Rapid recommendations

Updates from 2020 guidelines: part 3

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This is the third and final article in a 3-part series summarizing relevant 2020 guideline updates that have the potential to affect primary care in Canada substantially.[1,2] Being aware of relevant changes in recommendations is the first step in appraising those changes and integrating them into practice. This article provides a synopsis of important updates to allow family physicians to further explore areas of interest or potential gaps in knowledge. As with all literature, it is essential to consider the level of supporting evidence and reflect on recommendations using a primary care lens.

Guideline updates

The American College of Rheumatology (ACR) recommends starting urate-lowering therapy (ULT) for patients who have previously experienced more than 1 lifetime flare of gout even if infrequent (fewer than 2 per year; conditional recommendation, moderate-quality evidence).[3] A randomized controlled trial demonstrated a decreased risk of subsequent gout flares in patients with 2 or more infrequent lifetime flares taking ULT (relative risk reduction = 27%, absolute risk reduction = 11%, number needed to treat [NNT] = 9 over 2 years). This guideline strongly supports ULT for patients with subcutaneous tophi, patients with gout resulting in damage visible on radiographs, and patients with 2 or more flares per year. It also conditionally recommends ULT for patients experiencing their first flare and chronic kidney disease stage 3 or higher, serum urate level greater than 535 µmol/L, or urolithiasis. Do not prescribe patients ULT for otherwise uncomplicated first flares or asymptomatic hyperuricemia with no flares or tophi.

The ACR recommends allopurinol over all other types of ULT (strong recommendation, moderate-quality evidence) and recommends continuing ULT indefinitely (conditional recommendation, very low-quality evidence) for the management of gout.[3] This recommendation de-emphasizes the use of febuxostat and is based on efficacy, tolerability, safety, and cost. In addition, a single case series found that 87% of patients who had been in clinical remission with a serum urate level below target for years had recurrent gout flares within 5 years of ULT discontinuation. This guideline continues to recommend a treat-to-target strategy (<360 µmol/L), although this recommendation differs from other guidelines.[4]

The ACR recommends against the use of hyaluronic acid injections for the treatment of osteoarthritis (OA) of the knee and hip (strong recommendation for hip, conditional recommendation for knee).[5] There is high-quality evidence demonstrating a lack of benefit for hip OA. A meta-analysis showed a clinically irrelevant benefit for knee OA but a clinically relevant increase in adverse events. Hyaluronic acid may be more favourable than no intervention for patients with knee OA pain refractory to all other treatments. The ACR guideline supports the use of exercise, cognitive-behavioural therapy, acupuncture, and thermal interventions in addition to topical and oral nonsteroidal anti-inflammatory drugs, intra-articular glucocorticoid injections, acetaminophen, duloxetine, and tramadol. The authors also recommend against the use of insoles, massage, manual therapy, transcutaneous electrical nerve stimulation, glucosamine and chondroitin, nontramadol opioids, biologics, botulinum toxin, and platelet-rich plasma.

A 2020 Canadian clinical practice guideline on obesity says pharmacotherapy, including liraglutide, naltrexone-bupropion combination, or orlistat, can be used for the treatment of obesity (level 2a, grade B).[6] This recommendation pertains to patients with a body mass index of 30 kg/m^2 or greater as well as patients with a body mass index of 27 kg/m^2 or greater and obesity-related complications. Pharmacotherapy is meant to be used in conjunction with health behaviour change. All 3 medications were associated with statistically significantly greater weight loss at 1 year compared with placebo (with average placebo-subtracted effects on weight of -5.4% with liraglutide, -4.8% with naltrexone-bupropion, and -2.9% with orlistat), and higher proportions of patients assigned to the medications achieved 10% weight loss or more compared with those taking placebo (liraglutide NNT = 4, naltrexone-bupropion NNT = 6, orlistat NNT = 8).[7] The guideline recommends discontinuing the medications if weight loss of 5% or more is not obtained within 3 months of therapeutic dosing.[6] The guideline also emphasizes providing a comprehensive assessment, addressing the root cause of obesity, reviewing the patient's activities of daily living, and facilitating access to a registered dietitian to develop an individualized nutrition therapy plan that is not a dieting approach (although there is evidence to support the use of WW, Optifast, Jenny Craig, and Nutrisystem programs).

