CURRENT
Practice Guidelines in Primary Care

2018

Concise summaries of the latest disease-screening, prevention, and management guidelines

JOSEPH S. ESHERICK • EVAN D. SLATER • JACOB A. DAVID

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CURRENT Practice Guidelines in Primary Care

2018

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This book is dedicated to all of our current and
former residents at the Ventura County Medical Center.

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Preface

Current Practice Guidelines in Primary Care, 2018 is intended for all clinicians interested in updated, evidence-based guidelines for primary care topics in both the ambulatory and hospital settings. This pocket-sized reference consolidates information from nationally recognized medical associations and government agencies into concise recommendations and guidelines of virtually all ambulatory care topics. This book is organized into topics related to disease screening, disease prevention, and disease management for quick reference to the evaluation and treatment of the most common primary care disorders.

The 2018 edition of *Current Practice Guidelines in Primary Care* contains updates or new chapters in over 80 primary care topics. It is a great resource for residents, medical students, midlevel providers, and practicing physicians in family medicine, internal medicine, pediatrics, and obstetrics and gynecology.

Although painstaking efforts have been made to find all errors and omissions, some errors may remain. If you find an error or wish to make a suggestion, please e-mail us at EditorialServices@mheducation.com.

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Disease Screening

1

ABDOMINAL AORTIC ANEURYSM

Population

–Men age 65–75 y who have ever smoked.

Recommendations

▶ USPSTF 2014, ACC/AHA 2006, Canadian Society for Vascular Surgery 2006

–Screen once, with ultrasounography.

–In men in this age group who have never smoked, no recommendation for or against screening.

Sources

–*Ann Intern Med*. 2014;161(4):281-90

–*J Vasc Surg*. 2007;45:1268-1276

Population

–Men/women at high risk.

Recommendations

▶ Canadian Society for Vascular Surgery 2008

–All men age 65–75 y be screened for AAA.

–Individual selective screening for those at high risk for AAA:

a. Women older than 65 y at high risk secondary to smoking, cerebrovascular disease, and family history.

b. Men younger than 65 y with positive family history.

Source

–*Can J Surg*. 2008;51(1):23-34

Population

–Women who have never smoked.

Recommendation

▶ USPSTF 2014

–Routine screening is not recommended.

Source

–*Ann Intern Med*. 2014;161(4):281-90

Population

–Women age 65–75 y who have ever smoked.

Recommendation

▶ UPSTF 2014

–Current evidence is insufficient to assess the balance of benefits and harms.

Source

–*Ann Intern Med*. 2014;161(4):281-90

Population

–Men age 65–75 y who have smoked at least 100 cigarettes in their lifetime or people at risk who have a family history of AAA.

Recommendation

▶ ESVS 2011

–Men should be screened with a single scan at age 65 y. Screening should be considered at an earlier age in those at higher risk for AAA.

Source

–Moll FL, Powell JT, Fraedrich G, et al. Management of abdominal aortic aneurysms clinical practice guidelines of the European Society for Vascular Surgery. *Eur J Vasc Endovasc Surg*. 2011;(41):S1-S58

Comments

1. Cochrane review (2007): Significant decrease in AAA-specific mortality in men (OR, 0.60, 95% CI 0.47–0.99) but not for women. (*Cochrane Database Syst Rev.* 2007;2:CD002945; http://www.thecochranelibrary.com)
2. Early mortality benefit of screening (men age 65–74 y) maintained at 7-y follow-up. Cost-effectiveness of screening improves over time. (*Ann Intern Med*. 2007;146:699)
3. Surgical repair of AAA should be considered if diameter ≥5.5 cm or if AAA expands ≥0.5 cm over 6 mo to reduce higher risk of rupture. Meta-analysis: endovascular repair associated with fewer postoperative adverse events and lower 30-d and aneurysm-related

mortality but not all-cause mortality compared with open repair. (*Br J Surg*. 2008;95(6):677)

4. Asymptomatic AAA between 4.4 and 5.5 cm should have regular ultrasound surveillance with surgical intervention when AAA expands >1 cm in a year or diameter reaches 5.5 cm. *(Cochrane Database Syst Rev.* 2008, CD001835; http://www.thecochranelibrary.com)
5. Medicare covers one-time limited screening. (http://www.medicare.gov/coverage/ab-aortic-aneurysm-screening.html)

Populations

–Male >65 y.

