choices.

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Obstetrics and Gynaecology

Twelve Things Physicians and Patients Should Question

by

Society of Obstetricians and Gynaecologists of Canada

Last updated: August 2021



1 **Avoid the use of routine episiotomy in spontaneous vaginal births.**

Routine episiotomy has been shown to cause more harm than good. Studies demonstrate that restrictive episiotomy policies are associated with less posterior perineal trauma, less suturing, and fewer complications, with no difference for most pain measures or severe vaginal and/or perineal trauma. When the perineum is preventing delivery, particularly if the fetal heart rate is abnormal, an episiotomy may expedite a vaginal birth.

2 **Don't do electronic fetal monitoring for low risk women in labour; use intermittent auscultation.**

Continuous electronic fetal monitoring (EFM) leads to significantly greater rates of caesareans and operative vaginal deliveries in low risk patients compared to those monitored with intermittent auscultation. Intermittent auscultation results in no significant difference in the number of infant deaths during and shortly after labour, cerebral palsy rates, use of drugs for pain relief, and cord blood acidosis in low risk patients. Further, EFM restricts movement and positioning, excludes the option of using a birthing pool, and requires greater resource use to continuously interpret fetal heart rate tracings. EFM therefore increases risk of intervention and decreases choice without providing meaningful benefit to patient or neonatal outcomes in low risk patients.

3 **Don't perform routine urinalysis (protein, glucose) at every antenatal visit (in low risk normotensive women).**

Routine urinalysis (for glucose and protein) in low-risk pregnancies is not recommended. For screening of healthy pregnant women, urinalysis for glucose to assess the risk of developing gestational diabetes is not recommended due to low sensitivity. For assessing the potential development of preeclampsia in pregnant women, routine urine dipstick or urinalysis are not recommended as the test for albumin levels is unreliable. Do not rely on proteinuria to screen for gestational hypertension; periodically check the blood pressure.

4 **Don't perform umbilical artery Doppler studies as a routine screening test in uncomplicated pregnancies with normal fetal growth.**

Placental integrity, specifically vascular resistance, may be assessed by evaluating flow in the umbilical arteries using Doppler ultrasound. When this is done with high risk pregnancies the perinatal death rate is reduced and interventions may be appropriately timed or withheld. "High risk" in these investigations were principally intrauterine growth restriction and maternal hypertension. When Doppler studies were extended to low-risk pregnancies however there was no improvement in outcome and abnormal results were more likely to be false positives.

5 **Don't routinely screen with Pap smears if under 21 years of age or over 69 years of age.**

Screening should be initiated at 21 years of age for those who are asymptomatic and immunocompetent. Studies have shown the largest number of false positive test results occurring in adolescents younger than 21 years and have the lowest incidence of cervical cancer. There is no protective effect in screening those younger than 21 years. There are few studies that address the age of cessation. Modelling studies have not shown increase in protective effect when screening those greater than 70 years who have had prior routine screening.

6 **Don't routinely order hormone levels including estradiol, progesterone, follicle-stimulating hormone and luteinizing hormone in postmenopausal women or after a hysterectomy, either to diagnose menopause or to manage hormone therapy.**

The frequency and severity of menopausal symptoms do not correlate to the levels of either follicle-stimulating hormone (FSH) or serum estradiol. Reproductive estrogen levels are typically much higher than required to reduce symptoms. Management with hormone therapy is based on using the lowest effective dose to reduce symptoms to an acceptable level. Relying on elevated FSH to make a diagnosis may result in women being denied effective therapy for disruptive symptoms; use of an unreliable test may in this way contribute to less than optimal care. Using blood levels to adjust hormone therapy may result in higher doses of hormone therapy than are needed to reduce and manage symptoms.

7 Don't screen for ovarian cancer in asymptomatic women at average risk.

Screening for ovarian cancer does not improve clinical outcomes in asymptomatic women without a family history of the disease. Screening does not decrease all-cause mortality, ovarian cancer mortality or the risk of diagnoses of advanced stage ovarian cancer. There is no demonstrable benefit on mortality following transvaginal ultrasonography or routine pelvic screening examinations and the use of CA125 or other biomarkers for ovarian cancer but such screening resulted in false-positive tests, overdiagnosis, and overtreatment with inevitable complications.

8 Don't offer hysterectomy to women with asymptomatic fibroids on the basis of risk malignancy.

Rapid growth of a fibroid is not a predictor of leiomyosarcoma. In women undergoing surgery for fibroids approximately 1 in 400 (0.25%) is at risk of having a leiomyosarcoma. However, growth and/or new onset of symptoms post-menopause should carry a higher index of suspicion for malignancy. Incidental uterine leiomyosarcomas have been encountered during routine resectoscopic myomectomy, though their incidence appears to be lower than that reported following hysterectomy (0.13%). Leiomyomas and leiomyosarcomas cannot reliably be distinguished clinically or by any imaging technique.

9 Don't do any surgical intervention, including ablation, for abnormal uterine bleeding until medical management (including the progesterone intra-uterine system) has been offered and either declined or found unsuccessful.

There are several non-hormonal and hormonal agents that have proven to be effective in the treatment of abnormal uterine bleeding. Some of these may have the added benefit of providing symptom relief for dysmenorrhoea and offer contraceptive coverage. These agents may help stabilize anaemia and provide symptom relief alone, or may be utilized prior to surgical management of heavy menstrual bleeding. Medical management allows for early initiation of treatment in a primary care setting whereas surgical intervention may be limited by access to specialist consultation and operating facilities. All potential treatment options for abnormal uterine bleeding should be discussed with the patient and their side-effects, relative effectiveness, risks, costs and impact on fertility outlined so that an informed shared treatment decision can be made and a treatment plan instituted.

10 Don't remove ovaries in premenopausal women without strong clinical indications.

Large US population-based databases have estimated the rate of bilateral salpingo-oophorectomy (BSO) at the time of hysterectomy for benign indications to be 46.4%. When stratified by age, the rates of oophorectomy in women 45-49 years is approximately 60%, and in women >55 years is 65-75%. Studies have shown increase in all-cause mortality, coronary heart disease and cardiovascular death in women with BSO <50 years. These risks may be modified with hormone therapy. BSO has also been shown to increase risk of cognitive impairment and dementia, as well as increase long-term risks of depressive and anxiety symptoms. While BSO has been shown to reduce incidence of ovarian and breast cancer, there are conflicting studies on the impact of BSO on colorectal and lung cancer. Clinical indications for BSO in premenopausal women include women with increased genetic risk for ovarian cancer (BRCA 1, BRCA 2, and Lynch Syndrome) and endometriosis.

11 Don't do a caesarean delivery for the sole indication of failure of progress in labour in the latent phase of labour for a woman at term with a singleton fetus and cephalic presentation.

Women who do not make progress in cervical dilatation at less than 4 cm can be managed expectantly, with analgesia and rest as needed. They generally have good outcomes and can often deliver vaginally with no further complications, similar to women who did not have a prolongation of the latent phase of labour. According to the SOGC Clinical Practice Guideline on Management of Labour, "Dystocia cannot be diagnosed prior to the onset of labour or during the latent phase of labour; caesarean section carried out at this time for an indication of dystocia is inappropriate." The end of the latent phase is subject to reassessment, the transition to an active phase is easier to diagnose retrospectively. A description of labour curves suggest that the end of the latent phase may be at 6 cm, rather than 4 cm and that overall progress is slower than that originally described. Each obstetrical unit must decide the definition of entry into the active phase of the first stage of labour. Regardless, intervention for a diagnosis of presumed dystocia is inappropriate in whatever may be considered the latent phase. Women should be allowed the opportunity to advance in labour, which many will do if given time, and achieve a vaginal delivery and avoid a caesarean delivery.

12 Don't give antenatal corticosteroid therapy unless the pregnant woman meets the gestational age criteria and the risk of delivery within the next 7 days is very high.

The likelihood of preterm delivery and also the gestational age need to be carefully considered when contemplating the use of antenatal corticosteroid therapy among pregnant women. The efficacy of such therapy is highest when the course is given 24 hours to 7 days prior to delivery. Administration more than 7 days before delivery leads to reduced benefit and potentially unnecessary adverse effects. Trials enrolling pregnant women from 24 + 0 to 34 + 6 weeks gestation at high risk of preterm birth show that antenatal corticosteroid therapy significantly reduces perinatal death, respiratory distress syndrome, and intraventricular hemorrhage in the infants who in fact delivered pre-term. Evidence from cohort studies shows a significant reduction in perinatal mortality among infants exposed to antenatal corticosteroid therapy at less than 24 weeks gestation. Women between 22 + 0 weeks and 23 + 6 weeks gestation at high risk of preterm birth within the next 7 days should be provided with a multidisciplinary consultation regarding the high likelihood for severe perinatal morbidity and mortality, and associated maternal morbidity. Steroids should be given if intensive care for the baby is planned.

How the list was created

The Society of Obstetricians and Gynaecologists of Canada (SOGC) struck a small working group to oversee the Choosing Wisely Canada list development process. An initial list of recommendations was compiled from all published SOGC guidelines. The list was reviewed by the Choosing Wisely committee, who provided input and guidance. A long list was then created from four sources: SOGC guidelines, Choosing Wisely recommendations published by American societies (notably the American College of Obstetricians and Gynaecologists), Canadian Choosing Wisely recommendations relevant to Ob/Gyn, and other proposals from SOGC members. The refined list was circulated to all members of the Clinical Practice – Obstetrics and Gynaecology committees then further refined by the Board of Directors. A list consisting of 24 recommendations (sorted based on specialty: obstetrics; gynaecology and generalist) was generated and circulated to the wider SOGC membership to obtain the final list.

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About The Society of Obstetricians and Gynaecologists of Canada

The Society of Obstetricians and Gynaecologists of Canada (SOGC) is a proud partner of the Choosing Wisely Canada campaign. The SOGC promotes excellence in the practice of obstetrics and gynaecology and to advance the health of women through leadership, advocacy, collaboration, and education. It has over 3,500 members, comprised of obstetricians, gynaecologists, family physicians, nurses, midwives, and allied health professionals working in the field of sexual reproductive health.



About Choosing Wisely Canada

Choosing Wisely Canada is the national voice for reducing unnecessary tests and treatments in health care. One of its important functions is to help clinicians and patients engage in conversations that lead to smart and effective care choices.

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Occupational Medicine

Six Things Physicians and Patients Should Question

by

Occupational Medicine Specialists of Canada

Last updated: September 2021



1 Don't endorse clinically unnecessary absence from work.

There is substantial evidence to support the positive link between work and health (physical, mental and social health). Both employment and income are separate determinants of health and are used as health status indicators. Absence from work contributes to declining health, slower recovery times, and longer duration of disability. Maintaining and restoring working capacity is an important function of health services which improves function and can also impact upon recovery and prognosis. Supporting unnecessary restrictions or total disability (absence from work) creates disability which in turn negatively impacts upon health. When asked to provide an opinion on functional abilities to employers or insurers, the focus should be on abilities; restrictions should be objective, specific, and listed only when absolutely medically indicated.

2 Don't prescribe opiates for the treatment of acute or chronic non-cancer pain without first assessing side effects, work status, and capacity to drive a motor vehicle.

Increases in opioid prescribing have been accompanied by simultaneous increases in abuse, serious injuries, and deaths from overdose. Compared to those on no, or lower opiate doses, those prescribed higher opiate doses have increased disability risk and duration. The use of opiates can result in effects such as euphoria, drowsiness or inability to concentrate. Cognitive and psychomotor ability are essential functions for driving a motor vehicle and other complex work tasks. Those who prescribe opiates may be obligated to report a patient's inability to drive safely.

3 Don't order X-rays for acute low back pain in the absence of red flags.

Acute low back pain is a common health problem affecting between 50-90% of people over the course of a lifetime with less than 2% of cases representing potentially serious conditions requiring surgical or medical intervention. Red flags suggesting additional testing include such things as a history of significant trauma, cauda equina syndrome, symptoms suggestive of tumour or infection (fever, weight loss, history of cancer), steroid use, etc. However, the majority of acute low back pain episodes are benign, self-limited cases that do not warrant any imaging studies. Unnecessary imaging can be harmful due to the potential adverse health effects associated with radiation exposure and due to attribution of symptoms to unrelated incidental findings leading to prolonged disability.

4 Don't order blood mercury levels unless: dietary history suggests risk; the patient is pregnant or planning to become pregnant; and/or the patient is occupationally exposed to organomercury compounds.

Although clinically significant exposures may still occur in Canada, less than 1% of Canadian adults have total blood mercury concentrations above Health Canada's guidance value. As such, the large majority of individuals who present with concerns of metal toxicity do not actually have toxicity, and testing results in false positives (values above the reference range but not in the range of toxicity). Occupationally exposed workers and childbearing women are susceptible subgroups therefore testing in these populations is warranted in cases where a careful occupational and/or environmental history suggests a significant exposure. In the absence of clinical presentation and history indicating toxicity risk, testing should be avoided because it may lead to misinterpretation and unnecessary concern or interventions (dietary restriction, chelation) that may cause harm.

5 Don't repeat chest X-rays when screening exposed workers for asbestosis unless clinical indications are present or required by legislation.

Asbestosis generally becomes manifest clinically 15-20 years after the onset of exposure. High resolution CT (HRCT) is more sensitive than both chest radiography and conventional CT for detecting parenchymal fibrosis (asbestosis) but a normal HRCT scan cannot completely exclude asbestosis. Given the long latency between asbestos exposure and asbestosis and given that no effective treatment is available to improve the outcome, screening and early detection of asbestosis is unlikely to allow any remedial action to be taken in the workplace or to confer any health advantage on asbestos-exposed individuals. Repeated imaging exposes the patient to radiation, which is not without risk. Therefore, while it is appropriate to obtain a baseline X-ray at the time of first assessment, for screening purposes, radiation risk outweighs the benefit of frequent chest X-rays. Radiation exposure would also be a concern for repeated CT scans.

Do not use a test-based requirement for return to work clearance following COVID-19 when time-based strategies are appropriate.

Reverse Transcription-Polymerase Chain Reaction (RT-PCR) amplification tests remain positive in some people's respiratory samples after recovery from coronavirus disease 2019 (COVID-19) infection with prolonged viral RNA shedding demonstrated without direct evidence of there being viable virus capable of replicating or causing infection. Test-based strategies relying on the absence of viral fragments, such as RNA or antigen, for return to work clearance may therefore inappropriately delay return to work. The United States Centres for Disease Control (US-CDC) recommends time-based approaches. A time-based approach based on epidemiologic studies suggests that it is safe to return to work 10 to 20 days after symptom onset depending on the severity of the illness and symptom resolution criteria. Return to work criteria requiring one or more negative RT-PCR or other approved tests may still be considered in high risk occupational settings such as working with high risk persons in a health care setting.

How the list was created

The Occupational Medicine Specialist of Canada (OMSOC) established its Choosing Wisely Canada Top 5 recommendations by consensus and literature review methods. The first step was to examine the list and references developed and provided to us by The American College of Occupational and Environmental Medicine (ACOEM). This list was used as a starting point for extensive survey consultation with the membership of OMSOC and also with the membership of The Occupational and Environmental Medicine Association of Canada (OEMAC). This process enabled input from a breadth of health care providers working in the field of occupational medicine, including both occupational medicine specialists as well as family medicine practitioners with a special interest in the field. The comments and topic suggestions that emerged from this consultation were qualitatively categorized by an OMSOC member with expertise in qualitative research. There was high initial agreement; the emergent topics fit into 6 categories overall, 5 of which are represented on the list. The excluded item was least consistent with a campaign to help physicians and patients engage in conversations about the overuse of tests and procedures because of its administrative nature. With the assistance of Health Quality Ontario, a small committee reviewed literature, identified clinical practice guideline repositories, and organizational and government statements to identify the supporting references. Draft list items, rationale statements, and references were provided to members of OMSOC and also made available to OEMAC for feedback. This resulted in minor modifications to specific wording but no changes to topics. The Board of Directors of OMSOC reviewed and approved the Choosing Wisely Canada list.

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About Occupational Medicine Specialists of Canada

Occupational Medicine Specialists of Canada (OMSOC) is a proud partner of the Choosing Wisely Canada campaign. OMSOC's membership comprises occupational physicians certified as specialists by The Royal College of Physicians and Surgeons of Canada or le Collège des Médecins du Québec as well as specialists from other medical and surgical specialties with an interest in occupational medicine. OMSOC provides a forum for advancing the practice of occupational medicine by facilitating dialogue amongst physician specialists and between occupational medicine practitioners and members of allied fields, notably government, industry, management, and the law.



About Choosing Wisely Canada

Choosing Wisely Canada is the national voice for reducing unnecessary tests and treatments in health care. One of its important functions is to help clinicians and patients engage in conversations that lead to smart and effective care choices.

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Oncology

Ten Things Physicians and Patients Should Question

by
Canadian Association of Medical Oncologists
Canadian Association of Radiation Oncology
Canadian Partnership Against Cancer
Canadian Society for Surgical Oncology
Last updated: July 2021



1 **Don't order tests to detect recurrent cancer in asymptomatic patients if there is not a realistic expectation that early detection of recurrence can improve survival or quality of life.**

In some specific situations, the early detection of cancer recurrence (local and/or distant) may increase the likelihood of successful subsequent curative treatment. However, in many circumstances, earlier knowledge of recurrence does not improve outcome. As such, it is important to balance the information that can come from advanced testing with what is best for the individual patient. Specifically, the need for patient reassurance should be balanced against the anxiety and uncertainty provoked by extensive follow-up testing when there is not a realistic expectation that the early identification of recurrence may improve survival or quality of life.

2 **Don't perform routine cancer screening, or surveillance for a new primary cancer, in the majority of patients with metastatic disease.**

Screening for cancer can be lifesaving in otherwise healthy at-risk patients. While screening tests lead to a mortality benefit which emerges years after the test is performed, they expose patients to immediate potential harms. In general, patients with metastatic cancer have competing mortality risks that would outweigh the mortality benefits of screening as demonstrated in healthy patients. In fact, patients with metastatic disease may be more likely to experience harm since patients with limited life expectancy are more likely to be frail and more susceptible to complications of testing and treatments. Therefore, the balance of potential benefits and harms does not favor recommending screening for a new asymptomatic primary malignancy in most patients with metastatic disease. Screening may be considered in a very small subgroup of patients where metastatic disease is relatively indolent, or its treatment is expected to result in prolonged survival.

3 **Avoid chemotherapy and instead focus on symptom relief and palliative care in patients with advanced cancer unlikely to benefit from chemotherapy (e.g., performance status 3 or 4).**

Studies show that, in general, cancer directed treatments are likely to be ineffective for patients with solid organ tumours who are markedly debilitated by their cancer (i.e., performance status 3 or 4). Exceptions may include patients with functional limitations due to other conditions resulting in a low performance status, or selected patients with specific disease types (e.g., germ cell cancer) or characteristics (e.g., mutations) that suggest a high likelihood of response to therapy. It has also been shown that appropriate symptom control and palliative care can significantly improve quality of life.

4 **Don't perform routine colonoscopic surveillance every year in patients following their colon cancer surgery; instead, frequency should be based on the findings of the prior colonoscopy and corresponding guidelines.**

Studies have shown clearly that, in the absence of heredity syndromes, the progression from polyp to cancer (adenoma carcinoma sequence) occurs over many years. Thus, the timing of a follow-up surveillance colonoscopy should be determined based on the results of a previous high-quality colonoscopy. Typical colonoscopic surveillance following colon cancer surgery consists of a colonoscopy at one year; thereafter it should not typically exceed every 3 years following detection of an advanced polyp, or every 5 years following a normal exam or one showing small polyps. In Canada, there is both evidence of overuse of surveillance colonoscopy following colon cancer resection and, in areas, a limited availability of endoscopy resources.

5 Don't delay or avoid palliative care for a patient with metastatic cancer because they are pursuing disease-directed treatment.

Numerous studies—including randomized trials—show that palliative care improves pain and symptom control, improves family satisfaction with care, and reduces costs. Palliative care does not accelerate death, and may prolong life in selected populations. The benefits of disease-directed treatment (e.g., chemotherapy or radiation) can be enhanced by early consideration of palliative care.

6 Don't recommend more than a single fraction of palliative radiation for an uncomplicated painful bone metastasis.

Randomized trials have established that single-fraction radiation to a previously unirradiated, uncomplicated peripheral bone or vertebral metastasis provides comparable pain relief and morbidity compared to multiple-fraction regimens, while optimizing patient and caregiver convenience. Although it results in a higher incidence of retreatment at a later date (20% vs. 8 % for multi-fraction regimens), the decreased patient burden usually outweighs any considerations of long-term effectiveness for those with a limited life expectancy.

7 Don't initiate management in patients with low-risk prostate cancer (T1/T2, PSA < 10 ng/ml, and Gleason score < 7) without first discussing active surveillance.

