Rapid recommendations

Updates from 2019 guidelines: part 2

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Continuing medical education is essential to improving the care that clinicians provide to patients. However, it can be overwhelming to read the increasing volume of medical literature. This article is the second part of a 2-part series[1] and summarizes guideline updates from 2019 that have the potential to substantially affect primary care in Canada. This synopsis is meant to bring to light interesting and novel changes in recommendations, to allow clinicians to explore topics of interest more fully, and to appraise the recommendations. Family physicians should note that many of the recommendations are based on low-quality evidence or expert opinion and should be considered through a primary care lens before integrating them into practice.

Guideline updates

The Canadian Paediatric Society removed finite time limits on screen use and instead recommends monitoring quality of content.[2] Limit children to low-to-moderate use that is individualized, with content limits. Caregivers need to be present and engaged when screens are in use and encourage meaningful content (educational, active, social). In addition, monitor for problematic behaviour or negative effects, model healthy screen use, and prioritize healthy daily routines such as physical activity, sleep, and face-to-face interactions.

The Society of Obstetricians and Gynaecologists of Canada (SOGC) recommends that pregnant women with obesity (body mass index [BMI] >30 kg/m²) and 1 additional risk factor for preeclampsia take low-dose acetylsalicylic acid once pregnancy is confirmed, preferably before 16 weeks' gestational age (level of evidence I, class of recommendation A).[3] This guideline aligns with that of the US Preventive Services Task Force.[4] Acetylsalicylic acid is strongly recommended in patients with a history of preeclampsia, chronic hypertension, multifetal gestation, diabetes, and renal or autoimmune disease. Consider acetylsalicylic acid if 2 or more of the following risk factors are present: nulliparity, obesity, family history of preeclampsia, age 35 years and older, sociodemographic risk factors (low socioeconomic status, etc), or personal history factors (fetus is small for gestational age, previous adverse pregnancy outcomes, etc).

The SOGC recommends that pregnant women with a BMI of 40 kg/m² or greater consider delivery before 39 to 40 weeks' gestational age to decrease risk of stillbirth (level of evidence II-2, class of recommendation A).[3] Women with obesity have a 3-fold to 8-fold increased risk of stillbirth at 40 weeks. To accurately monitor fetal growth, ultrasounds should be done at 28, 32, and 36 weeks' gestational age and then weekly after 37 weeks instead of a symphysis fundal height measurement. As with women in all BMI classes, consider elective cesarean section if the projected birth weight (using estimated fetal weight at 34 to 36 weeks) is 5000 g or greater for patients without diabetes and 4500 g for patients with diabetes.

The SOGC recommends prenatal screening for rubella in pregnant women with no record of past immunity or no proof of immunizations (level of evidence III, class of recommendation B).[5] The previous 2008 guideline recommended obtaining antibody status for all pregnant women to determine susceptibility.[6] In this update, women do not need prenatal rubella screening in current or future pregnancies if they have 2 documented doses of the measles, mumps, and rubella vaccine or positive test results for rubella immunoglobulin G.

The SOGC recommends considering delay of postpartum rubella vaccinations for susceptible women who have received products containing immunoglobulin during pregnancy or peripartum (level of evidence III, class of recommendation B).[5] To improve efficacy, consider delaying immunization for 3 to 11 months if the patient received products such as Rh immune globulin, intravenous immunoglobulin, or blood products during pregnancy or peripartum. The length of delay varies by product and dosing. If immunization is not delayed, then confirmation of immunity is recommended.

The SOGC recommends considering bimanual examination during physical examinations for cervical cancer cytology screening in asymptomatic women (weak, very low–grade evidence).[7] Owing to lack of evidence, there is no universal recommendation for or against pelvic examination. This recommendation, which aligns with that of the American College of Obstetricians and Gynecologists,[8] and was approved by the College of Family Physicians of Canada and the Society of Gynecologic Oncology of Canada, encourages discussion and shared decision making with patients regarding this examination. In contrast, in 2016, the Canadian Task Force on Preventive Health Care recommended against screening pelvic examinations,[9] and in

2017 the US Preventive Services Task Force stated there was insufficient evidence to recommend for or against screening pelvic examinations.[10] Continue to do pelvic examinations in symptomatic women, including during the workup of sexually transmitted infections, but these examinations are not necessary before prescribing hormonal contraceptives in healthy, asymptomatic women.

The SOGC recommends considering periodic screening of asymptomatic women 70 years of age and older for vulvar disease (weak, low-grade evidence).[7] Survey findings have shown patient knowledge deficits in vulvovaginal health and that when discussion with health care professionals does happen on this subject, it is often during physical examinations. In addition, studies have noted that women 70 years of age and older are often diagnosed with vulvar cancers at a later stage than younger women are, and the authors hypothesize this might be owing to delays in pelvic examinations. Therefore, the guideline suggests periodic inspection of the vulva, perineum, and anus in asymptomatic women 70 years of age and older. This guideline was approved by the College of Family Physicians of Canada and the Society of Gynecologic Oncology of Canada.