–Female >65 y.

Recommendations

▶ ESC 2014

–Ultrasound screening is recommended in all men > 65 y of age.

–Ultrasound screening may be considered if history of current/past smoking is present.

–Screening is not recommended in female nonsmokers without family history of AAA.

–Targeted screening for AAA with ultrasound should be considered in first-degree siblings of a patient with AAA.

Sources

–Erbel R, Aboyans V, Boileau C, et al. 2014 ESC guidelines on the diagnosis and treatment of aortic diseases. *Eur Heart J. doi:10.1093/eurheartj/ehu281 Eur Heart J.* doi:10.1093/eurheartj/ehu281

Comment

–Abdominal echocardiography used for mass screening in subgroups at risk was associated with a significant 45% decreased risk of AAA-related mortality at 10 y.

Populations

–Male ≥65 y.

–Female ≥ 65 y with cardiovascular risk factors.

Recommendations

▶ ACR[a]/AIUM/SRU 2014

–Ultrasound screening is recommended in all men ≥ 65 y and women ≥ 65 y with cardiovascular risk factors.

–Patients ≥ 50 y with a family history of aortic and/or peripheral vascular aneurysmal disease.

[a]ACR, American College of Radiology

–Patients with a personal history of peripheral vascular aneurysmal disease.

–Groups with additional risk include patients with a history of smoking, hypertension, or certain connective tissue diseases (eg, Marfan syndrome).

Source

–ACR-AIUM-SRU Practice Parameter for the Performance of Diagnostic and Screening Ultrasound of the Abdominal Aorta in Adults. 2014.

ADENOCARCINOMA OF GASTROESOPHAGEAL JUNCTION

Population

–Diagnosis—Barrett esophagus with or without gastroesophageal reflux disease. (*N Engl J Med*. 2014;371:836)

Recommendation

▶ ASGE 2011

–**Barrett's Follow-up**

- No dysplasia—scope every 3 y.
- Mild dysplasia—scope in 6 mo, then yearly.
- High-grade dysplasia—surgery or endoscopic therapy. (*Gastrointest Cancer Res*. 2012;5:49)

Source

–*Gastrointest Endosc.* 2006;63:570

Comments

–In 2016, 16,910 Americans diagnosed with esophageal cancer and 15,690 died from this malignancy. Fourfold increase in males compared to females.

–Adenocarcinoma most common (4:1 versus squamous cell CA). Squamous cell cancer most common in African Americans (6:1).

–Risk of adeno CA increases with gastroesophageal reflux disease (GERD) and high BMI (>30kg/m2) Squamous cell related to tobacco use, alcohol, malnutrition and HPV infection.

–*Benefits:* There is fair evidence that screening would result in no decrease in gastric CA mortality in the United States. *Harms:* There is good evidence that esophagogastroduodenoscopy screening would result in rare but serious side effects, such as perforation, cardiopulmonary events, aspiration pneumonia, and bleeding. (*NCI*, 2008)

ALCOHOL ABUSE AND DEPENDENCE

Population

–Adults older than 18 y of age.

Recommendation

▶ AAFP 2010, USPSTF 2013, VA/DOD 2009, ICSI 2010

–Screen all adults in primary care settings, including pregnant women, for alcohol misuse.

–Provide persons engaged in risky or hazardous drinking with brief behavioral counseling interventions to reduce alcohol misuse.

–Provide brief intervention to those who have a positive alcohol misuse screen. Brief interventions during future visits.

Sources

–ISCI Preventive Services for Adults, 20th ed. 2014.

–Management of Substance Use Disorders Work Group. VA/DoD clinical practice guideline for the management of substance use disorders. Version 3.0. Washington (DC): Department of Veterans Affairs, Department of Defense; 2015.