Patients with localized prostate cancer have a number of reasonable management options. These include surgery, radiation, as well as conservative monitoring without therapy in appropriate patients. Shared decision-making between the patient and the physician can lead to better alignment of patient goals with treatment and more efficient care delivery. The use of patient-directed written decision aids concerning prostate cancer can give patients confidence about their choices, and improve compliance with therapy. Discussion regarding active surveillance should include both the elements and timing of such surveillance, and emphasize the need for compliance.

8 Don't initiate whole breast radiotherapy in 25 fractions as a part of breast conservation therapy in women age ≥50 with early stage invasive breast cancer without considering shorter treatment schedules.

Whole breast radiotherapy is beneficial for most women with invasive breast cancer treated with breast conservation therapy. Many studies have utilized “conventionally fractionated” schedules that deliver therapy over 5 to 6 weeks, often followed by 1 to 2 weeks of boost therapy. However, more recent evidence (including a major study from Canada) has demonstrated equivalent tumour control and cosmetic outcome in specific patient populations with shorter courses of therapy (approximately 3 to 4 weeks). Patients and their physicians should review these options to determine the most appropriate course of therapy.

9 Don't deliver care (e.g., follow-up) in a high-cost setting (e.g., inpatient, cancer center) that could be delivered just as effectively in a lower-cost setting (e.g., primary care).

Several studies (including randomized clinical trials) have demonstrated that surveillance following definitive cancer therapy can be performed equally well, and in a more patient-centered fashion, within a primary care setting. With the substantial increase in cancer survivors, the traditional practice of providing routine follow-up care through specialist cancer centres is placing rising demands and competing with other care delivery functions of such centres. Primary care providers are both willing to provide follow-up cancer care and have repeatedly assumed such responsibility. Despite this, the transition to primary care in Canada has been both variable and incomplete.

10 Don't routinely use extensive locoregional therapy in most cancer situations where there is metastatic disease and minimal symptoms attributable to the primary tumour (e.g., colorectal cancer).

In the past, extensive local regional therapies (e.g., surgery) were often provided in patients with metastatic disease, regardless of the symptomatology of the primary tumour. However, recent evidence has suggested that in many cases these therapies do not improve outcome and, at times, delay the more important treatment of metastatic disease (e.g., chemotherapy). In general, patients with metastatic disease from solid organ malignancies and a relatively asymptomatic primary tumour should be considered for systemic therapy as a priority; the delay in systemic therapy and potential additional morbidity arising from extensive locoregional therapies should be avoided in these patients.

How the list was created

To help create the cancer specific list for Choosing Wisely Canada, a Tri-Society Task Force was convened by the Canadian Partnership Against Cancer in late 2013. The Task Force included representatives from the Canadian Association of Radiation Oncology (CARO), Canadian Association of Medical Oncologists (CAMO) and Canadian Society of Surgical Oncology (CSSO). Through a multipronged consensus process of the Task Force, along with broader society member engagement, an initial list of 66 practices was generated. In addition, a framework for subsequent selection of low value/harmful practices was established and included the following elements: (1) the size of population to which practice is relevant; (2) the frequency of use of the practice in Canada; (3) the cost of the practice; (4) the evidence/degree of harm of practice; and (5) the potential for change in use of the practice. Based on this framework, and after an iterative adjudication and voting process, this list was first reduced to a long list of 41 practices, then to a short list of 19 practices, and subsequently to a final list of 10 low value, unnecessary, or harmful practices. Many practices were considered, including cancer-related practices previously identified in the U.S. Choosing Wisely® campaign. Recommendation 3 was adapted with permission from the Five Things Physicians and Patients Should Question, © 2014 American Society of Clinical Oncology. Recommendations 5 and 6 were adapted with permission from the Five Things Physicians and Patients Should Question, © 2013 American Academy of Hospice and Palliative Medicine. Recommendations 7 and 8 were adapted with permission from the Five Things Physicians and Patients Should Question, © 2013 American Society for Radiation Oncology.

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About the Canadian Society of Surgical Oncology (CSSO)

The Canadian Society of Surgical Oncology (CSSO) is a proud partner of the Choosing Wisely Canada campaign. The CSSO is a national association of surgical oncologists that promotes the optimum treatment of the patient with cancer through a multi-disciplinary treatment approach. The association fosters the development of education in cancer for both graduate, undergraduate and continuing medical education and encourages the development of research in oncologic surgery. The CSSO believes in facilitating communication between surgeons whose primary interest lies in the field of oncology and encourages the formation of surgical oncology training programs among Canadian Universities.



About The Canadian Association of Medical Oncologists

The Canadian Association of Medical Oncologists (CAMO) is a proud partner of the Choosing Wisely Canada campaign. CAMO, a national specialty society of the Royal College of Physicians and Surgeons of Canada, will contribute to cancer control, through research, education, and clinical practice in prevention, screening, diagnosis, treatment, supportive care, palliative care and rehabilitation. CAMO is committed to achieving and maintaining, among its members, excellence in clinical and scholarly activity, within a culture of compassion and respect for human dignity.



About The Canadian Partnership Against Cancer

The Canadian Partnership Against Cancer (CPAC) is a proud partner of the Choosing Wisely Canada campaign. CPAC is an independent organization funded by the federal government to accelerate action on cancer control for all Canadians. CPAC works with cancer experts, charitable organizations, governments, cancer agencies, national health organizations, patients, survivors and others to implement Canada's cancer control strategy.



About Canadian Association of Radiation Oncology

The Canadian Association of Radiation Oncology (CARO) is a proud partner of the Choosing Wisely Canada campaign. CARO is a national professional association representing the official voice of radiation oncology in Canada in relation to the public interest and professional interest in the provision of radiation oncology consultative and treatment services. The association's regionally representative board structure and national membership facilitate the execution of its mission.



About Choosing Wisely Canada

Choosing Wisely Canada is a campaign to help physicians and patients engage in conversations about unnecessary tests, treatments and procedures, and to help physicians and patients make smart and effective choices to ensure high-quality care.

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Orthopaedics

Ten Things Physicians and Patients Should Question

by

The Canadian Orthopaedic Association

The Canadian Arthroplasty Society

Arthroscopy Association of Canada

Last updated: September 2021



1 **Don't use arthroscopic debridement as a primary treatment in the management of osteoarthritis of the knee.**

Several recent meta-analyses have culminated in clinical practice guidelines recommending against the use of arthroscopic debridement for the treatment of degenerative knee arthritis or degenerative and meniscal tears, as it appears there is no maintained benefit of arthroscopic surgery over conservative management (exercise therapy, injections, and drugs). However, this does not preclude the judicious use of arthroscopic surgery when indicated to manage symptomatic co-existing pathology in the presence of osteoarthritis or degeneration.

2 **Don't order a knee MRI when weight-bearing x-rays demonstrate osteoarthritis and symptoms are suggestive of osteoarthritis as the MRI rarely adds useful information to guide diagnosis or treatment.**

The diagnosis of knee osteoarthritis can be effectively made based upon the patient's history, physical examination, and plain radiography consisting of weight-bearing posterior-anterior, lateral and skyline views. Ordering MRI scans incurs further waiting times for patients, can cause unnecessary anxiety while waiting

3 **Don't order a hip MRI when x-rays demonstrate osteoarthritis and symptoms are suggestive of osteoarthritis as the MRI rarely adds useful information to guide diagnosis or treatment.**

The diagnosis of hip osteoarthritis can be effectively made based upon the patient's history, physical examination and plain radiography. Ordering MRI scans incurs further waiting times for patients, can cause unnecessary anxiety while waiting for specialist consultation, and can delay MRI imaging for appropriate patients.

4 **Don't prescribe opioids for management of osteoarthritis before optimizing the use of non-opioid approaches to pain management.**

The use of opioids in chronic non-cancer pain is associated with significant risks. Optimization of non-opioid pharmacotherapy and non-pharmacologic therapy is strongly recommended. Treatment with opioids is not superior to treatment with non-opioid medications in improving pain-related function over 12 months in patients with moderate to severe hip, knee or back pain due to osteoarthritis.

5 **Don't routinely request pathological examination of tissue from uncomplicated primary hip and knee replacement surgery undertaken for degenerative arthritis.**

Several large reviews including thousands of patients have demonstrated that routine pathological examination of operative specimens from uncomplicated primary hip and knee arthroplasty surgeries does not alter patient management or outcome.

6 **Avoid performing routine post-operative deep vein thrombosis ultrasonography screening in patients who undergo elective hip or knee arthroplasty.**

Since ultrasound is not effective at diagnosing unsuspected deep vein thrombosis (DVT) and appropriate alternative screening tests do not exist, if there is no change in the patient's clinical status, routine post-operative screening for DVT after hip or knee arthroplasty does not change outcomes or clinical management.

7 **Don't use needle lavage to treat patients with symptomatic osteoarthritis of the knee for long-term relief.**

The use of needle lavage in patients with symptomatic osteoarthritis of the knee does not lead to measurable improvements in pain, function, 50-foot walking time, stiffness, tenderness or swelling.

8**Don't use glucosamine and chondroitin to treat patients with symptomatic osteoarthritis of the knee.**

Both glucosamine and chondroitin sulfate do not provide relief for patients with symptomatic osteoarthritis of the knee.

9**Don't use lateral wedge insoles to treat patients with symptomatic medial compartment osteoarthritis of the knee.**

In patients with symptomatic osteoarthritis of the knee, the use of lateral wedge or neutral insoles does not improve pain or functional outcomes. Comparisons between lateral and neutral heel wedges were investigated, as were comparisons between lateral wedged insoles and lateral wedged insoles with subtalar strapping. The systematic review concludes that there is only limited evidence for the effectiveness of lateral heel wedges and related orthoses. In addition, the possibility exists that those who do not use them may experience fewer symptoms from osteoarthritis of the knee.

10**Don't use post-operative splinting of the wrist after carpal tunnel release for long-term relief.**

Routine post-operative splinting of the wrist after the carpal tunnel release procedure showed no benefit in grip or lateral pinch strength or bowstringing. In addition, the research showed no effect in complication rates, subjective outcomes or patient satisfaction. Clinicians may wish to provide protection for the wrist in a working environment or for temporary protection. However, objective criteria for their appropriate use do not exist. Clinicians should be aware of the detrimental effects including adhesion formation, stiffness and prevention of nerve and tendon movement.

How the list was created:

Recommendations 1-5

The Canadian Orthopaedic Association (COA) established its Choosing Wisely Canada Top 5 recommendations by asking its National Standards Committee to review the evidence base associated with the five treatments and procedures chosen by the American Academy of Orthopaedic Surgeons for the Choosing Wisely® campaign in the United States. Satisfied that the list was relevant to the Canadian clinical context, the Committee recommended its adoption to the COA's Executive Committee, and the motion was then unanimously approved by the Board of Directors. Therefore, all five items were adopted with permission from the Five Things Physicians and Patients Should Question, © 2013 American Academy of Orthopaedic Surgeons.

Recommendations 6-10

This list was developed by the COA in collaboration with the Canadian Arthroplasty Society (CAS) and the Arthroscopy Association of Canada (AAC).

Recommendation 6 arises from the position statement from the AAC concerning arthroscopy of the knee joint. Recommendations 7, 8 and 10 were brought forth by members of the CAS at their Annual Meeting in 2017. Recommendation 9 was brought forth by members of the COA Standards Committee following the COA Annual Meeting in June 2017.

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The Canadian Orthopaedic Association

The Canadian Orthopaedic Association (COA) is a proud partner of the Choosing Wisely Canada campaign. With some 1,300 members, the COA is the national professional association that represents Canada's orthopaedic surgeons. Its mandate is to promote excellence in bone and joint care through continuing professional development, models of care, practice-management strategies, government relations and a code of ethics. The COA has met annually since 1945, providing a venue for Canada's orthopaedic surgeons to update and refine their skills, as well as discuss and respond to professional and patient issues. Faced with increasing subspecialization, the COA has avoided fragmentation by forming subspecialty societies within the parent organization. Thus, the COA continues to speak with a united voice on behalf of the orthopaedic community in Canada.



About Choosing Wisely Canada

Choosing Wisely Canada is the national voice for reducing unnecessary tests and treatments in health care. One of its important functions is to help clinicians and patients engage in conversations that lead to smart and effective care choices.

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Otolaryngology: Head and Neck Surgery

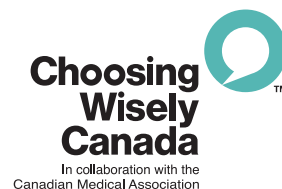
Three Things Physicians and Patients Should Question

by

Canadian Society of Otolaryngology - Head & Neck Surgery

Canadian Association of Head and Neck Surgical Oncologists

Last updated: July 2021



1 **Don't order imaging - computer tomography (CT) or magnetic resonance imaging (MRI) - as the initial investigation for patients presenting with a chief complaint of hoarseness.**

Many patients presenting with hoarseness do not have an underlying head and neck malignancy. Hence, ordering imaging initially does not help to make a diagnosis. Persistent hoarseness, lasting greater than 6 weeks, can be one of the first signs of malignancy of the larynx or voice box. This is particularly true in current or ex-smokers and individuals with a current or previous history of alcohol abuse. Laryngoscopy as part of a thorough physical examination is the best initial investigation of persistent hoarseness. If the laryngoscopy demonstrates a vocal cord paralysis or a mass/lesion of the larynx, imaging to further evaluate is evidence-based.

2 **Don't perform open biopsy or excision of a neck mass without having first considered a fine needle aspiration (FNA) biopsy.**

A fine needle aspiration biopsy (FNA) is the gold standard for initial work up for a neck mass and has numerous advantages over an open neck biopsy. FNA holds less risk and avoids the chance of seeding cancer cells in the neck and making subsequent treatment of a confirmed malignancy more challenging. It is also inexpensive, quickly obtained without a general anaesthetic, and can be performed with or without the use of imaging to assist with the placement of the needle depending on the location of the neck mass, particularly if it is partially cystic or near vital structures. Open neck biopsies should only be considered for a neck mass if the result of a FNA biopsy is non-diagnostic and no primary carcinoma is identified upon a complete head and neck examination. If there is a strong suspicion of lymphoma (previous history of lymphoma, night sweats, weight loss, wide spread lymphadenopathy) an open or core biopsy can be considered in lieu of a FNA.

3 **Don't order neck ultrasound to investigate odynophagia (discomfort or pain with swallowing) or globus sensation.**

Odynophagia and globus sensation are common symptoms and the differential diagnosis can be extensive, including inflammatory, infectious, neoplastic, autoimmune and traumatic causes. Odynophagia and globus sensation are infrequently due to an underlying neck mass, and if so, the underlying lesion is usually quite apparent on physical examination. Neck or thyroid ultrasonography ordered to investigate patients with odynophagia and globus sensation are more likely to detect other entities such as benign thyroid nodules, rather than confirming a diagnosis that explains the patient's symptoms and can lead to a cascade of other unnecessary tests that can be harmful to patients. Unfortunately, using tests to exclude conditions, can sometimes identify other diseases such as thyroid nodules, leading to further testing such as a FNA or repeat ultrasounds and in some cases treatment in the form of a thyroidectomy that may be unnecessary or harmful to patients.

How the list was created

This list was created by the Canadian Association of Head and Neck Surgical Oncologists of the Canadian Society of Otolaryngology – Head & Neck Surgery. Members of each group, representing the national leaders within their respective subspecialties, were asked to create a list of recommendations for unnecessary tests that were seen to be commonly ordered or unnecessary interventions that were commonly performed. These unnecessary tests and interventions are often invasive and incur risk to patients and unwarranted costs to our public health care system. The evidence was then reviewed to further refine the recommendations. The final version of the list was then circulated and approved by the members of the groups.

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Otolaryngology-Head & Neck Surgery



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Otolaryngology: Otology and Neurotology

Five Things Physicians and Patients Should Question

by

Canadian Society of Otolaryngology - Otology & Neurotology Subspecialty Group

Last updated: January 2020



1 **Don't order specialized audiometric and vestibular neurodiagnostic tests in an attempt to screen for peripheral vestibular disease.**

The diagnosis of the dizzy patient should be guided by the presenting symptoms and office examination. Tests such as ABR (auditory brainstem response), ECOG (electrocochleography), ENG/VNG (electronystagmography/ videonystagmography), VEMP (vestibular evoked myogenic potential), vHIT (video head impulse test), CDP (computerized dynamic posturography) and RCT (rotational chair testing) should only be ordered if clinically indicated. In general, advanced balance tests should be ordered and interpreted by otolaryngologists with specialized training in the diagnosis and treatment of vestibular disorders (otologists/neurotologists). Clinical indications for testing can include: side localization and stage of progression for Meniere's disease, assessment of central compensation for acute vestibular loss and confirmation of superior semicircular canal dehiscence syndrome. Specialized tests are rarely indicated in the management of benign paroxysmal positional vertigo.

2 **Don't perform computed tomography or blood work in the evaluation of a patient with sudden sensorineural hearing loss (SSNHL) given its presumed viral etiology.**

Blood work which typically would consist of a CBC, differential and electrolytes along with an autoimmune panel are often normal and would not change initial clinical management if abnormal. The CT scan which is done to rule out central causes is not sensitive enough to pick up most cases of retrocochlear pathology. MRI scans should be considered instead. If verified to be sensorineural with audiometric testing, urgent treatment with steroid therapy can be initiated. There is no role for antiviral treatment, thrombolytics or vasoactive substances.

3 **Don't perform auditory brainstem responses (ABR) in patients with asymmetrical hearing loss. Asymmetrical hearing loss is defined as bone conduction threshold difference of: (a) 20 dB threshold difference at a single frequency, (b) 15 dB threshold difference at 2 frequencies, (c) 10 dB threshold difference at 3 frequencies.**

If there is no obvious cause of the asymmetry such as unilateral trauma or unilateral noise exposure like gun blasts, a MRI should be ordered. MRI scans are superior in sensitivity for detecting retrocochlear pathologies such as vestibular schwannoma when compared to ABR testing.

4 **Don't use oral antibiotics as a first line treatment for patients with painless ear drainage associated with a tympanic membrane perforation or tympanostomy tube unless there is evidence of developing cellulitis in the external ear canal skin and pinna.**

First line therapy constitutes a short course of topical antibiotic/steroid drops. The potential ototoxicity of any topical medication entering the middle ear space should be considered in selecting an appropriate agent. Where available, fluoroquinolone combination preparations (e.g., ciprofloxacin and dexamethasone) should be used as a first choice and caution should be exercised in using topical aminoglycosides. Microdebridement and further assessment should be considered in the following circumstances: (a) failure to respond after a 7 day course, or (b) where follow up does not permit a clear view of a normal tympanic membrane allowing the exclusion of more sinister middle ear disease such as cholesteatoma.

5 **Don't perform particle repositioning maneuvers (Epley or Semont) without a clinical diagnosis of posterior semicircular canal benign paroxysmal positional vertigo in the affected ear.**

Posterior semicircular canal benign paroxysmal positional vertigo should be diagnosed and confirmed with a positive Dix-Hallpike test, and only then should a particle repositioning maneuver be performed. If a patient with positional vertigo has a Dix-Hallpike test that is repeatedly negative or results in atypical nystagmus, less common BPPV variants or central positional vertigo should be considered.

How the list was created

This list was created by the Otology & Neurology subspecialty group (items 1-5) and the Canadian Association of Head and Neck Surgical Oncologists (CAHNSO; items 6-8) of the Canadian Society of Otolaryngology – Head & Neck Surgery (CSO-HNS). Members of each group, representing the national leaders within their respective subspecialties, were asked to create a list of recommendations for unnecessary tests that were seen to be commonly ordered or unnecessary interventions that were commonly performed. These unnecessary tests and interventions are often invasive and incur risk to patients and unwarranted costs to our public health care system. The evidence was then reviewed to further refine the recommendations. The final version of the list was then circulated and approved by the members of the groups.

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Otolaryngology: Rhinology

Five Things Physicians and Patients Should Question

by

Canadian Society of Otolaryngology - Head & Neck Surgery

Rhinology Subspecialty Group

Last updated: January 2022



1 Don't prescribe antibiotics to patients with acute sinusitis who do not meet the diagnostic criteria for acute bacterial rhinosinusitis

The prevalence of a bacterial infection during acute rhinosinusitis is estimated to be 2%–10%, whereas viral causes account for 90%–98%. Management of viral rhinosinusitis is primarily focused on symptomatic relief, which may include use of intranasal corticosteroids, analgesics, nasal saline rinses, oral or topical decongestants, and mucolytics. Antibiotics are ineffective for viral illness and do not provide direct symptom relief. Despite this, 82% of Canadian patients diagnosed with acute sinusitis received a prescription for antibiotics. Differentiating viral rhinosinusitis from acute bacterial rhinosinusitis (ABRS) is challenging because the symptoms are overlapping, but is critical to avoid inappropriate antibiotic prescriptions.

