Choosing Wisely Canada

In partnership with the Canadian Medical Association

CGS·SCG

Canadian Geriatrics Society

Five Things Physicians and Patients Should Question

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*.

Sources

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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.

For more information on *Choosing Wisely Canada* or to see other lists of Five Things Physicians and Patients Should Question, visit www.choosingwiselycanada.org. Join the conversation on Twitter @ChooseWiselyCA.

About The Canadian Geriatrics Society

The Canadian Geriatrics Society (CGS) is a proud partner of the *Choosing Wisely Canada* campaign. 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.