–USPSTF: Alcohol Misuse: Screening and Behavioral Counseling in Primary Care. 2013.

Comments

1. Screen annually using validated tool.
2. AUDIT[a] score ≥4 for men and ≥3 for women and SASQ reporting of ≥5 drinks in a day (men) or ≥4 drinks in a day (women) in the past year are valid and reliable screening instruments for identifying unhealthy alcohol use.
3. The TWEAK and the T-ACE are designed to screen pregnant women for alcohol misuse.

Population

–Children and adolescents.

Recommendation

▶ AAFP 2010, USPSTF 2013, ICSI 2010

–Insufficient evidence to recommend for or against screening or counseling interventions to prevent or reduce alcohol misuse by adolescents.

Sources

–USPSTF: Alcohol Misuse: Screening and Behavioral Counseling Interventions in Primary Care. 2013.

[a]AUDIT, alcohol use disorders identification test; SASQ, single alcohol screening question.

–https://www.icsi.org/guidelines__more/catalog_guidelines_and_more/catalog_guidelines/
–Alcohol Misuse: Screening and Behavioral Counseling Interventions in Primary Care

Comments

1. AUDIT and CAGE questionnaires have not been validated in children or adolescents.
2. Reinforce not drinking and driving or riding with any driver under the influence.
3. Reinforce to women the harmful effects of alcohol on fetuses.

ANEMIA

Population

–Infants age 6–24 mo.

Recommendation

▶ USPSTF 2015, AAFP 2015

–Current evidence is insufficient to recommend for or against screening.
–Consider selective screening in high-risk children[a] with malnourishment, low birth weight, or symptoms of anemia.

Sources

–AAFP Clinical Recommendations: Iron Deficiency Anemia
–USPSTF: Iron Deficiency in Young Children: Screening. 2015.

Comment

–Reticulocyte hemoglobin content is a more sensitive and specific marker than is serum hemoglobin level for iron deficiency.
–One-third of patients with iron deficiency will have a hemoglobin level >11 g/dL.

Population

–Infants and young children 0–3 y.

Recommendation

▶ AAP 2010

–Universal screening of Hgb at 12 mo. If anemic, measure ferritin, C-reactive protein, and reticulocyte hemoglobin content.

[a]Includes infants living in poverty, Blacks, Native Americans, Alaska natives, immigrants from developing countries, preterm and low-birth-weight infants, and infants whose principal dietary intake is unfortified cow's milk or soy milk. Less than two servings per day of iron-rich foods (iron-fortified breakfast cereals or meats).

Source

–*Pediatrics*. 2010;126(5):1040-1050

Comment

–Use of transferring receptor 1 (TfR_1) assay as screening for iron deficiency is under investigation.

Population

–Pregnant women.

Recommendation

▶ USPSTF 2015, AAFP 2015

–Screen all women with hemoglobin or hematocrit at first prenatal visit.

Sources

–http://www.ahrq.gov/clinic/cpgsix.htm

–*Ann Intern Med*. 2015;162:566

Comments

–Insufficient evidence to recommend for or against routine use of iron supplements for non-anemic pregnant women (USPSTF).

–When acute stress or inflammatory disorders are not present, a serum ferritin level is the most accurate test for evaluating iron deficiency anemia. Among women of childbearing age, a cutoff of 30 ng/mL has sensitivity of 92%, specificity of 98%. (*Blood.* 1997;89:1052-1057).

–Severe anemia (hemoglobin <6) associated with abnormal fetal oxygenation and transfusion should be considered. In iron-deficient women intolerant of oral iron or non compliant, intravenous iron sucrose or iron dextran should be given.

–IV iron preferred in 3rd trimester with hemoglobin less than 10 g/dL. Cobalamin and folate deficiency should be excluded. (*Blood*. 2017; 129:940)

ATTENTION-DEFICIT/HYPERACTIVITY DISORDER

Population

–Children age 4–18 y with academic or behavioral problems and inattention, hyperactivity, or impulsivity.