The “**PODS**” clinical criteria suggest ABRS with two or more of facial **P**ain/pressure/fullness, nasal **O**bsttruction, nasal purulence/dicoloured postnasal **D**ischarge, decreased/absent **S**mell that persist for more than 7-10 days (*Canadian Clinical Practice Guidelines for Acute and Chronic Rhinosinusitis* for full details). A bacterial infection is so unlikely prior to this timeframe that antibiotics generally should be avoided unless symptoms have persisted for at least 7 days.

In patients who meet the criteria for ABRS with mild or moderate symptoms, intranasal corticosteroids alone are often sufficient. Antibiotics can be considered for patients with severe symptoms or those who fail a 72 hour trial of intranasal corticosteroids after the diagnosis of ABRS* has been made.

*This [table](#) outlines how ABRS diagnosis requires the presence of at least 2 persistent or worsening symptoms.

2 Don't order a CT scan for uncomplicated acute rhinosinusitis

Radiographic imaging for patients presenting with uncomplicated acute rhinosinusitis to distinguish acute bacterial rhinosinusitis (ABRS) from viral rhinosinusitis is not recommended, unless a complication or alternative diagnosis is suspected. A sinus CT scan is a highly sensitive test for rhinosinusitis, and a normal study confidently rules out active sinusitis of any etiology. However, abnormal sinus CT imaging findings, including air-fluid levels, mucosal thickening, and complete sinus opacification, are nonspecific and can be seen with both bacterial and viral sinusitis, as well as in up to 42% of asymptomatic healthy individuals. In a prospective study of healthy young adults experiencing a new cold, CT scans showed that 87% of the subjects had significant abnormalities of their maxillary sinuses. Therefore, in acute rhinosinusitis, a CT scan has minimal utility because its findings are not specific to a diagnosis of acute rhinosinusitis, and does not help guide the need for antibiotics since it cannot reliably distinguish viral from bacterial rhinosinusitis. Consider CT imaging of the sinuses when a complication of ABRS is suspected based on severe headache, altered mental status, facial swelling, cranial nerve palsies, proptosis of the eye, or other clinical findings.

3 Don't order plain film sinus x-rays

Plain film x-rays of the sinuses should not be ordered in the work-up of sinusitis. Plain films have poor sensitivity and specificity and they cannot be relied upon to confirm or reject the diagnosis of either acute or chronic sinusitis. Findings such as air-fluid levels and complete sinus opacification are not reliably present in rhinosinusitis, and cannot differentiate between viral and bacterial etiologies. The complicated anatomy of the ethmoid sinuses and critical sinus drainage pathways are not delineated effectively with plain films, and are inadequate for operative planning. Given that the findings of a sinus x-ray cannot be relied upon to diagnose rhinosinusitis, guide antibiotic prescribing, or plan surgery, they do not provide value in patient care and should be avoided.

4**Don't swab the nasal cavity as part of the work up for rhinosinusitis**

Acute bacterial rhinosinusitis is a clinical diagnosis that does not require proof of a culture-identified pathogen. When patients meet criteria for uncomplicated ABRS, empiric antibiotic selection should be based on typical causative pathogens (i.e. *Streptococcus pneumoniae*, *Hemophilus influenza*, *Moraxella catarrhalis*, and *Staphylococcus aureus*), local bacterial resistance patterns, and patient factors. Nasal swabs are contaminated by normal nasal flora and results correlate poorly with causative pathogens in rhinosinusitis. In many hospitals, a nasal swab will only be processed to report on the presence or absence of *S. aureus*, rather than a full culture for speciation. In situations where cultures are required, such as intraorbital or intracranial complications, endoscopically-guided culture of the middle meatus or a maxillary sinus aspirate are the preferred methods for obtaining samples of the causative pathogen.

5**Don't order a plain film X-ray in the evaluation of nasal fractures**

Plain film x-rays should not be ordered as part of the management of nasal fractures. The decision to reduce a nasal fracture depends on numerous factors including patient preference, external deformity, and breathing difficulty, none of which are effectively assessed by an x-ray. They have a very low sensitivity and specificity, with 63.3% and 55.7% respectively. As such, plain x-rays are unable to accurately diagnose occult fractures. Despite being commonly ordered for medicolegal documentation of nasal fractures, the poor sensitivity and specificity brings into question their value in medicolegal proceedings. In studied cohorts, no unsuspected facial fractures were identified solely on nasal x-rays, and no negative effects on management occurred when an institution instituted a "no nasal x-ray policy". Overall, nasal x-rays do not contribute to diagnosis, documentation, or management decisions, and should not be ordered.

How the list was created

This list was created by the Rhinology Specialty Group of the Canadian Society of Otolaryngology – Head & Neck Surgery. Members of the group, representing the national leaders within their respective subspecialties, were asked to create a list of recommendations for unnecessary tests that were seen to be commonly ordered or unnecessary interventions that were commonly performed. These unnecessary tests and interventions incur risk to patients and unwarranted costs to our public health care system. The evidence was then reviewed to further refine the recommendations. The final version of the list was then circulated and approved by the members of the group. Choosing Wisely Canada groups across multiple specialties reviewed and refined the consensus recommendations.

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Pediatric Infectious Diseases and Medical Microbiology

Four Things Physicians and Patients Should Question

by

Association of Medical Microbiology and Infectious Disease Canada

Last updated: July 2020



1 **Don't routinely use antibiotics other than amoxicillin in the treatment of children with presumed community-acquired pneumonia (in the outpatient setting).**

Preschool-aged children with CAP (community acquired pneumonia) frequently do not require antibiotics, as most disease is caused by viral infections. Children with suspected CAP of bacterial origin should usually receive amoxicillin for outpatient treatment, or ampicillin or penicillin G for inpatient treatment. These agents have sufficient activity against the common bacterial pathogens causing CAP without being unnecessarily broad. Third-generation cephalosporins should be reserved for children who are unimmunized or with severe infection, or where there are high rates of penicillin-resistance among invasive pneumococcal isolates. Additional agents may be indicated in cases of suspected staphylococcal pneumonia, atypical pathogens, or influenza.

2 **Don't use a bag for collection of urine cultures to diagnosis urinary tract infections.**

Bacterial growth in cultures of bag urine specimens are more likely to be falsely positive in young children with suspected urinary tract infection (UTI) due to contamination with perineal flora. A bag urine culture cannot therefore be used to establish the diagnosis of UTI and may lead to overtreatment. Although a negative bag culture would rule out a UTI, a positive culture requires confirmation by a more specific method, incurring substantial delay. Cultures of urine specimens obtained by catheterization or suprapubic aspiration are more specific and as such are preferred as the routine method of urine collection in non-toilet trained children. Clean-catch, the standard technique of urine collection for toilet-trained children, is a non-invasive method sometimes attempted in infants but is also associated with relatively high rates of contamination.

3 **Don't routinely collect or process specimens for Clostridium difficile testing in infants less than one year of age with diarrhea.**

Infants are commonly asymptomatic carriers of *C. difficile* (14-63%), but clinical illness is rarely reported before 12-24 months of age. It has been hypothesized that infants lack the cellular machinery for Clostridium toxin internalization. When investigating an infant with diarrhea, alternative diagnoses should be considered even with a positive test for *C. difficile*. Testing should be limited to immunosuppressed infants or those with underlying intestinal conditions (e.g. Hirschsprung disease, inflammatory bowel disease) when other etiologies have been ruled out. Therefore, it is prudent to avoid routine testing in children less than 12 months, and for children 1-3 years of age, test for other causes of diarrhea first, particularly viral.

4 **Don't routinely treat uncomplicated acute hematogenous osteomyelitis with prolonged intravenous therapy.**

Large retrospective cohort studies have shown no difference in treatment failure rate between children with uncomplicated acute hematogenous osteomyelitis treated with prolonged IV therapy when compared with shorter IV therapy and early transition to oral, to complete the course of therapy. "Prolonged" IV therapy definitions varied and ranged from 7 days or more in one cohort to the entire treatment course of 3 to 6 weeks in another. Of note, complications with PICC lines in the prolonged treatment arms were seen at a rate between 3-15%. Consideration for use of prolonged IV therapy is in complicated disease (significant bone destruction; resistant or unusual pathogen; immunocompromised patient; sepsis or septic shock; venous thrombosis; metastatic foci or important abscess formation). Guidance as to when to consider transition to oral therapy includes a good clinical response and consideration of the following: afebrile for 48-72 hours; normalization of inflammatory markers or decrease in CRP by 50%; absence of complications or metastatic foci; and negative blood culture if culture was initially positive.

How the list was created

The recommendation list was developed by a representative working group of the Pediatric Committee of AMMI Canada in collaboration with AMMI Canada's CWC leads that put forth the Infectious Diseases and Medical Microbiology recommendations. This working group sent out electronic correspondence to all AMMI Canada members for suggestions, to solicit candidate recommendations. The top ten recommendations were selected by the working group members through multiple teleconferences. The top ten statements were then disseminated to the AMMI Canada membership for comments, and the working group incorporated comments from the membership at large. During a face-to-face consensus meeting (held in Toronto at the annual AMMI Canada/CACMID meeting on Saturday May 6th, 2017), all attending members were invited to discuss and vote on the top five statements. Finally the selected top five recommendations were redistributed to the membership at large, requesting any further input/modification. This list was then submitted to CWC in December of 2017 and after being reviewed by all participating societies the list was published as four recommendations in February 2018.

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About The Association of Medical Microbiology and Infectious Disease Canada

The Association of Medical Microbiology and Infectious Disease Canada (AMMI) is a proud partner of the Choosing Wisely Canada campaign. AMMI Canada is the national association that represents physicians, clinical microbiologists and researchers specializing in the fields of medical microbiology and infectious diseases. Through promotion of the diagnosis, prevention and treatment of human infectious diseases and by our involvement in education, research, clinical practice and advocacy, AMMI Canada aims to serve and educate the public and also to enhance the career opportunities of its members through professional development and advocacy initiatives.



About Choosing Wisely Canada

Choosing Wisely Canada is the national voice for reducing unnecessary tests and treatments in health care. One of its important functions is to help clinicians and patients engage in conversations that lead to smart and effective care choices.

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Paediatric Surgery

Six Things Physicians and Patients Should Question

by

Canadian Association of Paediatric Surgeons

Last updated: July 2020



1 Don't order a routine ultrasound for umbilical and/or inguinal hernia.

Umbilical and inguinal hernias are one of the most common reasons a primary care patient may need referral for surgical intervention. The history and physical examination are usually sufficient to make the diagnosis. The routine use of ultrasound for these two conditions is not necessary and will not help the pediatric surgeon to reach a diagnosis.

2 Don't order C-reactive protein (CRP) levels in children with suspected appendicitis.

Appendectomy is one of the most common surgical conditions in children. The diagnosis of appendicitis should be based on clinical findings coupled, where necessary, with imaging. Evidence shows that the routine measurement of CRP levels in patients with suspected appendicitis is not necessary and will not affect the physician's diagnosis.

3 Don't do computed tomography (CT) for the evaluation of suspected appendicitis in children until after ultrasound has been considered as an option.

Although CT is accurate in the evaluation of suspected appendicitis in the pediatric population, ultrasound is nearly as good in experienced hands. Appendicitis may be diagnosed based on physical examination. If imaging is needed, ultrasound (including serial ultrasounds) are the preferred initial modality in children. If the results of the ultrasound exams are equivocal, it may be followed by CT. This approach reduces potential radiation risks and has excellent accuracy, with reported sensitivity and specificity of 94 percent.

4 Don't order a routine ultrasound for children with undescended testes.

Undescended testes is the most common congenital genitourinary anomaly in boys. Diagnosis is made on physical examination and if necessary, imaging. The evidence shows that it is not necessary to order a routine ultrasound in children with suspected undescended testes before referring to a pediatric surgeon.

5 Don't delay referral for undescended testes beyond 6 months of age.

The ideal timing for surgical correction of undescended testes is 6 months – 1 year of age. Orchiopexy should not be performed before 6 months of age, as testes may descend spontaneously during the first few months of life. The highest quality evidence recommends orchiopexy between 6 and 12 months of age. Surgery during this time frame may optimize spermatogenic functions.

6 Don't delay testing for total and conjugated (direct) bilirubin in any newborn with persistent jaundice beyond 2 weeks of age.

Biliary atresia clinically manifests by 2 weeks of age with jaundice due to a conjugated hyperbilirubinemia and pale acholic stools. All babies with jaundice persisting beyond 2 weeks should have a blood test for total and conjugated (direct) bilirubin. If the conjugated (direct) bilirubin fraction is >20% of the total bilirubin, prompt referral to assess for biliary atresia is necessary. Timely diagnosis and early surgical intervention before 30 days of age offers the best outcomes for patient survival with their own liver without the need for liver transplantation. For more information please see www.cbar.ca.

How the list was created

The Canadian Association of Pediatric Surgeons (CAPS) established its Choosing Wisely Canada Top 6 recommendations by consensus among CAPS members during the winter CAPS meeting in Calgary (March 2015).

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About The Canadian Association of Paediatric Surgery

The Canadian Association of Paediatric Surgery (CAPS) is a proud partner of the Choosing Wisely Canada campaign. The CAPS is dedicated to improving the health of children and committed to making a difference in the lives of children, youth and families by improving quality of health care through education and research. The three main areas of diagnosis, treatment and research which are of special concern to Pediatric Surgeons include Infants Born With Congenital Anomalies, Malignancy In Childhood and Trauma.



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Choosing Wisely Canada is the national voice for reducing unnecessary tests and treatments in health care. One of its important functions is to help clinicians and patients engage in conversations that lead to smart and effective care choices.

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Pediatrics

Five Things Physicians and Patients Should Question

by
Canadian Paediatric Society
Last updated: July 2021



1 **Don't routinely use acid blockers or motility agents for the treatment of gastroesophageal reflux in infants.**

Medications that decrease acidity in the stomach do not improve infants' crying or spitting up. These symptoms are common and usually improve on their own, as the child grows up. Studies show that infants who take medications that block stomach acid secretion have more respiratory and gastrointestinal infections. Motility agents do not improve symptoms of reflux in infants but they can have side effects on the heart and nervous system, as well as dangerous interactions with other medications. For example, domperidone can increase the QTc interval on the EKG, particularly when used with other medications that affect liver metabolism, and metaclopramide can cause tardive dyskinesia. Infants with gastroesophageal reflux and poor growth, who have recurrent respiratory problems or who bleed from their gastrointestinal tract, need further evaluation and may need medication. However, most infants will not need them.

2 **Don't perform screening panels (IgE tests) for food allergies without previous consideration of the pertinent medical history.**

Allergy tests for food may be falsely positive when they are performed in children who don't have a history suggesting a serious (IgE mediated) allergy to that food. These results can lead to avoidance of foods to which a true allergy has not been validly documented. When symptoms suggest a food allergy, a careful history should be completed before ordering specific tests, and these should be selected based on the history. A history that suggests serious allergy to a food may include: (1) combinations of the skin, ocular, respiratory, gastrointestinal and cardiovascular symptoms of anaphylaxis that occur within minutes to hours of eating the specific food, or (2) moderate to severe atopic dermatitis. Testing should be selected based on the history and should not include large screening panels.

3 **Don't administer psychostimulant medications to preschool children with Attention Deficit Disorder (ADD), but offer parent-administered behavioural therapy.**

The treatment of preschool-aged children with ADD should involve evidence-based behavioural therapy first, as it is more effective than psychostimulants in this age group. Preschool-aged children are more sensitive to all psychostimulant side effects, including those associated with growth velocity. Behavioural therapy requires more time and resources, but the benefits are more sustained with minimal adverse events.

4 **Don't routinely do a throat swab when children present with a sore throat if they have a cough, rhinitis, or hoarseness as they almost certainly have viral pharyngitis.**

When children with a sore throat present symptoms strongly suggestive of viral illness, such as a runny nose (rhinorrhea), cough or a hoarse voice, a throat swab is unlikely to change management, as these children seldom have 'Strep Throat' as the cause of their sore throat.

5 **Don't recommend the use of cough and cold remedies in children under six years of age.**

Cough and cold remedies sold over the counter often contain combinations of several medications. Research shows that they are not effective when given to children. They can, however, cause serious harmful effects, including accidental overdose, particularly when combined with other medications. For these reasons, since 2008, Health Canada has advised against their use in children less than six years of age.

How the list was created

The Canadian Paediatric Society (CPS) established its Choosing Wisely Canada list through the leadership of a 7-member task force. CPS Committee Chairs and Section Presidents were consulted and sought input from committee and section executive members about items they felt should be included in the campaign. They were made aware of the American Academy of Pediatrics' list as well as the Society of Hospital Medicine's Pediatric Hospital Medicine list, published through the American Choosing Wisely® campaign. Current CPS statements were also considered during list development. Committees' and sections' submissions were reviewed by the task force. Using Delphi methodology, the task force established a list of 7 topics that were submitted to the CPS Board, including some recommendations that were previously made by other medical associations or societies. Principles used to inform decision-making were the following: a) is lack of effectiveness of the test, intervention or treatment well supported by evidence; b) is there evidence of harm resulting from unnecessary use of the test, intervention or treatment; c) is the test, intervention or treatment used commonly by physicians and health care workers treating children across Canada. The list was reviewed by the CPS Board and Executive and was narrowed down to five items.

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About The Canadian Paediatric Society

The Canadian Paediatric Society (CPS) is a proud partner of the Choosing Wisely Canada campaign. The CPS represents more than 3,000 paediatricians, paediatric subspecialists, paediatric residents and others to advance the health of children and youth by nurturing excellence in health care, advocacy, education, research and support of its membership.



About Choosing Wisely Canada

Choosing Wisely Canada is a campaign to help physicians and patients engage in conversations about unnecessary tests, treatments and procedures, and to help physicians and patients make smart and effective choices to ensure high-quality care.

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Palliative Care

Five Things Physicians and Patients Should Question

by

Canadian Society of Palliative Care Physicians

Last updated: October 2020



1 Don't delay palliative care for a patient with serious illness who has physical, psychological, social or spiritual distress because they are pursuing disease-directed treatment.

Palliative care provides an added layer of support to patients with life-limiting disease and their families. Symptomatic patients can benefit regardless of their diagnosis, prognosis or disease treatment regimen. Studies show that integrating palliative care with disease-modifying therapies improves pain and symptom control, as well as patient quality of life and family satisfaction. Early access to palliative care has been shown to reduce aggressive therapies at the end of life, prolong life in certain patient populations, and significantly reduce hospital costs.

2 Don't delay advance care planning conversations.

Advance care planning is a process, which includes choosing a surrogate or alternate decision-maker and communicating values or wishes for medical care. This helps prepare a person for in-the-moment medical decision-making, as well as guiding their surrogate or alternate decision-maker should the person lose capacity for decision-making. Advance care planning is appropriate for healthy adults and patients with their family and healthcare providers, early, recurrently, and as circumstances change. Evidence shows that advance care planning conversations improve patient and family satisfaction with care and concordance between patients' and families' wishes, increase the completion of advance care planning documents, reduce the likelihood of patients receiving hospital care and the number of days spent in hospital, and increase the likelihood of receiving hospice care.

3 Don't use oxygen therapy to treat non-hypoxic dyspnea.

Oxygen is frequently used to relieve shortness of breath in patients with advanced illness; however, supplemental oxygen does not benefit patients who are breathless but not hypoxic. Supplemental flow of air has been found equally effective to oxygen in this context.

4 Don't use stool softeners alone to prevent opioid induced constipation

Docusate is a widely used stool softener. A review of the evidence found that docusate is no more effective than placebo in the prevention or management of constipation and suggests that the drug has very little utility when given alone for opioid-induced constipation. Compared with placebo, docusate did not increase stool frequency or soften the stool. Docusate also failed to alleviate the common symptoms of opioid-induced constipation such as difficulty passing stools, hard stools, abdominal cramping, and incomplete stool passage.

5 Don't transfuse red blood cells for arbitrary hemoglobin or hematocrit thresholds in the absence of symptoms, or if no benefit was perceived from previous transfusions.

Indications for blood transfusion depend on clinical assessment and are also guided by the etiology of the anemia. No single laboratory measurement or physiologic parameter can predict the need for blood transfusion. Transfusions are associated with increased morbidity and mortality in high-risk hospitalized inpatients. Adverse events range from mild to severe, including allergic reactions, acute hemolytic reactions, anaphylaxis, transfusion related acute lung injury, transfusion associated circulatory overload, and sepsis.

How the list was created

The Canadian Society of Palliative Care Physicians (CSPCP) established its Choosing Wisely Canada Top 5 recommendations by first establishing a small group of its members to compile a short list of 10 suggestions. Recommendations were based on experience and relevance to palliative care practice in Canada. The short list was circulated to the CSPCP board members and to all relevant national and provincial palliative care bodies representing a broad range of geographical regions, practice settings, institution types and experience for feedback. Following this review, members of the CSPCP were asked to participate in an online survey and rank the 10 suggestions in order of importance and relevance. The online survey was launched at the Annual International CSPCP conference. From the feedback of the survey the top 5 suggestions were chosen and refined. The recommendations were discussed and revised with the Choosing Wisely Canada campaign team to ensure the recommendations were in keeping with the overall campaign objectives. A literature search to support the recommendations was completed with the assistance of the independent Canadian Agency for Drugs and Technologies in Health (CADTH) and Health Quality Ontario (HQO). Item 1 was adapted with permission from the Five Things Physicians and Patients Should Question in Hospice and Palliative Medicine, © 2013 American Academy of Hospice and Palliative Medicine. Item 5 was adopted with permission from the Five Things Physicians and Patients Should Question, © 2014 Canadian Society of Internal Medicine.