A guideline developed in collaboration with the Canadian Urological Association recommends offering cranberry prophylaxis to women with recurrent urinary tract infection (conditional recommendation, grade C evidence).[11] Although previous studies found conflicting evidence,[12] more recent studies found that cranberry prophylaxis decreased recurrent urinary tract infection by 1 or more episodes per year, lowered the risk of antibiotic resistance, and in some studies, had no statistical difference in efficacy compared with antibiotic prophylaxis. Of note, cranberry products used in studies are often not available to the public and concentrations vary greatly, but there is little risk to their use.

A guideline developed with representatives from the American College of Emergency Physicians, the American College of Radiology, and the American Urological Association recommended not doing a computed tomography scan for young adults who present with typical symptoms of uncomplicated kidney stones and adequate pain relief regardless of history of previous stones (expert opinion).[13] **Table 1** outlines the guideline recommendations for various patient populations and clinical presentations.[13]

The European League Against Rheumatism (EULAR) and the American College of Rheumatology (ACR) developed a new classification system to aid in the diagnosis of systemic lupus erythematosus.[14] The EULAR-ACR system has a higher sensitivity (96.1%) and specificity (93.4%) than the previous 1997 ACR and 2012 Systemic Lupus International Collaborating Clinics criteria. The EULAR-ACR classification system requires positive results for antinuclear antibodies (≥ 1:80) as an entry criterion. The rest of the algorithm involves 7 clinical and 3 immunologic categories that have weighted and hierarchically clustered criteria. This new classification is expected to improve systemic lupus erythematosus research, although given its complexity, its clinical usefulness is uncertain.

The new Parkinson Canada guideline recommends using the International Parkinson and Movement Disorder Society clinical diagnostic criteria in diagnosing Parkinson disease.[15] This tool has an entry criterion of bradykinesia plus resting tremor or rigidity.[16] Considering symptoms in the 3 categories of supportive criteria, absolute exclusion criteria, and red flags, this diagnostic tool provides a diagnosis of either *clinically established* or *clinically probable* Parkinson disease. Consider a trial of dopamine replacement therapy to aid in diagnosis. Avoid acute challenge testing with either levodopa or apomorphine, or objective olfactory testing for diagnostic clarity, and do not routinely order brain magnetic resonance imaging, computed tomography, or positron emission tomography in diagnostic workup. Clinicians can consider the use of ^{123}I-FP-CIT (iodine I 123–radiolabeled 2β-carbomethoxy-3β-[4-iodophenyl]-*N*-[3-fluoropropyl] nortropane) single-photon emission computed tomography in specific patients.

In the new Parkinson Canada guideline, amantadine has been de-emphasized, as there is "insufficient evidence to support [its] use" in early Parkinson disease (grade A recommendation).[15] Levodopa remains the first-line pharmacotherapy. Dopamine agonists (including the new transdermal patch) and monoamine oxidase B inhibitors continue to be an option for treatment. This guideline also introduces the use of subcutaneous apomorphine infusions or injections and intrajejunal levodopa-carbidopa enteric gel to aid in managing motor complexities and complications. Finally, this update has also reinforced the use of deep brain stimulation, which has stronger supporting evidence.

The updated Canada's Food Guide has eliminated the 4 food group categories (fruits and vegetables, grain, milk, and meats) and now has 3 groupings: fruits and vegetables, whole grains, and protein foods.[17] This guideline has eliminated daily servings and focuses on proportions, recommending that fruits and vegetables make up half the plate at every meal. In addition, the experts focus on plant-based foods for proteins, replacing saturated fats with unsaturated fats, and limiting processed foods. Finally, it also emphasizes water being the "beverage of choice" and recommends limiting sugary and alcoholic beverages.

Table 1. Imaging methods for suspected kidney stones recommended by a panel of experts: ***Rows that suggest 2 imaging methods indicate cases of only moderate agreement among panel members. Most clinical vignettes were done with male patients and noted minimal difference between sexes but stated "it may be more reasonable to forego CT in a female than a male patient (slightly more risk of radiation and somewhat higher likelihood of finding an alternative diagnosis in the pelvis/adnexa) with ultrasound."[13]***

POPULATION	CLINICAL PRESENTATION	NO IMAGING	POCUS	RPUS	RDCT
Young adults (age about 35 y)	History of kidney stones and typical presentation	✓	✓*		
	No history of kidney stones and typical presentation		✓*	✓†	
	History of kidney stones and atypical presentation		✓‡		✓
	No history of kidney stones and atypical presentation				✓
Pregnant or pediatric	No history of kidney stones and typical presentation			✓*	
Middle-aged adults (age about 55 y)	History of kidney stones and typical presentation	✓	✓		
	No history of kidney stones or atypical presentation				✓
Older adults (age about 75 y)	All clinical presentations				✓
Any adult	Inadequate pain relief				✓