The American Urological Association recommends using risk stratification for patients with asymptomatic microscopic hematuria to determine which

investigations to pursue (strong recommendation, level C evidence).[8] This applies to patients who have persistent asymptomatic microscopic hematuria despite the treatment and resolution of gynecologic or nonmalignant genitourinary sources of microhematuria (such as urinary tract infection) in addition to patients with suspected medical renal disease. Patients at low risk are women younger than 50 and men younger than 40 with less than a 10-pack-year history of smoking, those with no risk factors for urothelial cancer, and those with 3 to 10 red blood cells per high-powered field on single urinalysis. These patients can repeat urinalysis in 6 months or proceed to cystoscopy and renal ultrasound immediately. If repeat urinalysis shows hematuria, recategorize the patients as being at intermediate or high risk. In contrast, patients at high risk are 60 years or older or have more than a 30-pack-year history of smoking, a history of gross hematuria, or more than 25 red blood cells per high-powered field. Patients at intermediate risk include those who do not meet all the criteria for the low-risk category or any of the criteria for high risk. All patients at intermediate or high risk should have cystoscopy and imaging, with patients at intermediate risk having a renal ultrasound and patients at high risk having a computed tomography urogram. The guideline also recommends cytology not be a routine initial investigation but instead be used for persistent hematuria with irritative symptoms or risk factors for carcinoma in situ. This differs from the 2009 Canadian guidelines, which recommend cytology and renal ultrasound for all patients and cystoscopy if risk factors are present or if the patient is older than 40 years.[9]

The Society of Obstetricians and Gynaecologists of Canada (SOGC) recommends urinalysis and, if indicated, urine microscopy and culture and postvoid residual bladder volume during the workup of urinary incontinence (strong recommendation, moderate-quality evidence).[10] Urinalysis assesses for complicating factors such as hematuria, proteinuria, glucosuria, and positive cultures. Positive cultures are associated with more frequent episodes of incontinence. Depending on the patient's presentation, hemoglobin A_{1c} measurement (query diabetes), serum creatinine measurement (query outlet obstruction), and imaging may also be indicated. Cystoscopy and urodynamics do not need to be done for patients with uncomplicated urinary incontinence. For patients who are overweight or obese, weight loss of 5 kg or more is associated with reduced severity of symptoms. Pelvic floor muscle training and intravaginal devices (eg, pessaries) continue to be the first line of management. Adjuncts such as biofeedback, electrical stimulation, and vaginal cones provide no clear benefit.

The SOGC recommends a trial of labour for low-lying placenta when the placental edge is 11 mm to 20 mm from the cervical os (strong recommendations, moderate-quality evidence).[11] For these women there is a 57% to 93% chance of successful vaginal delivery. The diagnosis of placenta previa or low-lying placenta should not be made before 18 weeks' gestational age (GA) and should be confirmed with ultrasound after 32 weeks' GA. Women with placental edges 10 mm or less from the cervical os should be considered for cesarean section at 37 weeks 0 days to 37 weeks 6 days' GA if they have risk factors and at 38 weeks 0 days to 38 weeks 6 days without risk factors, as there is a 29% chance of antepartum hemorrhage. An ultrasound should be done within 7 to 14 days before cesarean section.

The SOGC recommends starting daily vaginal progesterone at 16 to 24 weeks' GA in women with previous spontaneous preterm birth or with short cervical length and continuing up to 34 to 36 weeks' GA (strong recommendation, moderate-quality evidence).[12] The authors define short cervical length as 25 mm or less at 16 to 24 weeks' GA. For women with prior preterm birth or short cervical length, vaginal progesterone reduces the risks of preterm birth (<37 weeks' GA; odds ratio=0.51, NNT=7) and neonatal death (odds ratio=0.41, NNT=30). Vaginal progesterone is more effective than intramuscular administration, and the authors recommend 200 mg daily for singleton pregnancies and 400 mg daily for a multiple pregnancy.

The Canadian Paediatric Society recommends exploring the 7 Ps to obtain thorough sexual health histories for all adolescents.[13] The goal is to improve sexual health education and prevent adverse outcomes of sexual activity such as sexually transmitted infections, unplanned pregnancy, and teen dating violence. **Table 1** presents the 7 Ps.[13]

Conclusion

This article concludes a 3-part series summarizing guideline updates in the areas of rheumatology, obesity, pediatrics, obstetrics and gynecology, and urology. Family physicians should review these guidelines critically before implementing them or to confirm their current practices.

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Competing interests
None declared

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Table 1. The 7 Ps approach to sexual and reproductive health

THE 7 Ps TO DISCUSS WITH ADOLESCENTS	POINTERS
Partners	Determine the number of partners, whether partners are new, and the partners' risk factors for sexually transmitted infections
Practices	Assess knowledge regarding relationship safety, consent, sexting, and teen dating violence
Protection from sexually transmitted infections Past history of sexually transmitted infections	• Recommend condom use • Ensure human papillomavirus vaccination is up to date • Screen all sexually active patients younger than 25 y • Consider preexposure prophylaxis or postexposure prophylaxis if there are HIV risks
Prevention of pregnancy	Discuss contraceptive options and provide pregnancy testing if most recent menstrual period occurred more than 4 wk ago
Permission (consent)	Be aware of consent laws
Personal identity	Discuss gender identity

Based on information from Johnson N; Canadian Paediatric Society, Adolescent Health Committee. Comprehensive sexual health assessments for adolescents. *Paediatr Child Health* 2020;25(8):551. Available from: **https://cps.ca/en/documents/position/comprehensive-sexual-health-assessments-for-adolescents**. Accessed 2022 Jan 18.[13]

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Can Fam Physician 2022;68:114-6. DOI: 10.46747/cfp.6802114

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