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About The Canadian Society of Palliative Care Physicians

The Canadian Society of Palliative Care Physicians (CSPCP) is a proud partner of the Choosing Wisely Canada campaign. CSPCP is a membership organization composed of clinicians, educators, academics, researchers and specialists dedicated to the improvement of palliative care for patients and their families, through the advancement and improvement of palliative medicine and training.



About Choosing Wisely Canada

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Pathology

Five Things Physicians and Patients Should Question

by
Canadian Association of Pathologists
Last updated: June 2021



1 **Don't perform population based screening for 25-OH-Vitamin D deficiency.**

Vitamin D deficiency is common in many populations, particularly in patients at higher latitudes, during winter months and in those with limited sun exposure. Over the counter Vitamin D supplements and increased summer sun exposure are sufficient for most otherwise healthy patients. Laboratory testing is appropriate in higher risk patients when results will be used to institute more aggressive therapy (e.g., osteoporosis, chronic kidney disease, malabsorption, some infections).

2 **Don't screen with Pap smears if under 21 years of age or over 69 years of age.**

Follow provincial guidelines for cervical cancer screening. Screening before the recommended age of initiation (age 21 in most provinces), screening those over the age of 69, or annual screening is not recommended.

3 **Avoid routine preoperative laboratory testing for low risk surgeries without a clinical indication.**

Most preoperative laboratory tests (typically a complete blood count, prothrombin time and partial thromboplastin time, basic metabolic panel and urinalysis) performed on elective surgical patients are normal. Findings influence management in under 3% of patients tested. In almost all cases, no adverse outcomes are observed when clinically stable patients undergo elective surgery, irrespective of whether an abnormal test is identified. Preoperative laboratory testing is appropriate in symptomatic patients and those with risks factors for which diagnostic testing can provide clarification of patient surgical risk.

4 **Avoid standing orders for repeat complete blood count (CBC) on inpatients who are clinically/laboratorily stable.**

Standing orders for inpatients for CBC testing should be avoided as this can lead to over-testing in relatively stable patients. Particularly in patients with longer term hospital stays, there is some evidence that repeated blood testing can have a negative effect on patients including some increase in anemia. Trauma patients often have blood draws repeated frequently even in the absence of indications of hematologic instability on admission.

5 **Don't send urine specimens for culture on asymptomatic patients including the elderly, diabetics, or as a follow up to confirm effective treatment.**

There is no evidence that antibiotic treatment is indicated in any of these patients. Thus sending urine specimens in asymptomatic patients will only result in inappropriate antibiotic use and increased risk of resistance. The only exceptions are screening of pregnant women early in pregnancy for whom there are clear guidelines for screening/management; and screening for asymptomatic bacteriuria before urologic procedures for which mucosal bleeding is anticipated.

How the list was created

The Canadian Association of Pathologists (CAP-ACP) list of recommendations was developed in conjunction with the Canadian Leadership Council on Laboratory Medicine Laboratory (CLCLM) Utilization Subcommittee, under the joint leadership of the President of CAP-ACP and the President of the Canadian Society of Clinical Chemists (CSCC). The joint committee reviewed the recommendations made by the American Society for Clinical Pathology (ASCP) to the Choosing Wisely US campaign and modified two of those to reflect Canadian practice. Additional recommendations, dealing with cervical cancer screening, standing orders for hematology testing and urine cultures on asymptomatic patients, were added to make up the set of recommendations. The joint committee solicited review and input on these recommendations from the various subspecialty groups in laboratory medicine. Recommendations 1 and 3 were adopted with permission from the Five Things Physicians and Patients Should Question, © 2013 American Society for Clinical Pathology.

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About The Canadian Association of Pathologists

The Canadian Association of Pathologists (CAP-ACP), is a proud partner of the Choosing Wisely Canada campaign. The CAP-ACP was founded in 1949 and has in the years since then played a role in promoting pathology to the national and international health care communities and to Canadian society. CAP-ACP, a voluntary professional organization, advances the interests of our profession and promotes high quality standards for patient care by providing national leadership and promoting excellence in pathology and laboratory medicine practice, education and research.



About Choosing Wisely Canada

Choosing Wisely Canada is the national voice for reducing unnecessary tests and treatments in health care. One of its important functions is to help clinicians and patients engage in conversations that lead to smart and effective care choices.

Pediatric Neurosurgery

Five Things Physicians and Patients Should Question

by

Canadian Pediatric Neurosurgery Study Group

Last updated: September 2021



1 Don't order a CT to initially investigate macrocephaly (order an ultrasound or MRI).

A common pediatric neurosurgery referral is a young child with a rapidly increasing head circumference crossing percentiles. The differential diagnosis is broad and includes benign expansion of the subarachnoid spaces (BESS), subdural collections, hydrocephalus, and neoplasm. When the fontanelle is open, the etiology can usually be diagnosed on head ultrasound, and this should therefore be the initial screening test of choice. In the absence of an open fontanelle, or if there are other signs and symptoms of acute raised intracranial pressure (vomiting, headache, irritability, drowsiness, full fontanelle, sun setting eyes), the etiology should be diagnosed with MRI, if available, in order to limit radiation exposure. There is growing evidence that exposure to radiation through CT imaging increases a child's life long risk of cancer, and so all care should be taken to minimize this exposure as much as possible. Ultrasound (when fontanelle open), and/or MRI (when fontanelle closed), are therefore the screening tests of choice to investigate macrocephaly.

2 Don't image a midline dimple related to the coccyx in an asymptomatic infant or child.

Sacroccoccygeal dimples (also called simple sacral dimples or sacroccoccygeal pits) are common findings in newborns, with a prevalence of approximately 2 to 5%. They are not associated with any increased risk of occult spinal dysraphism (e.g., low lying conus, fatty filum, lipomyelomeningocele, split cord malformation, dermal sinus tract, etc.) compared with the general population of infants without sacroccoccygeal dimples. There is therefore no need to investigate infants with this finding, with either ultrasound or MRI. Red flags for which investigating would be indicated include the presence of midline tuft of hair, sacral dimple or sinus tract above the gluteal cleft, hemangioma, dermal appendage, and/or a subcutaneous lump. The ideal choice for initial investigation (ultrasound or MRI) would depend on the specific cutaneous findings and clinical symptoms present.

3 Don't use CT scans for routine imaging of children with hydrocephalus. Fast sequence non-sedated MRIs or ultrasounds provide adequate information to assess patients without exposing them to radiation or an anesthetic.

Children with hydrocephalus, on average, obtain two head imaging assessments annually until the age of 20. Their lifetime increase risk of fatal cancer is estimated to be 1 excess case of fatal cancer per 97 patients if standard head CT is used, or 1 excess case of fatal cancer per 230 patients if low-dose head CT is used. Head ultrasound (in infants with open fontanelles), and rapid sequence MRI (in all other children) do not require ionizing radiation and adequately assess for radiographic change in ventricle size. A rapid sequence MRI can be obtained without sedation and in under 3 minutes. It is therefore recommended that ultrasound (in infants with open fontanelles), or rapid sequence MRI (in all other children) be used for surveillance imaging in hydrocephalus at minimum, and ideally in emergency assessments as well when available. In the emergent setting, or when MRI is not available, low-dose non-contrast CT is appropriate.

4 Don't recommend helmets for mild to severe positional flattening.

Positional flattening is very common, affecting up to 40% of infants since the Back to Sleep campaign began in 1992. There is now prospective, randomized control trial evidence that helmeting is no better at improving head shape in mild to severe positional flattening compared with physical therapy and providing general positioning recommendations such as maximizing tummy time while awake, and limiting time in swings and car seats. New guidelines from the Congress of Neurological Surgeons, following a systematic literature review including a review of the randomized trial mentioned above, consider helmeting as an option for severe cases of positional flattening. The prevalence of positional flattening in teens from the era following the Back to Sleep campaign but before helmets were widely used was less than 2%, suggesting that regardless of both the intervention used and the severity of the flattening, the vast majority of cases of positional flattening will cosmetically normalise. The cost of helmeting is also significant; a helmet costs thousands of dollars, and requires frequent adjustments over several months to adjust to an infant's growing head. There are also risks associated with helmeting, including pressure sores and interference with parental attachment. With its associated high cost and only very weak evidence of benefit in treating positional flattening, there is no clear additional value in recommending helmets for infants with mild to severe positional flattening in addition to traditional positioning recommendations and physiotherapy.

5 Don't do routine surveillance imaging for incidentally discovered Chiari I malformation.

Chiari I malformation, defined as cerebellar tonsillar herniation greater than or equal to 5mm below the foramen magnum on MRI brain, is a frequent incidental finding in children, with an estimated prevalence of 1 to 3%. The vast majority of children with incidentally discovered, asymptomatic Chiari I malformations have no clinically significant progression of tonsillar descent on routine follow-up, and symptom development is often unassociated with radiographic change. Radiographic follow-up in the absence of new symptomatology is therefore unnecessary.

How the list was created

The Canadian Pediatric Neurosurgery Study Group (CPNSG)'s membership is composed of pediatric neurosurgeons practicing in Canada. Contact information for the group's members was used to invite pediatric neurosurgeons practicing in Canada to complete two anonymized emailed questionnaires, first to brainstorm recommendations, and then to rate them. Recommendations that had overall support were presented for discussion at the CPNSG annual meeting in 2016. From this list, suggested recommendations were eliminated if they were felt by the study group to not be adequately evidence-based, or if they were felt to not be significantly impactful on a pediatric neurosurgical patient population. A final questionnaire was then sent out to Canadian pediatric neurosurgeons, asking each participant to rank each of the final suggested recommendations. The top five suggested recommendations with the strongest support were then selected as the Choosing Wisely Canada recommendations for pediatric neurosurgery and presented to Choosing Wisely Canada for final approval and endorsement.

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About The Canadian Pediatric Neurosurgery Study Group

The Canadian Pediatric Neurosurgery Study Group (CPNSG) is a proud partner of the Choosing Wisely Canada campaign. The CPNSG is a national collaborative representing all provincial pediatric neurosurgery centres across Canada and is dedicated to optimizing Canadian pediatric neurosurgical patient care through collaborative data collection, clinical research and innovation.

About Choosing Wisely Canada

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Pediatric Rheumatology

Seven Things Clinicians and Patients Should Question

by

Canadian Rheumatology Association

Last updated: June 2021



1

Do not order ANA as a screening test without specific signs or symptoms of a rheumatic condition.

Anti-nuclear antibody (ANA) should not be used as a screening test in patients without specific signs or symptoms of systemic lupus erythematosus or other systemic autoimmune rheumatic disease (e.g. inflammatory arthritis, malar rash, photosensitivity, etc.) since ANA positivity may occur in non-rheumatic conditions and in “healthy” populations (up to 20%). In consideration of juvenile idiopathic arthritis (JIA), a positive ANA indicates increased risk of uveitis, but is not a useful screening test for the diagnosis of JIA. Inappropriate ANA testing may be misleading, precipitate further unnecessary testing, and lead to patient anxiety.

2

Do not order labs for drug toxicity monitoring (i.e. CBC, liver enzymes, creatinine) more often than every 12 weeks for patients on a stable dose of non-biologic DMARDs.

Pediatric patients on stable doses of non-biologic disease modifying anti-rheumatic drugs (DMARDs) (e.g. methotrexate, sulfasalazine) without specific risk factors (e.g. obesity, diabetes mellitus, renal disease, alcohol use, concomitant use of hepatotoxic or myelosuppressive medications) are at a low overall risk of toxicity. More frequent blood draws pose an unnecessary burden to pediatric patients and the health-care system. Patients new to treatment, on escalating doses, or with abnormal baseline labs typically require more frequent monitoring.

3

Do not order HLA-B27 unless spondyloarthropathy is suspected based on clinical signs or symptoms.

Back pain is a common symptom relative to the incidence of spondyloarthropathy (SpA) in children. In addition, the prevalence of HLA-B27 is 2-8% in the general population, and individuals with a positive HLA-B27 have a low probability of developing SpA. As such, HLA-B27 testing is not useful as a single diagnostic test in a patient with low back pain without specific signs or symptoms of SpA (e.g., inflammatory back pain, peripheral arthritis, enthesitis, or acute anterior uveitis) or suggestive findings on MRI. Of note, patients with confirmed Juvenile Idiopathic Arthritis (JIA) may have HLA-B27 testing in order to classify their JIA subtype.

4

Do not order RF or anti-CCP in patients with arthralgia but no arthritis on exam.

In children, the vast majority of musculoskeletal (MSK) pain is non-inflammatory (97%) and is rarely secondary to a rheumatic disease. For patients with arthralgia (joint pain) but no arthritis on physical exam (defined as presence of joint effusion or ≥ 2 of warmth, tenderness, stress pain, reduced range of motion), testing rheumatoid factor (RF) or anti-cyclic citrullinated peptide (anti-CCP) is not clinically useful and has low diagnostic utility. For example, a positive RF may result from various infections. Performing such tests without clinical relevance may result in unnecessary additional testing and anxiety.

5

Do not order Lyme disease serology as an explanation for musculoskeletal symptoms without an exposure history and exam findings.

Lyme disease is most likely to occur if an individual resides in or visits an endemic area. The most common musculoskeletal (MSK) manifestation of Lyme disease is persistent or intermittent arthritis in at least one joint (typically the knee) which develops within weeks to months after a tick bite. Chronic diffuse arthralgias, myalgias or fibromyalgia alone are not criteria for MSK Lyme disease. Testing for Lyme disease should be limited to children with characteristic clinical signs and risk of exposure to Lyme to avoid false positive tests and unnecessary treatment.

6 Do not use intra-articular corticosteroid injections as a treatment approach for a large number of joints or joints that have been injected multiple times.

Pediatric patients with juvenile idiopathic arthritis (JIA) often benefit from treatment with intra-articular corticosteroid injections, especially when arthritis is impacting activities of daily living. However, in patients with polyarticular JIA (≥ 5 affected joints) the probability of a short-lived or poor response to corticosteroid injections is increased when compared to those with oligoarticular JIA (≤ 4 affected joints). Lack of concomitant initiation of a disease modifying anti-rheumatic drug (DMARD) in polyarticular disease is also a risk factor for suboptimal response to joint injections. In addition, repeating joint injections in the same joint (e.g. >2 -3 times/year) has a lower probability of achieving disease control compared to initiating a DMARD and may be a risk factor for the development of osteochondritis dissecans. Multiple or recurrent intra-articular corticosteroid injections may be considered as an adjunctive therapy while awaiting the effect of an escalation in systemic therapy.

7 Do not order a periodic fever genetic panel in patients with a classic presentation of PFAPA syndrome without features concerning for other genetic periodic fever syndromes.

Periodic fever, aphthous stomatitis, pharyngitis, adenitis (PFAPA) syndrome is a clinical diagnosis, and currently, no genetic mutations have been identified for this condition. Periodic fever genetic panel in patients with classic features of PFAPA—without any features of another periodic fever syndrome—rarely yields an alternate diagnosis and as such is costly and has no clinical benefit. However, genetic testing may be warranted if patients have atypical features at presentation, don't respond to treatment as expected, or develop concerning features over time.

How the list was created

The Canadian Rheumatology Association (CRA) Pediatrics Committee established its Choosing Wisely Canada Top 7 recommendations in a multistage process combining consensus methodology and literature review. A Choosing Wisely working group was formed including pediatric rheumatologists from across the country from diverse clinical settings, an allied health professional, a parent and a patient. This group generated candidate recommendations using a series of Delphi surveys. Recommendations with high content agreement and perceived prevalence advanced to a survey of all CRA members who practice pediatric rheumatology. CRA members ranked these top items based on content agreement, impact and item ranking. A methodology subcommittee discussed the items in light of their relevance to pediatric rheumatology, potential impact on patients and the member survey results. The Top 7 items were selected to advance for literature review. The list was reviewed by all pediatric committee members and patient partners, and has been approved by the CRA Board of Directors.

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About The Canadian Rheumatology Association

The Canadian Rheumatology Association (CRA) is a proud partner of the Choosing Wisely Canada campaign. Representing close to 600 rheumatologists across Canada, the mission of the CRA is to promote the pursuit of excellence in arthritis care, education and research. The CRA strives to provide the best services and support to its membership to provide the best quality of care possible to patients. This includes an amazing lineup of topics and speakers for the Annual Scientific Meeting, a website full of information, programs to attract more medical students into rheumatology, awards to recognize its members, guidelines development, research funding opportunities and excellent working partnerships with other organizations.



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Pediatric Sport & Exercise Medicine

Eight Things Clinicians and Patients Should Question

by

Canadian Academy of Sport and Exercise Medicine

Last updated: January 2022



1 **Don't order knee radiographs to diagnose Osgood Schlatter Disease in children.**

Osgood Schlatter disease (OSD) is a clinical diagnosis, based on an appropriate history and typical physical findings. Knee radiographs do not need to be performed if there is no acute concern (such as trauma, suspicion of an avulsion fracture or red flag symptoms such as night pain, joint swelling, constitutional symptoms, etc) and patients are responding to treatment.

2 **Don't order ultrasound as an initial investigation for shoulder/knee injuries in children.**

Bony injury is more common in children and should therefore be ruled out when assessing injuries in the pediatric patient. Conventional radiography is the primary and usually only imaging modality necessary for evaluating shoulder and knee injuries. Ultrasound should not be ordered as part of the initial diagnostic workup; however, if patients do not respond to conservative management, additional imaging may be necessary.

3 **Don't order scoliosis radiographic series for back pain.**

Scoliosis radiographic series consisting of full spine standing radiographs are not indicated in the evaluation of back pain unless there are clinical signs of scoliosis (asymmetry on Adams forward bend test, asymmetry of the shoulders, etc). When clinically indicated, radiographs are a good initial diagnostic tool to assess back pain but should be limited to the area of interest to limit radiation exposure.

4 **Don't order thoracic spine radiographs if there is clinical concern about scoliosis.**

Guidelines from the American College of Radiology (ACR) and the Society on Scoliosis Orthopedic and Rehabilitation Treatment (SOSORT) recommend full spine standing posterior-anterior (PA) and lateral radiography on initial examination of scoliosis and using lower-dose radiography techniques when available. Thoracic spine radiographs are not sufficient to evaluate scoliosis as they may not allow for adequate visualization of the curves, especially potential lumbar components. They also do not allow for assessment of the Risser index, a measure of the degree of iliac apophysis ossification and a marker for both skeletal maturity and potential curve progression.

5 **Don't order oblique radiographic views for investigation of spondylolysis.**

Due to their efficacy, low cost, and low radiation exposure, 2-view plain films are the best initial study. Oblique radiographs detect less than 30% of spondylolysis lesions and pose increased radiation exposure with little to no increased benefit. Advanced imaging (MRI, bone scan +SPECT) may detect stress injury not seen on radiographs.

6 **Don't order a head CT scan for minor head injuries/concussion.**

A significant number of children undergo CT scans for minor head injuries, which are often concussions, exposing children to the potentially harmful effects of ionizing radiation and imposing undue costs to the healthcare system. A number of clinical decision rules for use of CT for minor head injury in children, including PECARN, CATCH and CHALICE rules, have been developed in the last two decades and have shown that children with low risk for clinically important structural brain injury, as in the setting of concussion (no focal neurological deficits, no altered mental state, etc), do not require CT imaging.

7 **Don't immobilize a joint with suspected amplified pain syndrome (complex regional pain syndrome).**

Complex regional pain syndrome (CRPS) is a chronic severe pain condition that involves peripheral, central and autonomic nervous system and immune system mechanisms. Immobilization of the painful area can lead to prolonged symptoms and poor outcomes and should be avoided unless required for underlying pathology such as fracture management.

8 **Don't order follow-up radiographs for buckle fractures of the distal radius if there are no clinical symptoms at the time of follow-up.**

Most if not all buckle fractures heal without complications. Follow up radiographs are not indicated if symptoms have resolved, as this will expose the child to unnecessary radiation.

How the list was created

The Canadian Academy of Sport and Exercise Medicine (CASEM) Board approved the development of pediatric-specific sport and exercise medicine (SEM) Choosing Wisely Canada's recommendations. A small working group was created to review existing Choosing Wisely Canada recommendations. The working group then created a list of suggested pediatric-specific SEM recommendations based on existing research, experience and common practice patterns. This list was then sent to the Pediatric Interest Group of CASEM, as well as a pediatric orthopedic surgeon and a pediatric MSK radiologist at McMaster University, to seek feedback on each suggested recommendation. Following revisions based on the feedback, a national survey was conducted with CASEM's membership to solicit members' feedback for each recommendation. Further revisions were made by the working group and the list was then sent to CASEM's publication committee for review and feedback. Final edits were made and approved for submission to Choosing Wisely Canada by the CASEM Board.