Recommendation

▶ AAFP 2016, AAP 2011

–Initiate an evaluation for ADHD. Diagnosis requires the child meet DSM-IV criteria[a] and direct supporting evidence from parents or caregivers and classroom teacher.

–Evaluation of a child with ADHD should include assessment for coexisting disorders and alternative causes of the behavior.

Source

–AAFP Clinical Recommendation: ADHD in Children and Adolescents. AAFP. 2016

–*Pediatrics*. 2011;128(5):1007

–*Pediatrics*. 2000;105(5):1158

[a]DSM-IV Criteria for ADHD:
I: Either A or B.
A: Six or more of the following symptoms of inattention have been present for at least 6 mo to a point that is disruptive and inappropriate for developmental level. Inattention: (1) Often does not give close attention to details or makes careless mistakes in schoolwork, work, or other activities. (2) Often has trouble keeping attention on tasks or play activities. (3) Often does not seem to listen when spoken to directly. (4) Often does not follow instructions and fails to finish schoolwork, chores, or duties in the workplace (not due to oppositional behavior or failure to understand instructions). (5) Often has trouble organizing activities. (6) Often avoids, dislikes, or does not want to do things that take a lot of mental effort for a long period of time (such as schoolwork or homework). (7) Often loses things needed for tasks and activities (eg, toys, school assignments, pencils, books, or tools). (8) Is often easily distracted. (9) Is often forgetful in daily activities.
B: Six or more of the following symptoms of hyperactivity-impulsivity have been present for at least 6 mo to an extent that is disruptive and inappropriate for developmental level. Hyperactivity: (1) Often fidgets with hands or feet or squirms in seat. (2) Often gets up from seat when remaining in seat is expected. (3) Often runs about or climbs when and where it is not appropriate (adolescents or adults may feel very restless). (4) Often has trouble playing or enjoying leisure activities quietly. (5) Is often "on the go" or often acts as if "driven by a motor." (6) Often talks excessively.
Impulsivity: (1) Often blurts out answers before questions have been finished. (2) Often has trouble waiting one's turn. (3) Often interrupts or intrudes on others (eg, butts into conversations or games).
II: Some symptoms that cause impairment were present before age 7 y.
III: Some impairment from the symptoms is present in two or more settings (eg, at school/work and at home).
IV: There must be clear evidence of significant impairment in social, school, or work functioning.
V: The symptoms do not happen only during the course of a pervasive developmental disorder, schizophrenia, or other psychotic disorder. The symptoms are not better accounted for by another mental disorder (eg, mood disorder, anxiety disorder, dissociative disorder, or a personality disorder).

Comments

1. Stimulant prescription rates continue to rise. (*Lancet*. 2016.387(10024); 1240-1250)
2. Current estimates are that 7.2% of children/adolescents meet criteria for ADHD. (*Pediatrics*. 2015;135(4):e994.)
3. The U.S. Food and Drug Administration (FDA) approved a "black box" warning regarding the potential for cardiovascular side effects of ADHD stimulant drugs. (*N Engl J Med*. 2006;354:1445)

AUTISM SPECTRUM DISORDER

Population

–Children, age 12–36 mo.

Recommendation

▶ USPST 2016

–Insufficient evidence to screen routinely.

Source

–*JAMA*. 2016;315(7):691-6

Recommendation

▶ AAP 2014

–General developmental screening at routine 9-, 18-, and 24-mo visits, with autism-specific tool at 18 mo (M-CHAT is most commonly use—see Appendix).

Source

–*Pediatrics*. 2006;118(1):405. *Pediatrics*. 2014;135(5);e1520.

Comment

–Listen & respond to concerns raised by caregivers; signs may be identifiable by 9 mo of age.

–Prevalence is 1 in 68; 4.5:1 male:female ratio. (*MMWR Surveill Summ*. 2016;65(3):1–23.)

BACTERIURIA, ASYMPTOMATIC

Population

–Pregnant women.

Recommendation

▶ USPSTF 2008

–Recommend screening for bacteriuria at first prenatal visit or at 12–16 wk' gestation.