CT—computed tomography, POCUS—point-of-care ultrasound, RDCT—reduced-radiation-dose computed tomography, RPUS—radiology-performed ultrasound.
*No follow-up imaging regardless of presence or absence of hydronephrosis.
†Consider POCUS or RPUS in female patients.
‡Consider RDCT if hydronephrosis is absent.
Data from Moore et al.[13]

Conclusion

This article concludes the 2-part series summarizing guideline updates in the areas of pediatrics, obstetrics and gynecology, urology, rheumatology, and Parkinson disease care. It is recommended that clinicians appraise and explore these updates further to expand their knowledge or confirm current practice.

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Competing interests
None declared

References

1. O'Toole D. Rapid recommendations. Update from 2019 guidelines: part 1. *Can Fam Physician* 2020;66:338-40.
2. Ponti M; Digital Health Task Force. *Digital media: promoting healthy screen use in school-aged children and adolescents.* Ottawa, ON: Canadian Paediatric Society; 2019. Available from: **https://www.cps.ca/en/documents/position/digital-media**. Accessed 2020 Jan 1.
3. Maxwell C, Gaudet L, Cassir G, Nowik C, McLeod NL, Jacob CÉ, et al. Guideline no. 391—pregnancy and maternal obesity part 1: pre-conception and prenatal care. *J Obstet Gynaecol Can* 2019;41(11):1623-40.
4. LeFevre ML; US Preventive Services Task Force. Low-dose aspirin use for the prevention of morbidity and mortality from preeclampsia: US Preventive Services Task Force recommendation statement. *Ann Intern Med* 2014;161(11):819-26.
5. Boucoiran I, Castillo E. No. 368—rubella in pregnancy. *J Obstet Gynaecol Can* 2018;40(12):1646-56.
6. Dontigny L, Arsenault MY, Martel MJ. No. 203—rubella in pregnancy. *J Obstet Gynaecol Can* 2018;40(8):e615-21.
7. Evans D, Goldstein S, Loewy A, Altman AD. No. 385—indications for pelvic examination. *J Obstet Gynaecol Can* 2019;41(8):1221-34.
8. ACOG Committee Opinion no. 754: the utility of and indications for routine pelvic examination. *Obstet Gynecol* 2018;132(4):e174-80.
9. Tonelli M, Connor Gorber S, Moore A, Thombs BD; Canadian Task Force on Preventive Health Care. Recommendations on routine screening pelvic examination. Canadian Task Force on Preventive Health Care adoption of the American College of Physicians guideline. *Can Fam Physician* 2016;62:211-4 (Eng), e117-21 (Fr).
10. US Preventive Services Task Force; Bibbins-Domingo K, Grossman DC, Curry SJ, Barry MJ, Davidson KW, et al. Screening for gynecologic conditions with pelvic examination: US Preventive Services Task Force recommendation statement. *JAMA* 2017;317(9):947-53.
11. Anger J, Lee U, Ackerman AL, Chou R, Chughtai B, Clemens JQ, et al. Recurrent uncomplicated urinary tract infections in women: AUA/CUA/SUFU guideline. *J Urol* 2019;202(2):282-9. Epub 2019 Jul 8.
12. Dason S, Dason JT, Kapoor A. Guidelines for the diagnosis and management of recurrent urinary tract infection in women. *Can Urol Assoc J* 2011;5(5):316-22.
13. Moore CL, Carpenter CR, Heilbrun ML, Klauer K, Krambeck AC, Moreno C, et al. Imaging in suspected renal colic: systematic review of the literature and multispecialty consensus. *J Urol* 2019;202(3):475-83. Epub 2019 Aug 8.
14. Aringer M, Costenbader K, Daikh D, Brinks R, Mosca M, Ramsey-Goldman R, et al. 2019 European League Against Rheumatism/American College of Rheumatology classification criteria for systemic lupus erythematosus. *Arthritis Rheumatol* 2019;71(9):1400-12. Epub 2019 Aug 6.
15. Grimes D, Fitzpatrick M, Gordon J, Miyasaki J, Fon EA, Schlossmacher M, et al. Canadian guideline for Parkinson disease. *CMAJ* 2019;191(36):E989-1004.
16. Postuma RB, Berg D, Stern M, Poewe W, Olanow CW, Oertel W, et al. Movement disorder society clinical diagnostic criteria for Parkinson's disease. *Mov Disord* 2015;30(12):1591-601.
17. Health Canada. *Canada's dietary guidelines for health professionals and policy makers.* Ottawa, ON: Government of Canada; 2019. Available from: **http://publications.gc.ca/collections/collection_2019/sc-hc/H164-231-2019-eng.pdf**. Accessed 2019 Nov 11.

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