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About the Canadian Academy of Sport and Exercise Medicine

The CASEM was developed because of specific medical problems presented at the 1968 Summer Olympics in Mexico, and became officially incorporated on June 8, 1970. Since that time it has evolved from an organization providing medical care to elite athletes at international events to the leading source of information and expertise in the art and science of sport medicine.

The CASEM's affairs are managed by a Board of Directors who are elected annually. The office is based in Ottawa. Operating costs are supported through membership fees, corporate sponsorship, fundraising activities and charitable donations (the CASEM is registered as a charitable organization.)



About Choosing Wisely Canada

Choosing Wisely Canada is the national voice for reducing unnecessary tests and treatments in health care. One of its important functions is to help clinicians and patients engage in conversations that lead to smart and effective care choices.

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Pediatric Otolaryngology

Nine Things Clinicians and Patients Should Question

by

Canadian Society of Otolaryngology–Head & Neck Surgery
Pediatric Otolaryngology Subspecialty Interest Group

Last updated: December 2020



1 **Don't routinely order a plain film x-ray in the evaluation of pediatric nasal fractures.**

Nasal fractures are one of the most common facial fractures in the pediatric population. The decision to perform a closed reduction procedure in the operating room is based on factors such as breathing difficulty and external deformity, which are not assessed effectively by x-ray. Plain film x-rays are unable to accurately evaluate nasal fractures given its low sensitivity and specificity, at 72% and 73% respectively. Physical examination is often sufficient to make a diagnosis for children with displaced nasal fractures. Overall, x-rays do not add value to the diagnosis or treatment plan for children with nasal fractures and should not be ordered to avoid their associated costs and radiation exposure.

2 **Don't order imaging to distinguish acute bacterial sinusitis from an upper respiratory infection.**

Acute bacterial sinusitis (ABS) is a diagnosis that is made based on clinical criteria and has a low prevalence amongst children presenting with respiratory symptoms. Although a normal radiograph, CT, or MRI can help to rule out ABS, an abnormal result does not confirm the diagnosis. Given that many children will have abnormal imaging due to a viral upper respiratory infection during certain times of the year, combined with the potential for exposure to radiation, routine imaging is not recommended. Instances in which imaging would be warranted include if the child is immunocompromised, or if orbital, central nervous system, or other suppurative complications are present.

The American Academy of Pediatrics recommends diagnosing pediatric ABS when (1) cough, nasal discharge or both are persistent for >10 days without improvement; (2) there is worsening or new onset of cough, nasal discharge, or fever; or (3) there is a severe onset, with a fever greater $\geq 39^{\circ}\text{C}$, concurrently with purulent nasal discharge for at least 3 consecutive days.

3 **Don't place tympanostomy tubes in most children for a single episode of uncomplicated otitis media with effusion of less than 3 months' duration.**

Although tympanostomy tube insertion can be associated with short-term quality of life improvements, the natural history of otitis media with effusion (OME) is sufficiently favorable and most OME in children will spontaneously resolve within 3 months. Cases of OME which last longer than 3 months are typically chronic in nature, and less likely to resolve without intervention. Limited data exists regarding the efficacy of tympanostomy tube insertion in children with OME for less than 3 months. By delaying the consideration for tympanostomy tube insertion, potentially unnecessary procedures are avoided, along with the associated risks, tube related side effects, and costs. Children excluded from this recommendation include those who have risk factors for developmental difficulties such as trisomy 21, Autism-spectrum disorder, blindness, and permanent hearing loss independent of OME.

4 **Don't routinely prescribe intranasal/systemic steroids, antihistamines or decongestants for children with uncomplicated otitis media with effusion.**

In most cases, medical treatment using antihistamines, decongestants, systemic antibiotics and steroids have shown little to no effect on the long-term outcomes of uncomplicated otitis media with effusion (OME) in children. Because of this, and the costs and potential side effects, it is not recommended to prescribe these medical treatments for children with uncomplicated OME. The exception to this would be for children with coexisting conditions in which these medications are indicated for primary management.

5 **Don't prescribe oral antibiotics for children with uncomplicated tympanostomy tube otorrhea or uncomplicated acute otitis externa.**

The use of oral antibiotics where they are not necessary can promote antibiotic resistance and increase the risk of opportunistic infections. Topical antibiotics achieve higher concentrations in the ear canal, demonstrate improved patient satisfaction, are associated with fewer adverse events, and are shown to have equal efficacy for treatment of acute tympanostomy tube otorrhea (TTO) and acute otitis externa (AOE) when compared to oral antibiotics. For these reasons, topical antibiotics rather than oral antibiotics should be prescribed as first line treatment for acute uncomplicated TTO and uncomplicated AOE.

6 Don't prescribe codeine for post-tonsillectomy/adenoidectomy pain relief in children.

Codeine has been associated with a high rate of adverse drug reactions in children. This includes life-threatening respiratory depression. Appropriate dosing of codeine is challenging due to the genetic heterogeneity amongst patients for the CYP2D6 enzyme, which is responsible for codeine metabolism. Genetic screening of CYP2D6 is not routinely performed and can not reliably identify variations in codeine metabolism rates amongst patients. As such, children who are ultra-fast metabolizers of codeine are placed at increased risk of severe adverse drug reactions. Alternative analgesia should be used post-tonsillectomy/adenoidectomy.

7 Don't administer perioperative antibiotics for elective tonsillectomy in children.

Administration of perioperative antibiotics for children undergoing tonsillectomy shows no significant benefits in regard to common post-tonsillectomy morbidities. Overuse of systemic antibiotics increases bacterial resistance and the risk of adverse drug events unnecessarily. These concerns outweigh the reduction in postoperative fever which is the only potential benefit of perioperative antibiotic administration for elective tonsillectomy. Therefore, perioperative antibiotics are not indicated for children undergoing elective tonsillectomy, unless specific indications are present (e.g., cardiac conditions or those with a peritonsillar abscess or acute infection).

8 Don't perform tonsillectomy for children with uncomplicated recurrent throat infections if there have been fewer than 7 episodes in the past year, 5 episodes in each of the past 2 years, or 3 episodes in each of the last 3 years.

For children who have a lower number of recurrent throat infections, tonsillectomy has significantly less benefits when compared to those with more frequent infections, and many children with recurrent throat infections naturally improve without intervention. Therefore, where safely possible, avoidance of tonsillectomy for children with lower numbers of acute infections is recommended. This avoids unnecessary tonsillectomy and the costs and complications associated with the procedure (i.e., bleeding, pain, infection). If tonsillectomy is not indicated, children should be closely monitored and reconsidered for tonsillectomy if the infection frequency increases, as they would be less likely to naturally improve, and more likely to benefit from tonsillectomy. Families should be counselled on the limited benefits and potential harms of performing tonsillectomy for children and adolescents with low rates of recurrent throat infections. Shared decision making is of importance when considering tonsillectomy as individual patient and family factors can impact the decision.

9 Don't perform endoscopic sinus surgery for uncomplicated pediatric chronic rhinosinusitis prior to failure of maximal medical therapy and adenoidectomy.

While endoscopic sinus surgery (ESS) has been found to be an effective therapy in children with chronic rhinosinusitis, comparable outcomes can be achieved with medical therapy and adenoidectomy. A stepwise approach of medical therapy, progressing to adenoidectomy, then to ESS allows children to be treated with a less invasive and more cost-effective interventions as initial therapy, while saving ESS for those who are refractory to primary interventions. Maximal medical therapy should be exhausted prior to surgical intervention for uncomplicated patients. In cases with complications such as orbital or skull base involvement, ESS can be employed more readily.

How the list was created

This list was created by the Pediatric Otolaryngology Subspecialty Interest Group of the Canadian Society of Otolaryngology–Head & Neck Surgery. A list of 25 recommendations regarding unnecessary tests and interventions along with evidence supporting them were compiled. These unnecessary tests and interventions are often invasive and incur risk to patients and unwarranted costs to our public health care system. The members of the Subspecialty Interest Group were asked to provide feedback on the recommendations and to rate them regarding five factors: potential to affect clinical practice; cost-benefit ratio; evidence supporting recommendation; pervasiveness of test/intervention; and potential to cause harm. The final list was then selected and edited based on the group members ratings and feedback.

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About the Canadian Society of Otolaryngology-Head & Neck Surgery

The Canadian Society of Otolaryngology-Head & Neck Surgery (CSOHNS) is a proud partner of the Choosing Wisely Canada campaign. CSOHNS is an association that helps to serve the Canadian Otolaryngology-Head & Neck Surgery community. It is composed exclusively of otolaryngologists-head & neck surgeons and those training in the specialty. CSOHNS is dedicated to improving patient care through the support of education, the promotion of research, the dissemination of information, the scientific advancement of the Society, and the maintenance of high professional and ethical standards.



About Choosing Wisely Canada

Choosing Wisely Canada is the national voice for reducing unnecessary tests and treatments in health care. One of its important functions is to help clinicians and patients engage in conversations that lead to smart and effective care choices.

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Perinatal Transfusion Medicine

Four Things Clinicians and Patients Should Question

by

Canadian Obstetrical and Pediatric Transfusion Network

Canadian Society for Transfusion Medicine

Last updated: December 2020



1 **Do not routinely perform a group and screen test at the time of delivery unless there is no prior test during the current pregnancy and/or the risk of maternal hemorrhage or transfusion is high.**

The likelihood of requirement for transfusion at the time of delivery is low. In a patient with a prenatal record confirming maternal ABO, Rh and a negative antibody screen provision of emergency uncrossmatched units is relatively safe when required on rare occasions. Routine pre delivery group and screen is not cost effective given the very low risk of transfusion with either vaginal delivery or routine Caesarean section. In the rare occasion that patients require a blood transfusion, O negative un-crossmatched blood or a stat crossmatch could be done pre-transfusion.

2 **Do not perform serological weak D testing on antenatal samples with weak or variable RhD typing results.**

Serologically weak reactions with Anti D antisera ($\leq 2+$) should be investigated with RHD genotyping. Pregnant mothers with weak or variable RhD typing and with pending genotyping results should be treated as RhD negative and should receive RhIg. Patients with genotyping confirming weak D type 1, 2 or 3 should be treated as RhD positive. Patients with other weak and variant RHD genotypes should be treated as RhD negative.

3 **Do not repeat prenatal titrations for mothers with clinically significant antibodies (e.g. RhD, K) if prediction of fetal cognate antigen typing is feasible and is deemed to be negative.**

Testing of a paternal sample and finding a negative antigen status (when paternity is assured) and/or non-invasive prenatal determination of the fetal genotype from maternal plasma with prediction of a negative antigen status confirm that the fetus is not at risk for hemolytic disease of the fetus and newborn and that ongoing pregnancy monitoring is unnecessary.

4 **Avoid routinely performing direct antiglobulin test on all neonatal cord samples.**

The DAT is not a screening test for hyperbilirubinemia or hemolytic disease. Routine assessment of the DAT may reveal cases of ABO incompatibility which are clinically insignificant; conversely the DAT may fail to identify significant hemolysis due to non immune causes. The DAT should be performed only when anemia or hyperbilirubinemia is suspected or when maternal alloantibodies are present.

How the list was created

The Canadian Obstetrics and Pediatric Transfusion Network (COPTN) compiled its Choosing Wisely Canada list of recommendations by putting out a call to its membership for suggested list items. The chairs of COPTN compiled these suggestions and developed the rationale and references. These statements and rationale were presented virtually to the COPTN committee who ranked the suggestions according to their importance and refined the wording and the order of the item lists.

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About the Canadian Obstetrical Pediatric Transfusion Network

The Canadian Obstetrical Pediatric Transfusion Network (COPTN) is a sub-committee of the CSTM. It was founded in 2017 and its mandate is to assess, analyze and strive to implement best practices in pediatric and obstetrical transfusion practice in Canada.

About the Canadian Society for Transfusion Medicine

The Canadian Society for Transfusion Medicine (CSTM) is a proud partner of the Choosing Wisely Canada campaign. The CSTM is a multidisciplinary society which promotes and supports best practice in Transfusion Medicine in Canada through education, communication and partnerships.



About Choosing Wisely Canada

Choosing Wisely Canada is the national voice for reducing unnecessary tests and treatments in health care. One of its important functions is to help clinicians and patients engage in conversations that lead to smart and effective care choices.

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Pharmacist

Six Things Pharmacists and Patients Should Question

by
Canadian Pharmacists Association
Last updated: August 2020



1 **Don't use a medication to treat the side effects of another medication unless absolutely necessary.**

Side effects of drugs are often misdiagnosed as symptoms of another medical condition, and the result is that patients are prescribed more drugs to treat adverse drug reactions (ADRs). Prescribing cascades contribute to polypharmacy, which has several associated risks, such as drug interactions, increased frequency or severity of side effects and poor medication adherence. They can also exacerbate the harmful effects of unrecognized ADRs, impact a patient's quality of life and lead to avoidable hospital admissions and health system costs. Health practitioners should always investigate the possibility of an ADR presenting itself as a new symptom, especially in older adults, and avoid prescribing additional drug treatment until this possibility has been thoroughly investigated.

2 **Don't recommend the use of over-the-counter medications containing codeine for the management of acute or chronic pain. Counsel patients against their use and recommend safe alternatives.**

There is no evidence to support the use of low-dose codeine pain medication over non-opioid analgesics. Codeine is an addictive opioid with potential for abuse and dependence. Over-the-counter codeine products are often supplied in combination with non-opioid analgesics (i.e., NSAIDs and acetaminophen). In addition to concerns regarding codeine abuse and dependence, misuse of these codeine-containing combination analgesics may also result in serious adverse effects due to high doses of the simple analgesics (ibuprofen, acetaminophen or aspirin). Effects of high doses of simple analgesics may include liver toxicity, gastric perforation, haemorrhage and peptic ulcer, renal failure, chronic blood loss anaemia and low blood potassium (with potential fatal heart and neurological complications).

3 **Don't start or renew drug therapy unless there is an appropriate indication and reasonable expectation of benefit in the individual patient.**

Two-thirds of Canadians over 65 take five or more different medications and more than 40% of seniors 85 and older take 10 or more drugs. With each new drug, the risk of adverse drug reactions and subsequent hospitalization of the patient increases. In order to ensure the safety and appropriateness of therapy, all health care practitioners should have access to the therapeutic indication for a patient's drug therapy and start or renew medication only once they have determined that the benefits of therapy outweigh the risks to the patient.

4 **Don't renew long-term proton pump inhibitor (PPI) therapy for gastrointestinal symptoms without an attempt to stop or reduce (taper) therapy at least once per year for most patients.**

Proton pump inhibitors (PPIs) are among the most commonly prescribed drugs in Canada and many are becoming available as over-the-counter medications. While generally safe and well-tolerated for short-term use as needed in the treatment of gastro-esophageal reflux disease, PPIs can cause a number of adverse effects which may increase with a patient's age, long-term use or when the drug is inappropriately prescribed. Some adverse effects associated with long-term use of PPIs include increased risk of fracture, *Clostridium difficile* infection and diarrhea, community-acquired pneumonia (CAP), vitamin B12 deficiency, and hypomagnesemia. Guidelines indicate a preference for short-term use, H2-receptor antagonists or lifestyle changes over the chronic use of PPIs, and recommend discontinuing PPIs in adults who have completed a minimum of 4 weeks of treatment and whose symptoms have resolved. This does not apply to patients with Barrett esophagus, severe esophagitis grade C or D, or a documented history of bleeding gastrointestinal ulcers.

5**Question the use of antipsychotics as a first-line intervention to treat primary insomnia in any age group.**

Between 2005 and 2012, the sedating properties of certain atypical antipsychotics have led to a 300% increase in their off-label use for insomnia. Guidelines report a lack of evidence of benefit for atypical antipsychotics as first-line therapy and warn against their possible adverse effects, including weight gain and metabolic disorders. While antipsychotics may be appropriate in some patients with insomnia who have not benefited from other treatments, the use of these medications as first-line therapy for insomnia is discouraged due to the lack of evidence of benefit and potential for harmful adverse effects.

6**Don't prescribe or dispense benzodiazepines without building a discontinuation strategy into the patient's treatment plan (except for patients who have a valid indication for long-term use).**

Benzodiazepines are commonly prescribed drugs in Canada for anxiety disorders and insomnia. Strong evidence shows that long-term use of benzodiazepines in elderly patients is associated with tolerance, dependence and adverse effects, including sedation, impaired memory and cognition, falls, hip fractures, depression and increased hospital admissions. Prescribing guidelines recommend exploring alternative non-pharmacological and pharmacological options prior to prescribing benzodiazepines. If determined to be beneficial for the patient, benzodiazepines should not usually be prescribed for long-term use and discontinuation strategies should be built into the patient's treatment plan, such as gradual dose tapering, cognitive-behavioural therapy and alternative or tapering medications.

How the list was created

The Canadian Pharmacists Association (CPhA) established its Choosing Wisely Canada top six recommendations in two phases. The first phase comprised a call to pharmacists and pharmacy researchers from across Canada for recommendations in the fall of 2016. During the second phase, an expert committee was formed to review and finalize the recommendations submitted from the call to pharmacists. The committee was composed of CPhA member association representatives, pharmacy researchers, CPhA Board of Directors and staff who have broad knowledge and experience in pharmacy practice and quality improvement. Criteria used by the committee to finalize the list included relevance to practising pharmacists, impact and the available evidence to support each recommendation. The final list was approved by CPhA member associations and Board of Directors.

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About the Canadian Pharmacists Association

Since 1907, CPhA, a national, non-profit organization, has charted the course through many developments in pharmacy, and continues to be the national voice of Canadian pharmacists.



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About Choosing Wisely Canada

Choosing Wisely Canada is a campaign to help physicians and patients engage in conversations about unnecessary tests, treatments and procedures, and to help physicians and patients make smart and effective choices to ensure high-quality care.

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Physical Medicine and Rehabilitation

Six Things Physicians and Patients Should Question

by

Canadian Association of Physical Medicine and Rehabilitation

Last updated: July 2021



1 Don't treat asymptomatic urinary tract infections in catheterized patients.

Urinary tract infections (UTIs) in catheterized patients are considered “complicated UTIs”. However, this term can be misleading and prompt clinicians to over treat infections in this population. It is generally recommended that persons with spinal cord injury (SCI) be treated for bacteriuria only if they have symptoms. Specifically, the 2006 Consortium for Spinal Cord Medicine Guidelines for Healthcare Providers require that the following three criteria be met before an individual with SCI is diagnosed with a UTI: (1) significant bacteriuria, (2) pyuria, and (3) signs and symptoms of a UTI.

2 Don't regularly prescribe bed rest and inactivity following injury and/or illness unless there is scientific evidence that harm will result from activity.

Bed rest is often used to treat a variety of medical conditions. Prolonged bed rest causes major cardiovascular, respiratory, musculoskeletal and neuropsychological changes. Negative effects include thromboembolism, pneumonia, muscle wasting and physical deconditioning. Many of the negative effects begin within days of confinement, but consequences can last much longer. Specifically, in acute DVT/PE, bed rest has no impact on the risk of developing new PE. Furthermore, in acute low back pain, advice to stay active compared to rest in bed showed benefits in pain relief and functional improvement. Therefore, it is important to limit bed rest as much as possible.

3 Don't order prescription drugs for pain without considering functional improvement.

Prescription pain medications have been shown to be effective for pain relief. However, a number of adverse events have been established. While pain reduction is an important outcome measure for patients, they also highly value improved function and quality of life. The addition of prescription pain medications does not always improve functional outcomes, or even pain. There is also a significant risk of long-term addiction. It is imperative that providers work with patients to establish treatment goals, regularly reassess pain and function, and taper or discontinue medications as able or if patients experience harm.

4 Don't order CT scans for low back pain unless red flags are present.

Low back pain is one of the leading causes of disability, with a lifetime prevalence of 40%. Routine imaging for low back pain in the absence of red flag symptoms does not change clinical outcomes including pain, function, quality of life and mental health. Red flags include, but are not limited to, severe or progressive neurological deficits or when serious underlying conditions such as osteomyelitis are suspected. In comparing early versus late imaging for non-specific low back pain, there is no difference between groups in terms of overall treatment plan. Imaging can result in “labeling” of patients, exposure to radiation, and unnecessary invasive procedures.

5 Don't use benzodiazepines for the treatment of agitation in the acute phase of traumatic brain injury after initial stabilization.

After initial stabilization and when intracranial pressure is controlled, the use of benzodiazepines in the acute phase of traumatic brain injury should be limited to specific medical indications, such as alcohol withdrawal. In animal models of acute TBI, benzodiazepines have been associated with slowed or halted recovery. Moreover, benzodiazepines have adverse effects on cognition, and can cause respiratory depression, paradoxical agitation, and anterograde amnesia. Non-pharmacologic interventions are essential components of the management of agitation after TBI. Beta blockers, such as propranolol, are first line pharmacotherapeutic agents, and anticonvulsants can also be used to decrease agitated behaviours.

6 Don't recommend carpal tunnel release without electrodiagnostic studies to confirm the diagnosis and severity of nerve entrapment.

Carpal tunnel release is a highly effective treatment for Carpal Tunnel Syndrome. Clinicians considering referral for surgical management should be aware that good surgical outcome is best correlated with a combination of positive clinical and positive electrodiagnostic studies (EDX). Clinical tests together with EDX have a better association with surgical outcome than either alone. Pre-op nerve conduction study severity can also better predict time to resolution and degree of resolution of symptoms.

How the list was created

The Canadian Association of Physical Medicine and Rehabilitation (CAPM&R) established its Choosing Wisely Canada Top 6 recommendations as a result of a one-year long process. Special Interest Groups (SIGs) were asked to propose relevant items to be considered for Choosing Wisely Canada. As a result, 23 items were refined and distributed to all 385 CAPM&R members for ranking. The CAPM&R executive committee chose a final list of six items from the most highly ranked items on the national survey. At the May 2016 annual CAPM&R meeting, the six items with summary statements and literature reviews were presented to the CAPM&R membership and ultimately approved.

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About The Canadian Association of Physical Medicine and Rehabilitation

The Canadian Association of Physical Medicine and Rehabilitation (CAPM&R) is a proud partner of the Choosing Wisely Canada campaign. The CAPM&R is a member service organization that represents Canadian physiatrists and promotes their pursuit of excellence in the field of physical medicine and rehabilitation. The CAPM&R was founded in 1952 and has over 380 members today.



About Choosing Wisely Canada

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Psychiatry

Thirteen Things Physicians and Patients Should Question

by

Canadian Academy of Child and Adolescent Psychiatry

Canadian Academy of Geriatric Psychiatry

Canadian Psychiatric Association

Last updated: June 2021



1 **Don't use atypical antipsychotics as a first-line intervention for insomnia in children and youth.**

Recent research confirms a dramatic increase in the use of atypical antipsychotics with subsequent side-effects including obesity, which is already a major health issue. It is prudent to pursue nonpharmacological measures first, such as behavioural modifications and ensuring good sleep hygiene (such as eliminating daytime napping and shutting off electronics an hour before bedtime). If these interventions are not successful, then consider short-term use of melatonin.

2 **Don't use SSRIs as the first-line intervention for mild to moderately depressed teens.**

Evidence clearly indicates that antidepressant medication is less effective in children and adolescents up to the age of 17 years and first-line treatment for this group should include cognitive behavioural therapy or interpersonal psychotherapy. Attention should always be focused on children's and teens' environmental safety and adequate parental support to avoid missing cases of neglect or abuse. Following this, a first-line intervention should be psychoeducation on the importance of regular sleep, diet and exercise to ensure healthy, age-appropriate developmental support.

3 **Don't use atypical antipsychotics as a first-line intervention for Attention Deficit Hyperactivity Disorder (ADHD) with disruptive behaviour disorders.**

Treatment of ADHD should include adequate education of patients and their families, behavioural interventions, psychological treatments and educational accommodations first. If this approach is not sufficient, stimulant medication and a behavioural analysis to ensure appropriate support from the parent and classroom is indicated. The use of alpha 2 agonists (such as guanfacine) and atomoxetine should be considered before using atypical antipsychotics (such as risperidone) in children with disruptive behaviour disorders (oppositional defiant disorder, conduct disorder).

4 **Don't use psychostimulants as a first-line intervention in preschool children with ADHD.**

Preschool children with ADHD need to be assessed for other neurodevelopmental disorders and consideration given to environmental stressors such as neglect, abuse or exposure to domestic violence. Treatment also includes adequate education and support of parents followed by advice on behavioural management and community placement.

5 **Don't routinely use antipsychotics to treat primary insomnia in any age group.**

Second-generation antipsychotics (SGAPs), such as olanzapine and quetiapine, have sedative properties, and are often prescribed off-label for complaints of insomnia. These drugs carry significant risk of potential side-effects including weight gain and metabolic complications, even at low doses used to treat insomnia. In patients with dementia, they can also potentially cause serious side-effects of increased risk of cerebrovascular event and increased risk of death.

6 **Don't routinely order qualitative toxicology testing (urine drug screen) on all psychiatric patients presenting to the emergency room.**

There is no evidence to support ordering routine toxicology testing for all patients presenting to the psychiatry emergency room service. Furthermore, routine testing presents the potential for false positives and false negatives. Lastly, testing may delay psychiatric assessment and management.

7 **Don't routinely use antidepressants as first-line treatment for mild or subsyndromal depressive symptoms in adults.**

Antidepressant response rates are higher for depression of a moderate to severe nature. For mild or subsyndromal depressive symptoms a complete assessment, ongoing support and monitoring, psychosocial interventions and lifestyle modifications should be the first lines of treatment. This may avoid the side-effects of medication and establish etiological factors important to future assessment and management. Antidepressants are appropriate in cases of persistent mild depression, where there is a past history of more severe depression, or where other interventions have failed.

8 Don't routinely order brain neuroimaging (CT or MRI) in first episode psychoses in the absence of signs or symptoms suggestive of intracranial pathology.

Signs and symptoms suggestive of intracranial pathology include headaches, nausea and vomiting, seizure-like activity, and later-age of onset of symptoms. Multiple studies have found that routine neuroimaging in first episode psychoses does not yield findings which alter clinical management in a meaningful way. The risks of radiation exposure and delay in treatment also argue against routine neuroimaging.

9 Don't routinely continue benzodiazepines initiated during an acute care hospital admission without a careful review and plan of tapering and discontinuing, ideally prior to hospital discharge.

Benzodiazepines, while helpful for short-term relief of anxiety and insomnia, are associated with a variety of side-effects and long-term problems including cognitive and psychomotor impairment as well as abuse and dependence. Benzodiazepines are commonly used in hospital to treat anxiety or insomnia in association with either the presenting condition or the hospital environment. Once the presenting condition is treated, benzodiazepines should be tapered and discontinued. For patients who are still on benzodiazepines at the time of discharge, a plan for tapering and discontinuing them after discharge should be completed and specified in the discharge summary and prescription.

10 Don't routinely prescribe antidepressants as first-line treatment for depression comorbid with an active alcohol use disorder without first considering the possibility of a period of sobriety and subsequent reassessment for the persistence of depressive symptoms.

The concurrent management of psychiatric illness and alcohol use disorders requires evaluation of the role alcohol plays as a causative factor for depressive symptoms. Studies have found that response rates to antidepressants are higher when antidepressants are reserved for persistence of symptoms after a period of sobriety lasting from two to four weeks. Additionally, studies have demonstrated remission from depressive symptoms with sobriety in the absence of antidepressant treatment in a significant percentage of cases. Management of comorbid psychiatric illness and substance use disorders including alcohol dependence involves assessment and treatment delivered in a concurrent manner.

11 Don't routinely prescribe high-dose or combination antipsychotic treatment strategies in the treatment of schizophrenia.

High-dose and combination strategies involving atypical antipsychotics (AAPs) are used in clinical practice for patients with schizophrenia who are inadequately controlled with one or more AAPs used at standard doses. In terms of safety, no clinically significant differences were evident between combination or high-dose therapy in comparison with standard-dose monotherapy.

12 Don't use antipsychotics as first choice to treat behavioural and psychological symptoms of dementia.

People with dementia often exhibit challenging behavioural symptoms such as aggression and psychosis. In such instances, antipsychotic medicines may be necessary, but should be prescribed cautiously as they provide limited benefit and can cause serious harm, including premature death. Use of these drugs should be limited in dementia to cases where nonpharmacologic measures have failed, and where the symptoms either cause significant suffering, distress, and/or pose an imminent threat to the patient or others. A thorough assessment that includes identifying and addressing causes of behaviour change can make use of these medications unnecessary. Epidemiological studies suggest that typical (i.e., first generation) antipsychotics (i.e., haloperidol) are associated with at least the same risk of adverse events. This recommendation does not apply to the treatment of delirium or major mental illnesses such as mood disorders or schizophrenia.

13 Don't use benzodiazepines or other sedative-hypnotics in older adults as first choice for insomnia.

Nonpharmacological interventions such as cognitive behavioural therapy and brief behavioural interventions have proven benefit in the management of insomnia in older adults. Epidemiological studies have shown 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. Prescribing or discontinuing sedative-hypnotics in hospital can have substantial impact on long-term use. These potential harms and others such as impaired cognition need to be recognized when considering treatment strategies for insomnia. Use of benzodiazepines should be limited to as short a period as possible, in cases where nonpharmacological therapies have failed, and the symptoms of sleep disturbance cause significant suffering or distress.

How the list was created

The Canadian Psychiatric Association (CPA) determined its *Choosing Wisely Canada* recommendations by establishing a working group that included representatives from the CPA's Professional Standards and Practice Committee, Research Committee, and Member-in-Training Section, as well as the Canadian Academy of Geriatric Psychiatry (CAGP) and the Canadian Academy of Child and Adolescent Psychiatry (CACAP). A person with lived experience from the Canadian Mental Health Association was also a member of the working group. CPA members were invited to provide suggestions for potential list items, as were the provincial psychiatric associations, the Canadian Academy of Psychiatry and the Law (CAPL) and the Canadian Academy of Psychosomatic Medicine (CAPM). The working group considered suggestions received, and assistance was obtained from the Addiction and Mental Health Strategic Clinical Network for Alberta Health Services in conducting rapid literature reviews on a number of potential CPA list items. List items were further refined in subsequent working group teleconferences, and a next-to-final draft was recirculated to the provincial psychiatric associations, CAPL and CAPM for final comments, which were considered by the working group in preparing its final list.

A small subcommittee of the CAGP was organized, with input from representatives from the CAPM and the Canadian Geriatrics Society (CGS). The group reviewed the recommendations made by members of a CPA membership survey, as well as the CGS, AGS and the American Psychiatric Association's (APA) recommendations for Choosing Wisely. Two recommendations were selected and discussed, and minor revisions were made to the paragraphs underneath the recommendations. The CAGP also focused the recommendation about benzodiazepines and other hypnotics on insomnia, rather than on a variety of conditions.

The Executive Committee of the Canadian Academy of Child and Adolescent Psychiatry (CACAP) developed a draft list of items after reviewing recommendations made by members of a CPA membership survey, as well as the American Psychiatric Association's (APA) recommendations for Choosing Wisely. The list was further discussed and refined and additional feedback was obtained from the CACAP Board of Directors, as well as the Section of Child and Adolescent Psychiatry of the Alberta Psychiatric Association and colleagues elsewhere in the country.

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About The Canadian Academy of Child Psychiatry

The Canadian Academy of Child Psychiatry (CACAP) is a proud partner of the Choosing Wisely Canada campaign. CACAP promotes quality care and service to the children, youth and families of Canadians within an approach that includes the biological, the psychological and the social; that works with other professional disciplines; and across many sectors of health and other related service organizations.



About The Canadian Academy of Geriatric Psychiatry

The Canadian Academy of Geriatric Psychiatry (CAGP) is a proud partner of the Choosing Wisely Canada campaign. CAGP is a national organization of psychiatrists dedicated to promoting mental health in the Canadian elderly population through the clinical, educational, research and advocacy activities of its membership. It was founded in 1991, and is recognized as the voice of Geriatric Psychiatry in Canada. The CAGP is a member of the Council of Academies of the Canadian Psychiatric Association. There are over 300 current members.



About The Canadian Psychiatric Association

The Canadian Psychiatric Association (CPA) is a proud partner of the Choosing Wisely Canada campaign. CPA is the national voluntary professional association for Canada's 4,700 psychiatrists and 900 residents. As the national voice of Canada's psychiatrists, the CPA advocates for the professional needs of its members in meeting the mental health needs of Canadians, and promotes excellence in education, research and clinical practice. Its mission is to provide a strong, collective voice for psychiatrists across the country and to foster a community dedicated to ensuring the highest possible standards of professional practice in providing psychiatric services to Canadians.



Canadian Psychiatric Association
Association des psychiatres du Canada

About Choosing Wisely Canada

Choosing Wisely Canada is the national voice for reducing unnecessary tests and treatments in health care. One of its important functions is to help clinicians and patients engage in conversations that lead to smart and effective care choices.

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Public Health

Five Things Clinicians and Patients Should Question

by

Public Health Physicians of Canada

Last updated: August 2020



1 **Don't routinely do serologic testing post-immunization (i.e. Hepatitis B and Measles).**

Post-immunization titres to determine immunity following a complete vaccine series are often not necessary. For example, anti-HBs titres following completed hepatitis B virus vaccination series are unnecessary in the general population. Similarly, serologic testing for measles, mumps and rubella immunity following two doses of MMR is not necessary.

2 **Don't give rabies post-exposure prophylaxis unless indicated by a structured assessment of risk.**

Rabies post-exposure prophylaxis (including rabies vaccine and immunoglobulin) should only be offered to individuals with known or highly probable contact with the saliva of a potentially infected animal. Risk assessment should be based on type of exposure, local rabies epidemiology, symptoms of the animal, ability to test or observe the animal for rabies, prior rabies immunization of the animal and exposed person, and if necessary, consultation with local public health officials. In general, the risk of rabies from domestic animals (e.g., pets) is extremely low.

3 **Don't prescribe medications or recommend a management plan where there are financial and social barriers that might make the plan impractical for patients.**

Understanding a patient's perspective with a thorough social history will provide valuable information about their determinants of health, which is critical for nuanced diagnoses and a better adapted management plan. As barriers are identified and addressed management plans can be re-evaluated in collaboration with the patient.

4 **Don't do unnecessary screening tuberculin skin tests (TSTs).**

Pre-placement TSTs should not be a universal requirement of employees and volunteers in settings where healthcare services are not delivered. Workplace TB screening policies should only be implemented based on the findings of an organization-specific TB risk assessment. If implemented, workplace TB screening should avoid universal TST/IGRA testing by screening for individual TB risk factors first. TSTs should not be used on patients suspected of having active disease as they are unhelpful and unnecessarily delay diagnosis.

5 **Don't provide antibiotic prophylaxis to all contacts of severe invasive Group A Streptococcus (iGAS) infections.**

Antibiotic prophylaxis for iGAS is currently offered routinely for household and other close contacts of those infected with severe iGAS. However, it may not be necessary for all such contacts. Individuals in which prophylaxis should be considered are those who are immunocompromised or may be more susceptible to infection, particularly neonates. Prevention and monitoring measures should be discussed with all household and close contacts of confirmed iGAS cases.

How the list was created

Public Health Physicians of Canada (PHPC) member submitted recommendations from 2016 were reviewed for those relevant to CWC. Relevant previous suggestions as well as an informal brainstorm of PHPC executive with some external stakeholders was undertaken to develop a list of topic areas for consideration. Membership voted on 8 topic areas in Fall 2019. Approximately 100 votes were received and work proceeded with 6 topics in order to finalize at least 5 recommendations with experts.

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About the Public Health Physicians of Canada

The Public Health Physicians of Canada is the national specialty society for Public Health and Preventive Medicine (PHPM) Specialists. Public health physicians specialize in the health of communities and populations – among others, this includes work in population health assessment, surveillance, communicable disease, environmental health, health promotion, and disease/injury prevention. Through advocacy, education, mentorship, and other mechanisms, we support and represent the interests of both PHPM Specialists and other physicians working in public health across Canada.



About Choosing Wisely Canada

Choosing Wisely Canada is the national voice for reducing unnecessary tests and treatments in health care. One of its important functions is to help clinicians and patients engage in conversations that lead to smart and effective care choices.

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Radiology

Five Things Physicians and Patients Should Question

by

Canadian Association of Radiologists

Last updated: October 2021



1 **Don't do imaging for lower-back pain unless red flags are present.**

Red flags include suspected epidural abscess or hematoma presenting with acute pain, but no neurological symptoms (urgent imaging is required); suspected cancer; suspected infection; cauda equina syndrome; severe or progressive neurologic deficit; and suspected compression fracture. In patients with suspected uncomplicated herniated disc or spinal stenosis, imaging is only indicated after at least a six-week trial of conservative management and if symptoms are severe enough that surgery is being considered.

2 **Don't do imaging for minor head trauma unless red flags are present.**

Red flags include Glasgow Coma Scale (GCS) less than 13; GCS less than 15 at 2 hours post-injury; a patient aged 65 years or older; obvious open skull fracture; suspected open or depressed skull fracture; any sign of basilar skull fracture (e.g., hemotympanum, raccoon eyes, Battle's Sign, CSF otorrhorrhea); retrograde amnesia to the event lasting 30 minutes or longer after the event; "dangerous" mechanism (e.g., pedestrian struck by motor vehicle, occupant ejected from motor vehicle, or fall from higher than 3 feet or down more than 5 stairs); and coumadin-use or bleeding disorder.

3 **Don't do imaging for uncomplicated headache unless red flags are present.**

Red flags include recent onset, rapidly increasing frequency and severity of headache; headache causing the patient to wake from sleep; associated dizziness, lack of coordination, tingling or numbness, new neurologic deficit; and new onset of a headache in a patient with a history of cancer or immunodeficiency.

Don't perform resting echocardiography as part of preoperative assessment for asymptomatic patients undergoing low to intermediate-risk non-cardiac surgery.

Resting echocardiography has a clear role for resolving diagnostic questions in surgical patients, such as identifying the basis for suspicious systolic murmurs or new dyspnea on exertion. Outside these indications, resting echocardiography does not contribute significant additional prognostic information to usual clinical evaluation. It is not useful as a screening tool to identify surgical patients at risk for cardiac complications.

4 **Don't do computed tomography (CT) for the evaluation of suspected appendicitis in children until after ultrasound has been considered as an option.**

Although CT is accurate in the evaluation of suspected appendicitis in the pediatric population, ultrasound is nearly as good in experienced hands. Since ultrasound will reduce radiation exposure, ultrasound is the preferred initial imaging examination in children. If the results of the ultrasound exam are equivocal, it may be followed by CT. This approach is cost-effective, reduces potential radiation risks and has excellent accuracy, with reported sensitivity and specificity of 94 percent.

5 **Don't do an ankle X-ray series in adults for minor injuries.**

X-rays are only indicated if there is pain in the malleolar zone, bone tenderness at the posterior edge or tip of either malleolus, or inability to bear weight for four steps immediately after the trauma and in the emergency department.

How the list was created

The Canadian Association of Radiologists (CAR) established its Choosing Wisely Canada Top 5 recommendations by initially soliciting expert opinion from physician leaders within its Board of Directors. A working group was then formed to further identify common clinical scenarios in which imaging may be misused and should be reconsidered. The working group included CAR leaders in the areas of medical imaging appropriateness and access. The list was narrowed down based on the highest potential for improvement, representing a broad range of tests and the availability of strong guidelines. The first three recommendations had previously been researched, submitted and adopted for another appropriateness initiative underway in Canada in 2013. That process included obtaining stakeholder support from a range of colleagues including technologists, sonographers, nuclear medicine physicians, family physicians and physicists. Two additional recommendations were added using similar criteria, including a comprehensive literature search undertaken through the Canadian Agency for Drugs and Technologies in Health. The full list of proposed recommendations was then vetted by stakeholder organizations, such as provincial radiology organizations and the full CAR membership. Item 4 was adapted with permission from the Five Things Physicians and Patients Should Question, © 2012 American College of Radiology.

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About the Canadian Association of Radiologists

The Canadian Association of Radiologists (CAR) is a proud partner of the Choosing Wisely Canada campaign. The CAR is the national specialty society for radiologists in Canada, committed to promoting the highest standards in patient-centred imaging, lifelong learning and research. As the national voice of radiology, the CAR works on behalf of the more than 2,500 radiologists and radiologists in training in Canada.



Canadian Association of Radiologists
L'Association canadienne des radiologistes

About Choosing Wisely Canada

Choosing Wisely Canada is the national voice for reducing unnecessary tests and treatments in health care. One of its important functions is to help clinicians and patients engage in conversations that lead to smart and effective care choices.

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Respiratory Medicine

Seven Things Physicians and Patients Should Question

by
Canadian Thoracic Society

Last updated: March 2021



1 **Don't initiate long-term maintenance inhalers in stable patients with suspected COPD if they have not had confirmation of post-bronchodilator airflow obstruction with spirometry.**

A diagnosis of COPD should be considered in any patient who has dyspnea, chronic cough, and/or sputum production and an appropriate history of exposure to noxious stimuli. However, not all patients with these symptoms have COPD, and a spirometry demonstrating a post-bronchodilator forced expiratory volume in one second to forced vital capacity (FEV1/FVC) ratio < 70% (or less than the lower limit of normal, if available) is required to make a definitive diagnosis. Starting maintenance inhalers without first objectively diagnosing COPD results in unnecessary treatment in those patients who do not actually have the disease. In turn, this exposes these patients to both the side-effects and the cost of these medications, and might delay the appropriate diagnosis.

2 **Don't perform CT screening for lung cancer among patients at low risk for lung cancer.**

CT scan screening has no proven benefit in patients who are not at high risk for lung cancer, regardless of age, smoking history or other risk factors. Low dose chest CT screening has been found to reduce lung cancer mortality in a well-defined population of patients at high risk for lung cancer, defined by age 55-74, at least a 30-pack year history of tobacco use, and smoking within the last 15 years. However, screening is also associated with several harms, including false-negative and false-positive results, incidental findings, overdiagnosis (detecting indolent and clinically insignificant tumors that would not have been detected in the patient's lifetime without screening), and cumulative exposure to radiation (which can cause cancer). Screening also leads to unnecessary anxiety and invasive procedures, which carry their own complications. Accordingly, it should not be used in patients who do not meet these strict criteria, nor in patients with a health problem that substantially limits life expectancy or the ability or willingness to have curative therapy.

3 **Don't perform chest computed tomography (CT angiography) or ventilation-perfusion scanning to evaluate for possible pulmonary embolism in patients with a low clinical probability and negative results of a highly sensitive D-dimer assay.**

The majority of adults with chest pain and/or dyspnea do not have a pulmonary embolism (PE). There is strong evidence that in patients with low pre-test probability as determined by a clinical prediction rule (e.g., Wells score), a negative highly sensitive D-dimer assay effectively excludes clinically important PE. Furthermore, there are potential harms to performing CT pulmonary angiography (CTPA) or ventilation-perfusion (V/Q) scanning, including exposure to ionizing radiation, adverse events due to the administration of intravenous contrast, and identification of clinically insignificant PE leading to inappropriate anticoagulation. However, physicians should exercise clinical judgement in populations in whom this two-step algorithm has not been validated (e.g., pregnant patients).

4 **Don't treat adult cough with antibiotics even if it lasts more than 1 week, unless bacterial pneumonia is suspected (mean viral cough duration is 18 days).**

The majority of adults with a short duration of cough from an acute respiratory tract infection have a viral rather than a bacterial infection. Patients often underestimate the typical cough duration from an infectious illness, and when cough does not resolve within their expected time frame, may request antibiotics. The average duration of cough (not treated with antibiotics) is around 18 days, though patients only expect to cough for 5 to 7 days. Use of immediate or delayed antibiotics does not change clinical outcomes compared to no antibiotics in these situations. On the other hand, the harms of over-prescribing antibiotics include medication costs, adverse reactions, and the possibility of inducing bacterial resistance to antibiotics. Physicians should educate patients about the expected duration of cough and the consequences of inappropriate antibiotic use in acute respiratory tract infections.

5 Don't initiate medications for asthma (e.g., inhalers, leukotriene receptor antagonists, or other) in patients ≥ 6 years old who have not had confirmation of reversible airflow limitation with spirometry, and in its absence, a positive methacholine or exercise challenge test, or sufficient peak expiratory flow variability.

Although international guidelines uniformly recommend objective testing to establish an asthma diagnosis, this diagnosis is often made clinically and asthma medications are often initiated on that clinical basis. However, physical exam findings and symptoms such as cough, wheeze, and/or dyspnea can be caused by other conditions. As a result, up to one third of patients who have been diagnosed with asthma do not have evidence of asthma when objectively tested with pulmonary function tests. A false clinical diagnosis of asthma may delay diagnosis of the actual underlying condition, which may include serious cardiorespiratory conditions. Furthermore, patients with a false diagnosis of asthma who are started on asthma medications are unnecessarily exposed to both the side-effects and the costs of these medications. It should be noted, however, that this recommendation may not be applicable in patients who cannot reproducibly undergo objective testing for asthma (including children less than 6 years old), and in settings where such testing is not available.

6 Don't use antibiotics for acute asthma exacerbations without clear signs of bacterial infection.

Asthma exacerbations are characterized by decreased expiratory airflow as well as increased shortness of breath, cough, wheezing, chest tightness, or a combination of these symptoms. When such an attack is precipitated by an infection, it is much more likely to be viral than bacterial. The role of bacterial infection is often overestimated; however antibiotics should be reserved for relatively rare cases in which there is strong evidence of a bacterial infection, such as pneumonia or bacterial sinusitis. Potential harms of unnecessary antibiotic treatment include medication costs, side-effects (including a risk of allergy), and emergence of bacterial resistance.

7 Don't delay conversations about wishes and goals with patients who have serious or progressive chronic respiratory illness, such as COPD, IPF, PH, or CF. Unnecessary and potentially harmful treatments can be avoided by having discussions and documenting these conversations.

Supporting patients with serious or progressive respiratory illness to identify and document their values and treatment wishes is an important, but often neglected, intervention. While these patients often experience complex disease trajectories that make accurate prognostication challenging, these discussions can ensure future care is aligned with patients' preferences.

How the list was created

The Choosing Wisely Canada top six list in respiratory medicine was developed by the Canadian Thoracic Society (CTS) through an iterative consultation process with CTS content experts and its members. A list of candidate recommendations was developed through: 1) consultation with the CTS Choosing Wisely Core Task Force (5 members), all CTS guideline writers, and the CTS Executive Committee; 2) retrieving respiratory-related choosing wisely recommendations in existing US and Canadian lists; and 3) selecting all Canadian Medical Association (CMA) POEMs™ (Patient-Oriented Evidence that Matters) between 2012-2015 that were considered to "help to avoid unnecessary or inappropriate treatment, diagnostic procedures, preventative interventions or a referral" by ≥ 10% of readers [in the Information Assessment Method (IAM) rating tool]. The CTS Choosing Wisely Task Force (comprised of the CTS Choosing Wisely Core Task Force and the CTS Canadian Respiratory Guidelines Committee; 19 members) then selected and prioritized 20 of these recommendations based on pre-established criteria, through an electronic Delphi process. These 20 recommendations were then sent to the entire CTS membership for selection and prioritization of the top 10 recommendations, along with a solicitation for new ideas. A second electronic Delphi process with the CTS Choosing Wisely Task Force narrowed this list to a final top 10. The CTS Choosing Wisely Core Task Force then performed a narrative literature review for each of these recommendations, focusing on similar prior Choosing Wisely recommendations, guideline recommendations, systematic reviews, and individual studies. The results of this review were presented to the CTS Choosing Wisely Task Force in a 3rd electronic Delphi process, in which they were asked to select and prioritize the top 5 recommendations. Given that scores between the 5th and 6th rated recommendations were close, 6 recommendations were adopted. These recommendations were approved by the CTS Executive Committee and will be broadly disseminated to our membership, other professional groups, and the general public.

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About the Canadian Thoracic Society

The Canadian Thoracic Society (CTS) is a proud partner of the Choosing Wisely Canada campaign. CTS is Canada's national specialty society for respirology bringing together over 1,000 members representing specialists, physicians and researchers as well as healthcare professionals from a variety of disciplines working in respiratory health.



About Choosing Wisely Canada

Choosing Wisely Canada is the national voice for reducing unnecessary tests and treatments in health care. One of its important functions is to help clinicians and patients engage in conversations that lead to smart and effective care choices.

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Rheumatology

Seven Things Physicians and Patients Should Question

by
Canadian Rheumatology Association
Last updated: June 2021



1 **Don't order ANA as a screening test in patients without specific signs or symptoms of systemic lupus erythematosus (SLE) or another connective tissue disease (CTD).**

ANA testing should not be used to screen subjects without specific symptoms (e.g., photosensitivity, malar rash, symmetrical polyarthritis, etc.) or without a clinical evaluation that may lead to a presumptive diagnosis of SLE or other CTD, since ANA reactivity is present in many non-rheumatic conditions and even in "healthy" control subjects (up to 20%). In a patient with low pre-test probability for ANA-associated rheumatic disease, positive ANA results can be misleading and may precipitate further unnecessary testing, erroneous diagnosis or even inappropriate therapy.

2 **Don't order an HLA-B27 unless spondyloarthritis is suspected based on specific signs or symptoms.**

HLA-B27 testing is not useful as a single diagnostic test in a patient with low back pain without further spondyloarthropathy (SpA) signs or symptoms (e.g., inflammatory back pain ≥ 3 months duration with age of onset < 45 years, peripheral synovitis, enthesitis, dactylitis, psoriasis or uveitis) because the diagnosis of spondyloarthropathy in these patients is of low probability. If HLA-B27 is used, at least two SpA signs or symptoms, or the presence of positive imaging findings, need to be present to classify a patient as having axial SpA. There is no clinical utility to ordering an HLA-B27 in the absence of positive imaging or the minimally required SpA signs or symptoms.

3 **Don't repeat dual energy X-ray absorptiometry (DEXA) scans more often than every 2 years.**

The use of repeat DEXA scans at intervals of every 2 years is appropriate in most clinical settings, and is supported by several current osteoporosis guidelines. Because of limitations in the precision of testing, a minimum of 2 years may be needed to reliably measure a change in BMD. If bone mineral densities are stable and/or individuals are at low risk of fracture, then less frequent monitoring up to an interval of 5-10 years can be considered. Shorter or longer intervals between repeat DEXA scans may be appropriate based on expected rate of change in bone mineral density and fracture risk.

4 **Don't prescribe bisphosphonates for patients at low risk of fracture.**

There is no convincing evidence that anti-osteoporotic therapy in patients with osteopenia alone reduces fracture risk. The 2008 Cochrane Reviews for three bisphosphonates (Alendronate, Etidronate, Risedronate) found no statistically significant reductions for primary prevention of fracture in postmenopausal women. Fracture risk is determined using either the Canadian Association of Radiologists and Osteoporosis Canada risk assessment tool (CAROC) or FRAX®, a World Health Organization fracture risk assessment tool. Both are available as online calculators of fracture risk. Given the lack of proven efficacy, widespread use of bisphosphonates in patients at low risk of fracture is not currently recommended.

5 **Don't perform whole body bone scans (e.g., scintigraphy) for diagnostic screening for peripheral and axial arthritis in adults.**

The diagnosis of peripheral and axial inflammatory arthritis can usually be made on the basis of an appropriate history, physical exam and basic investigations. Whole body bone scans, such as the Tc-99m MDP scintigraphy, lack specificity to diagnose inflammatory polyarthritis or spondyloarthritis and have limited clinical utility. This approach is cost-effective and reduces radiation exposure.

6**Don't prescribe opioids for management of chronic rheumatic disease before optimizing the use of non-opioid approaches to pain management.**

Opioids in chronic non-cancer pain are associated with substantial risks. Optimize non-opioid pharmacotherapy and non-pharmacologic therapy. Opioids are not superior to non-opioid medications for pain-related function over 12 months in moderate to severe hip or knee osteoarthritis, or mechanical back pain. Opioids should only be prescribed by physicians skilled in their use.

7**Don't delay or avoid palliative symptom management and advance care planning for a patient with life-limiting rheumatic disease because they are pursuing disease-directed treatment.**

A palliative approach to care alongside disease-specific treatment should be part of the continuum of care for patients with advanced rheumatic disease toward the end of life. This approach aims to improve quality of life for patients with life-limiting illnesses, through the prevention and relief of suffering, the control of symptoms, and the management of physical, psychosocial and spiritual distress. Such an approach is supported by a growing body of evidence that demonstrates improved patient satisfaction with care, decreased symptom burden and, in some cases, better survival, when a palliative approach to care is integrated early in a patient's disease trajectory.

How the list was created

Recommendations 1 - 5

The Canadian Rheumatology Association (CRA) established its Choosing Wisely Canada Top 5 recommendations using a multistage process combining consensus methodology and literature reviews. A steering committee solicited a group of practicing rheumatologists from across the country from diverse clinical settings and an allied health professional to form the CRA Choosing Wisely Canada committee. This group generated candidate recommendations using the Delphi method. Recommendations with high content agreement and perceived prevalence advanced to a survey of CRA members. CRA members ranked these top items based on content agreement, impact and item ranking. A methodology subcommittee discussed the items in light of their relevance to rheumatology, potential impact on patients and the member survey results. The Top 5 candidate items were selected to advance for literature review. The list was approved by the CRA Board of Directors and has been reviewed by a group of patient collaborators with rheumatic diseases. Patient collaborators also worked with the CRA to ensure the CRA Choosing Wisely Canada statements were translated into lay-language and made accessible to patients and the public.

Recommendations 6 & 7

Recommendation 6 was approved by the CRA board in September, 2019. The statement was created by the CRA Choosing Wisely subcommittee and was selected for having good evidence and for being frequently encountered by rheumatologists. The statement was then adjudicated by the CRA Guidelines committee and the CRA Board, and the statement was further modified for language by the group.

Recommendation 7 was approved by the CRA board in February, 2021. This statement was created by the CRA Choosing Wisely subcommittee in response to the Choosing Wisely Canada campaign about serious illness conversations entitled "Time to Talk." The subcommittee liaised with a palliative care doctor on the wording of the statement, given the scarcity of evidence in this area to date in rheumatology.

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About The Canadian Rheumatology Association

The Canadian Rheumatology Association (CRA) is a proud partner of the Choosing Wisely Canada campaign. Made up of over 500 members, including just over 400 rheumatologists, the mission of the CRA is to promote the pursuit of excellence in arthritis care, education and research. The CRA strives to provide the best services and support to its membership to provide the best quality of care possible to patients. This includes an amazing lineup of topics and speakers for the Annual Scientific Meeting, a website full of information, programs to attract more medical students into rheumatology, awards to recognize its members, guidelines development, research funding opportunities and excellent working partnerships with other organizations.



About Choosing Wisely Canada

Choosing Wisely Canada is the national voice for reducing unnecessary tests and treatments in health care. One of its important functions is to help clinicians and patients engage in conversations that lead to smart and effective care choices.

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Rural Medicine

Five Things Clinicians and Patients Should Question

by

Society of Rural Physicians of Canada

Last updated: July 2020



1 **Don't send a patient for a specialist visit that requires several hours of transport if the visit can be done virtually or by a local physician.**

Due to the location of many rural communities, it is very challenging for rural patients to easily access many specialist physicians who typically practice in more urban centres. Travel away from a community removes patients from their support systems, induces financial burdens and can create safety concerns for patients, especially in the winter months. Telemedicine provides a cost-effective solution to improve access to care closer to home. Thus, if the option is available, and in consultation with the patient, physicians should consider utilizing telemedicine.

Another option is to have the out-of-town specialist communicate with the local physician who can provide follow up care. Local physicians should receive explicit detailed instructions as to what issues need to be addressed, and the appropriate time frame for follow-up.

2 **Don't send a low risk patient to a distant centre for a screening test (i.e. mammography) if the risk of injury from transportation to the centre is higher than the benefit of the test and if there are other screening options available in the local community (i.e. mobile mammography, mobile ophthalmology, fecal immunochemical test).**

In 2018, for every billion kilometers travelled by a motor vehicle in Canada there were 4.9 fatalities and 390 total injuries (including 24.2 serious injuries). The risk of travel in rural communities is greater than urban areas. Despite rural areas accounting for only 18% of the population, 54% of fatal motor vehicle collisions in Canada occur on rural roads. The danger of rural roads has been attributed to multiple factors including greater distances to medical facilities, inclement weather, higher speed limits, animal crossings, poor lighting, and poor maintenance.

Screening is important for disease prevention. It is important to weigh the risk of transportation with the benefit of the test, patient specific risk factors and patient preferences. Arranging screening tests when the patient is already visiting the centre for another reason is efficient.

3 **Don't transfer a palliative patient to a facility far from their friends and family without considering if their goals of care can be achieved locally.**

Advanced care planning is an important part of primary care to establish individual patient's goals of care. This is especially true for rural patients who may need to be transferred to an alternate community for care.

Studies have shown that rural patients prefer to die in their home communities. It is important to consider the patient's goals when contemplating sending them away from the community for medical treatment at the end of life. If the patient is transferred to an alternate community, ensure an updated, written advanced directive accompanies them to the receiving community.

4 **Don't call in staff for an investigation (i.e. blood test, imaging, operative procedures, etc.) at off-service hours unless it is likely to change management.**

Health personnel are valuable resources in rural communities. It is important that provider well-being is balanced with optimal patient care, especially where human resources are limited.

5 **Don't transfer a patient by ambulance with skilled personnel if the patient is unlikely to require medical intervention en route.**

Health personnel are valuable resources in rural communities. Sending a nurse or physician en route to an urban centre can leave a rural hospital without medical support for significant periods of time. Consider the evidence when deciding whether a patient needs to be accompanied during transport. Consider calling the receiving hospital to mutually agree on the need for skilled personnel during urgent or emergent transport.

How the list was created

The Society of Rural Physicians of Canada (SRPC) established its Choosing Wisely Canada top 5 recommendations through collaboration with its internal members and with medical students of the STARS program (Students and Trainees Advocating for Resource Stewardship). The list started with brainstorming overuse topics in rural medicine based on the experiences of rural practitioners across Canada. Over several months the list was refined based on feedback received from SRPC members, a peer-review process, and a review of relevant scholarly research. A preliminary list was shared at the SRPC Annual General Meeting in May 2020, from which a final list was established. Globally, this is the only known rural-focused Choosing Wisely recommendation list.

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About the Society of Rural Physicians of Canada

The Society of Rural Physicians of Canada (SRPC) is the national voice of Canadian rural physicians. Founded in 1992, the SRPC's mission is championing rural generalist medical care through education, collaboration, advocacy, and research.

On behalf of its members and the Canadian public, SRPC performs a wide variety of functions, such as developing and advocating health delivery mechanisms, supporting rural doctors and communities in crisis, promoting and delivering continuing rural medical education, encouraging and facilitating research into rural health issues, and fostering communication among rural physicians and other groups with an interest in rural health care.

The SRPC is a voluntary professional organization with over 2,200 members representing rural physicians and allied health care workers across the country.



About Choosing Wisely Canada

Choosing Wisely Canada is the national voice for reducing unnecessary tests and treatments in health care. One of its important functions is to help clinicians and patients engage in conversations that lead to smart and effective care choices.

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Spine

Eight Things Physicians and Patients Should Question

by
Canadian Spine Society
Last updated: September 2021



- 1 Don't perform fusion surgery to treat patients with mechanical axial low back pain from multilevel spine degeneration in the absence of:**
 - **leg pain with or without neurologic symptoms and/or signs of concordant neurologic compression**
 - **structural pathology such as spondylolisthesis or deformity.**

For over half a century back pain has been the most common reason for spinal fusion. Yet there is no unequivocal evidence that fusion is superior to comprehensive conservative treatment for treating back pain without focal structural pathology and concordant mechanical or neurological symptoms. It is often impossible to locate the precise source of the pain; in many cases the symptoms are multifactorial and can encompass elements such as centralized pain that exist outside the spine. The extreme heterogeneity of the low back pain population leads to unpredictable surgical results and consistently poor outcomes in those with pain from multilevel spine degeneration.

- 2 Don't routinely image patients with low back pain regardless of the duration of symptoms unless:**
 - **there are clinical reasons to suspect serious underlying pathology (i.e., red flags)**
 - **imaging is necessary for the planning and/or execution of a particular evidenced-based therapeutic intervention on a specific spinal condition.**

Unless the image has a direct bearing on the treatment decision it is not required. Spinal "abnormalities" in asymptomatic individuals are common and increase with age. For those with back dominant symptoms (i.e., axial back pain) there is an extremely high false positive rate; most of the findings have no correlation with the clinical picture. For the majority of low back complaints obtaining spinal imaging does not improve patient care but can lead to inappropriate interventions and does have a detrimental impact on patient outcomes. Red flags include cauda equina syndrome; severe or progressive neurologic deficits; suspected cancer; suspected infection; suspected fracture and suspected epidural abscess or hematoma.

- 3 Don't use epidural steroid injections (ESI) for patients with axial low back pain who do not have leg dominant symptoms originating in the nerve roots.**

Steroids are potent anti-inflammatory agents, but axial low back pain is not primarily an inflammatory condition and any inflammation that does exist generally cannot be accessed via the spinal canal. The outcomes of ESI for axial low back pain are poor compared to its use in radiculopathy due to disc herniation. Although serious adverse events are rare, catastrophic events can occur and any symptom relief from the injection typically lasts only for a matter of weeks. The inconsequential benefits of ESI for axial low back pain do not outweigh its risks, no matter how small they may be.

- 4 Don't miss the opportunity to brace the skeletally immature patient with adolescent idiopathic scoliosis (AIS) who has more than one year of growth remaining and a curve magnitude greater than 20 degrees.**

Significant controversy still exists regarding the use of bracing in AIS patients at risk for curve progression and eventual surgery. A recent high-level study has convincingly shown that bracing impacts the natural history of AIS and, in those properly braced, significantly reduces the need for a subsequent operation. In light of the resulting decrease in the indications for surgical intervention, the bias against bracing should be reevaluated.

- 5 Don't order peri-operative antibiotics beyond a 24-hour post-operative period for non-complicated instrumented cases in patients who are not at high risk for infection or wound contamination. Administration of a single pre-operative dose for spine cases without instrumentation is adequate.**

Although a deep surgical site infection associated with spinal implants can be a devastating adverse event, the prolonged use of peri-operative antibiotics has not been shown to reduce the incidence. Their extended use in routine low risk cases has no proven evidence of benefit but increases the chance of creating resistant bacterial strains. A rational, evidence-based approach is required.

6**Don't use an opioid analgesic medication as first-line treatment for acute, uncomplicated, mechanical, back-dominant pain.**

Over 90% of acute low back pain is a mechanical problem that is often self-limiting and can be controlled with physical treatment and non-narcotic medication. The most common entry point to prescription opioid addiction is through opioids prescribed for back pain. Adequate pain control using opioids is frequently not achieved and patients face the added risks of physical dependence and withdrawal hyperalgesia, which can lead to continued use.

7**Don't treat post-operative back pain with opioid analgesic medication unless it is functionally directed and strictly time limited.**

Using post-operative opioid analgesics creates problems with constipation, nausea and dizziness while interfering with early mobilization and, in some patients, promoting long term use. It should be used only in a strictly limited manner and with well-defined parameters. Alternate pain management regimens offer improved pain control, enhanced rehabilitation and fewer complications.

8**Don't use opioid analgesic medication in the ongoing treatment of chronic, non-malignant back pain.**

There is no clear evidence for the benefits of long-term opioid medication on pain, function or quality of life. There is a clear correlation with a range of adverse effects including falls, fractures, testosterone suppression, hyperalgesia and depression. It increases the risk of dependence, addiction and overdose. Long-term use either before or following spine surgery is associated with increased medical costs and a reduced rate of return to work.

How the list was created

The Canadian Spine Society (CSS) established its Choosing Wisely Canada Top 5 recommendations by compiling a committee of experts who took suggestions from the general membership and created a seven item preliminary statement. This was circulated to all the CSS members by email and they were asked to vote their order of preference and suggestions for wording as well as to add any topic they believed should be included. The amended list was recirculated, revised and sent to the membership for a third time. This list is the final agreed result.

Recommendations 6-8:

The Canadian Spine Society conducted a survey of its membership, which includes both academic and private neurosurgical and orthopaedic spine surgeons, on the use of opioids from back pain. The members were asked to specify both the nature of the back problem and the role for opioid medication.

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About The Canadian Spine Society

The Canadian Spine Society (CSS) is a proud partner of the Choosing Wisely Canada campaign. The CSS is a collaborative body of Canadian Neurosurgical and orthopaedic spine surgeons and other spine care professionals with a primary interest in advancing excellence in spine patient care, research and education. The CSS serves as the umbrella group for the leading spine-related organizations across Canada and maintains strong partnerships with The Rick Hansen Institute and major Canadian universities.



About Choosing Wisely Canada

Choosing Wisely Canada is a campaign to help physicians and patients engage in conversations about unnecessary tests, treatments and procedures, and to help physicians and patients make smart and effective choices to ensure high-quality care.

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Sport and Exercise Medicine

Five Things Physicians and Patients Should Question

by

Canadian Academy of Sport and Exercise Medicine

Last updated: September 2021



1 **Don't order an MRI for suspected degenerative meniscal tears or osteoarthritis (OA).**

Degenerate meniscal tears and osteoarthritis (OA) are extremely common in the general population. Early degenerative changes in the meniscus can be found in many subjects under the age of 30. By 50 to 60 years of age, full degenerative meniscal tears are commonly found in 33-50% of subjects. Unless associated with the presence of osteoarthritis (OA), these degenerative meniscal tears are most often asymptomatic. Magnetic resonance imaging (MRI) is not recommended for degenerative meniscal tears unless there are mechanical symptoms (e.g., locking) or lack of improvement with conservative treatment (exercise/therapy, weight loss, bracing, topical or oral analgesia, intra-articular injections). MRI is not recommended for the diagnosis or management of OA. Weight-bearing X-rays should be ordered instead.

2 **Don't prescribe opiates as first line treatment for tendinopathies.**

Tendinopathy is a broad term encompassing painful conditions occurring in and around tendons in response to overuse. Although acute inflammatory tendinopathies (i.e., tendinitis) exist, most patients seen in primary care will have chronic symptoms (tendinosis). Multimodality options (e.g., relative rest, activity modifications, physical or athletic therapy, etc.) should be considered as the first line treatment of tendinopathies. Opiates should not be used in the initial phase of treatment.

3 **Don't order orthotics for asymptomatic children with pes planus (flat feet).**

Pes planus is common in children. Although it rarely leads to disability, it is still a major concern for parents and is a common cause of clinic visits for pediatric foot problems. Most pediatric pes planus cases are characterized by a normal arch during non-weight bearing, and a flattening of the arch on standing. They are often painless, non-problematic, and resolve by adolescence. The current evidence suggests that it is safe and appropriate to simply observe an asymptomatic child with flexible pes planus.

4 **Don't order an MRI as an initial investigation for suspected rotator cuff tendinopathy.**

Initial management of rotator cuff tendinopathy includes relative rest, modification of painful activities, and an exercise program guided by a physical therapist or athletic therapist to regain motion and strength. The addition of subacromial cortisone/local anesthetic injections may be helpful. Should conservative management fail to relieve pain and restore function of the shoulder, consider plain radiographs to rule out bony or joint pathology, and ultrasound to assess for rotator cuff and bursal pathology. MRI or MRA (MR arthrogram) should be considered if symptoms don't resolve with conservative therapy and there is a concern of labral pathology.

5 **Don't immobilize ankle inversion sprains with no evidence of bony or syndesmotic injury.**

Ankle sprains are among the most common injuries seen in the ER or physician clinics. Ankle sprains cause a high incidence of absenteeism in professional and physical activities with important economic consequences. There is good evidence to show that functional bracing of the ankle instead of rigid immobilization is associated with improved and earlier functional improvement and an overall shorter recovery period. For ankle inversion sprains with no associated bony or syndesmotic injury, early mobilization using a functional ankle brace and physiotherapy/athletic therapy should be considered instead of rigid immobilization.

How the list was created

The Canadian Academy of Sport and Exercise Medicine (CASEM) Board approved the development of Choosing Wisely Canada's recommendations. A small working group was created to review existing Choosing Wisely Canada recommendations. The CASEM Board then created a list of suggested recommendations based on existing research, experience and common practice patterns. A national survey was conducted with CASEM's membership, soliciting members' feedback for each recommendation. The five recommendations with near unanimous support were selected to be included in CASEM's Choosing Wisely Canada's Top 5 List. Each recommendation was further developed by the small working group, and submitted to CASEM's publication's committee for review and feedback. Final edits were made and approved for submission to Choosing Wisely Canada by the CASEM Board.

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Canadian Academy of Sport and Exercise Medicine

The Canadian Academy of Sport and Exercise Medicine (CASEM) is a proud partner of the Choosing Wisely Canada campaign. CASEM is an organization of physicians committed to excellence in the practice of medicine as it applies to all aspects of physical activity. CASEM's mission is to forge a strong, collective voice for sport and exercise medicine; to be a leader in advancing the art and science of sport and exercise medicine, including health promotion and disease prevention, for the benefit of all Canadians.



About Choosing Wisely Canada

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Transfusion Medicine

Ten Things Physicians and Patients Should Question

by
Canadian Society for Transfusion Medicine
Last updated: September 2021



1 **Don't transfuse blood if other non-transfusion therapies or observation would be just as effective.**

Blood transfusion should not be given if other safer non-transfusion alternatives are available. For example, patients with iron deficiency without hemodynamic instability should be given iron therapy.

2 **Don't transfuse more than one red cell unit at a time when transfusion is required in stable, non-bleeding patients.**

Indications for red blood transfusion depend on clinical assessment and the cause of the anemia. In a stable, non-bleeding patient, often a single unit of blood is adequate to relieve patient symptoms or to raise the hemoglobin to an acceptable level. Transfusions are associated with increased morbidity and mortality in high-risk hospitalized inpatients. 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.

3 **Don't transfuse plasma to correct a mildly elevated (<1.8) international normalized ratio (INR) or activated partial thromboplastin time (aPTT) before a procedure.**

A mildly elevated INR is not predictive of an increased risk of bleeding. Furthermore, transfusion of plasma has not been demonstrated to significantly change the INR value when the INR was only minimally elevated (<1.8).

4 **Don't routinely transfuse platelets for patients with chemotherapy-induced thrombocytopenia if the platelet count is greater than 10 X 10⁹/L in the absence of bleeding.**

A platelet count of 10 X 10⁹/L or greater usually provides adequate hemostasis. Platelet transfusions are associated with adverse events and risks. Considerations in the decision to transfuse platelets include the cause of the thrombocytopenia, comorbid conditions, symptoms of bleeding, risk factors for bleeding, and the need to perform an invasive procedure.

5 **Don't routinely use plasma or prothrombin complex concentrates for non-emergent reversal of vitamin K antagonists.**

Patients requiring non-emergent reversal of warfarin can often be treated with vitamin K or by discontinuing the warfarin therapy. Prothrombin complex concentrates should only be used for patients with serious bleeding or for those who need urgent surgery. Plasma should only be used in this setting if prothrombin complex concentrates are not available or are contraindicated.

6 **Don't use immunoglobulin therapy for recurrent infections unless impaired antibody responses to vaccines are demonstrated.**

Immunoglobulin (gammaglobulin) replacement does not improve outcomes unless there is impairment of antigen-specific IgG antibody responses to vaccine immunizations or natural infections. Isolated decreases in immunoglobulins (isotypes or subclasses), alone, do not indicate a need for immunoglobulin replacement therapy. Exceptions include genetically defined/suspected disorders. Measurement of IgG subclasses is not routinely useful in determining the need for immunoglobulin therapy. Selective IgA deficiency is not an indication for administration of immunoglobulin.

7 Don't order unnecessary pre-transfusion testing (type and screen) for all pre-operative patients.

Pre-operative transfusion testing is not necessary for the vast majority of surgical patients (e.g., appendectomy, cholecystectomy, hysterectomy and hernia repair) as those patients usually do not require transfusion. Ordering pre-transfusion testing for patients who will likely not require transfusion will lead to unnecessary blood drawn from a patient and unnecessary testing performed. It may also lead to unnecessary delay in the surgical procedure waiting for the results. To guide you whether pre-transfusion testing is required for a certain surgical procedure, your hospital may have a maximum surgical blood ordering schedule or specific testing guidelines based on current surgical practices.

8 Don't routinely order perioperative autologous and directed blood collection.

There is no role for routine perioperative autologous donation or directed donation except for selected patients (for example, patients with rare red blood cell antigen types). Medical evidence does not support the concept that autologous (blood donated by one's self) or directed blood (blood donated by a friend/family member) is safer than allogeneic blood. In fact, there is concern that the risks of directed donation may be greater (higher rates of positive test results for infectious diseases). Autologous transfusion has risks of bacterial contamination and clerical errors (wrong unit/patient transfused). As well, autologous blood donation before surgery can contribute to perioperative anemia and a greater need for transfusion.

9 Don't transfuse O negative blood except to O negative patients and in emergencies for female patients of child-bearing potential of unknown blood group.

Males and females without childbearing potential can receive O Rh-positive red cells. O-negative red cell units are in chronic short supply, in some part due to over utilization for patients who are not O-negative. To ensure O-negative red cells are available for patients who truly need them, their use should be restricted to: (1) patients who are O-Rh-negative; (2) patients with unknown blood group requiring emergent transfusion who are female and of child-bearing age. Type specific red cells should be administered as soon as possible in all emergency situations.

10 Don't transfuse group AB plasma to non-group AB patients unless in emergency situations where the ABO group is unknown.

The demand for AB plasma has increased. Group AB individuals comprise only 3% of Canadian blood donors. Those donors who are group AB are universal donors for plasma, thus are the most in-demand type for plasma transfusion. Type-specific plasma should be issued as soon as possible in emergency situations to preserve the AB plasma inventory for those patients where the blood group is unknown.

How the list was created

The Canadian Society for Transfusion Medicine (CSTM) compiled its Choosing Wisely Canada list of recommendations by putting out a call to its membership for suggested list items. Members were asked to provide suggestions, rationale and references. Once all suggestions for list items had been received and the deadline for submissions had passed, the CSTM board voted on the accumulated list and ranked the items according to our assessment of what was most important. We met by conference call to discuss the outcome of the voting and worked together to refine the wording and the order of the list items and to find additional references as required.

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About The Canadian Society for Transfusion Medicine

The Canadian Society for Transfusion Medicine (CSTM) is a proud partner of the Choosing Wisely Canada campaign. The CSTM is a multidisciplinary society which promotes and supports best practice in Transfusion Medicine in Canada through education, communication and partnerships.



About Choosing Wisely Canada

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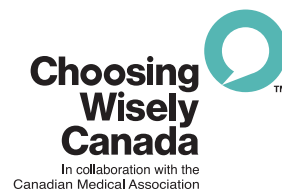
Trauma

Three Things Clinicians and Patients Should Question

by

Trauma Association of Canada

Last updated: April 2021



1 **Don't order imaging tests that duplicate prior imaging without clear clinical indications for the repetition.**

Trauma patients often require multiple imaging tests throughout the course of their care. Where possible, routine repetition of tests done in other institutions should be avoided. Repeat imaging of known injuries should only be undertaken if it is expected to impact the course of care.

2 **Avoid unnecessary tests and treatments by establishing your patient's preferences and goals of care.**

It is imperative that practitioners respect the pre-injury wishes of the patient. Clarifying these wishes as soon as appropriate, either with the patient or their substitute decision maker, can avoid subjecting patients and their decision makers to aggressive interventions that may not align with their goals.

3 **Don't use opioids without considering opioid sparing strategies and multimodal analgesia in patients after injury.**

Opioid use is associated with significant risks to health, including both side effects and dependence-related concerns. While opioid analgesia may be required by some patients after injury, alternative therapies such as non-opioid pain medications should be considered first. If opioid analgesia is required, the lowest dose for the shortest period required is recommended.

How the list was created

The Trauma Association of Canada (TAC) established its Choosing Wisely Canada recommendations by forming an expert working group tasked with creating an initial list of recommendations for consideration. The list of potential items was then refined by the Board of Directors, and further refined after discussion with the Chair of Choosing Wisely Canada.

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About the Trauma Association of Canada

The Trauma Association of Canada (TAC) is a not for profit national organization committed to reducing the incidence and relieving the burden of injury by bringing together a community of multidisciplinary trauma professionals involved in the care of the injured patient. Specific areas of focus for TAC include: quality improvement; education; research; interdisciplinary partnerships; injury prevention; and advocacy.



About Choosing Wisely Canada

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Urology

Five Things Clinicians and Patients Should Question

by
Canadian Urological Association
Last updated: November 2020



1 **Don't order a routine bone scan and CT scan of the pelvis in men with low-risk prostate cancer.**

Low-risk patients (defined by D'Amico criteria and National Comprehensive Cancer Network guidelines) are unlikely to have metastatic disease. Accordingly, imaging is generally unnecessary in patients with newly diagnosed prostate cancer who have a PSA <20.0 ng/mL and a Gleason score 6 or less unless the patient's history or clinical examination suggests distant disease. Metastases are much more likely in high-grade disease that is characterized by fast and aggressive growth into surrounding areas such as bones or lymph nodes.

2 **Don't order serum testosterone in men without symptoms of hypogonadism.**

In the evaluation of men with erectile dysfunction, testosterone should only be ordered if there are signs and/or symptoms of hypogonadism.

3 **Don't prescribe testosterone to men with erectile dysfunction who have normal testosterone levels.**

While testosterone treatment may increase sexual interest, there appears to be no significant influence on erectile function in men with normal testosterone levels.

4 **Don't use antimicrobials to treat asymptomatic bacteriuria in the elderly.**

Studies suggest that asymptomatic bacteriuria in the elderly does not carry significant risk of morbidity if left untreated. 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.

5 **Don't perform an ultrasound in children with undescended testes.**

Ultrasound is of minimal value in localizing the position or existence of testes that cannot be felt through physical examination. Studies have shown that there remained a significant chance that testes were present even after a negative ultrasound result. The likelihood of locating testes is low when using ultrasound.

How the list was created

The Canadian Urological Association (CUA) utilized its guidelines committee to review evidence from the association's guidelines and the suggestions put forward by the American Urological Association (AUA) to identify potential topics for nomination to the CUA's Choosing Wisely Canada list. The general membership had the opportunity to put forward suggestions after being notified of the process via email. The committee reviewed a number of recommendations and through a consensus process identified the five tests or procedures that should be questioned. These recommendations were reviewed and approved by the CUA guidelines committee. Recommendations 1, 3 and 5 were adopted with permission from the Five Things Physicians and Patients Should Question, © 2013 American Urological Association. Recommendation 4 was adopted with permission from the Ten Things Physicians and Patients Should Question, © 2015 American Geriatrics Society, New York, New York. Reprinted with permission. www.americangeriatrics.org.

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About The Canadian Urological Association

The Canadian Urological Association (CUA) is a proud partner of the Choosing Wisely Canada campaign. CUA represents and provides a voice for all Canadian urologists and fosters dedication of all members of the profession toward ensuring the highest possible standard of urologic care of Canadians.



About Choosing Wisely Canada

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Vascular Surgery

Five Things Physicians and Patients Should Question

by

Canadian Society for Vascular Surgery

Last updated: July 2021



1 **Don't perform percutaneous interventions or bypass surgery as first line therapy in patients with asymptomatic peripheral arterial disease (PAD) and in most patients with claudication.**

PAD is a marker of a systemic disease and patients with PAD may have atherosclerotic disease in other vascular beds, including the carotid and coronary circulation. Patients with mild to moderate PAD have a higher 5 year risk of stroke, myocardial infarction or cardiovascular death than amputation. Initial therapy should include smoking cessation and risk factor modification, medical therapy and a walking program. Lower extremity bypass surgery and endovascular therapy should be reserved for patients with limb threatening ischemia or truly disabling claudication.

2 **Don't perform carotid endarterectomies or stenting in most asymptomatic high risk patients with limited life expectancy.**

The purpose of carotid artery surgery and stenting is to prevent stroke and, when combined with appropriate medical therapy, is a successful strategy in selected, mainly symptomatic, patients. Medical therapy alone is an effective alternative in many asymptomatic patients and safer in those who are elderly or at high risk for surgery and stenting and don't have the life expectancy to benefit from such a prophylactic procedure.

3 **Don't perform open or endovascular repair in most asymptomatic patients with small abdominal aortic aneurysms (<5cm in women, <5.5cm in men).**

Repair of asymptomatic abdominal aortic aneurysms is recommended when the risk of rupture exceeds the risk of repair. Randomized controlled trials have failed to show a survival benefit for open or endovascular repair of most small aneurysms. Repair may be considered with specific growth patterns and aneurysm morphology.

4 **Don't perform endovascular repair of abdominal aortic aneurysms in most asymptomatic high-risk patients with limited life expectancy.**

Repair of asymptomatic abdominal aortic aneurysms is recommended when the risk of rupture exceeds the risk of repair and is performed in patients with sufficient life expectancy to allow them to benefit from such a prophylactic procedure. Most elderly, or medically high risk patients, have insufficient life expectancy and are at higher risk of complications following endovascular repair to warrant intervention.

5 **Don't perform unnecessarily frequent ultrasound examinations in asymptomatic patients with small abdominal aortic aneurysms. Abdominal Aortic Aneurysms between 4 to 4.9 cm in diameter should be surveyed by annual ultrasound.**

Regular ultrasound examination of asymptomatic patients with small abdominal aortic aneurysms is essential to document aneurysm growth and decide when intervention is warranted. The interval between examinations is dictated by the size of the aneurysm and its expected growth rate. Too frequent examinations can cause undue patient anxiety and are not cost effective.

How the list was created

The Canadian Society for Vascular Surgery (CSVS) established its Choosing Wisely Canada Top 5 recommendations by canvassing its members for suggestions for investigations or procedures that should not be performed, should be performed rarely or should only be performed under certain circumstances. A subgroup of the CSVS Executive Committee reviewed the membership's suggestions and made a list of five draft recommendations. The CSVS Executive Committee provided feedback and the evidence and literature were reviewed to make sure these recommendations were evidence based. The final list was approved by the CSVS Executive Committee.

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About the Canadian Anesthesiologists' Society

The Canadian Society for Vascular Surgery (CSVS) is a proud partner of the Choosing Wisely Canada campaign. The Canadian Society for Vascular Surgery is dedicated to excellence in the promotion of vascular health for Canadians through education, research, collaboration and advocacy.



About Choosing Wisely Canada

Choosing Wisely Canada is the national voice for reducing unnecessary tests and treatments in health care. One of its important functions is to help clinicians and patients engage in conversations that lead to smart and effective care choices.

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