Rapid recommendations

Updates from 2022 guidelines: part 3

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This is the final article in a 3-part series summarizing relevant 2022 guideline updates that could impact care delivered in family medicine.[1,2] With the increasing volume of clinical guidelines, it can be challenging for family physicians to stay up to date with the latest standards of care. This series provides a comprehensive overview of guideline updates from 2022, which can help expedite the integration of relevant changes in the practice of family medicine. By considering the level of supporting evidence and the primary care lens, family physicians can continue to build on their knowledge, address potential gaps in their practice, and reaffirm the care they provide. It is crucial for family physicians to carefully evaluate the new guidelines before integrating them into practice to ensure they are providing the best possible care to their patients.

Guideline updates

Cancer Care Ontario now recommends repeating cervical cytology at 12 months instead of 6 months after Papanicolaou test findings of atypical squamous cells of undetermined significance or a low-grade squamous intraepithelial lesion.[3] The authors state that 48% to 68% of these low-grade abnormalities regress on their own within 24 months.[4] They also support initiating cytology-based screening at age 25 for patients who are or have ever been sexually active, with the exception of those who are also immunocompromised, for whom screening should be initiated at age 21.[3] The recommendation for higher age of initiation for cervical screening aligns with the 2013 Canadian Task Force on Preventive Health Care recommendations.[5]

The Society of Obstetricians and Gynaecologists of Canada has updated its list of risk factors for preeclampsia warranting preventive therapy with acetylsalicylic acid to include obesity and assisted reproductive therapy.[6] Patients with 1 high-risk factor or 2 moderate-risk factors should be treated with low-dose acetylsalicylic acid (81 or 162 mg/day) at bedtime, preferably starting before 16 weeks' gestation and discontinuing by 36 weeks (**Box 1**).[6] A dose of 162 mg per day would maximize efficacy, while the lower dose of 81 mg per day would maximize safety, so consider the higher dose if the patient is at higher risk. This guideline also encourages the use of angiogenic markers, the uterine artery pulsatility index, and biochemical markers, where available, as well as treatment for all patients with blood pressure greater than 140/90 mm Hg, with a target diastolic blood pressure of less than 85 mm Hg.

The Society of Obstetricians and Gynaecologists of Canada now recommends 2 pre-conception options for patients whose fetuses are at high risk of neural tube defects: a standard care option and a personalized option (strong recommendation, moderate to high evidence).[7] The standard care option involves taking a total oral daily dosage of 4 mg folic acid, usually in the form of 1 mg in a multivitamin plus 3 tablets of 1 mg of folic acid, as well as an iron supplement of 16 mg to 20 mg daily along with 2.6 µg of vitamin B12. The personalized option involves taking a folic acid–containing multivitamin (0.4 to 1 mg/day of folic acid) and vitamin B12 for 4 to 6 weeks. If the patient's fasting folic acid level is within the optimal range after this period, the regimen would continue until the 12th week of gestation. If the level is suboptimal, the dosage would need to be increased.

The Canadian Task Force on Preventive Health Care recommends against using screening questionnaires for depression in all pregnant and postpartum patients (conditional recommendation, very low-certainty evidence).[8] This recommendation is due to the uncertain evidence that universal screening with a questionnaire has any benefit over usual care, which includes inquiring into and paying attention to the patient's mental health during pregnancy and the postpartum period. Furthermore, questionnaires can be time consuming and potentially lead to overreferral of cases with positive screening results. One

Box 1. Risk factors for preeclampsia

High risk (any 1)
- Prior preeclampsia
- Pre-pregnancy body mass index >30 kg/m^2
- Chronic hypertension
- Pre-gestational diabetes
- Chronic kidney disease
- Systemic lupus erythematosus or antiphospholipid antibody syndrome
- Assisted reproductive therapy

Moderate risk (any 2 or more)
- Prior placental abruption
- Prior stillbirth
- Prior reduced fetal growth rate
- Maternal age >40 y
- Nulliparity
- Multifetal pregnancy

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analysis found that for every 100 patients screened with the Edinburgh Postnatal Depression Scale, 3 would receive false-negative results and 5 would receive false-positive results.[8] However, this recommendation does not apply to patients with a current mental health disorder diagnosis.

The United States Preventive Services Task Force (USPSTF) recommends screening children aged 8 to 18 years old for anxiety[9] and aged 12 to 18 years for depression (grade B recommendations).[10] These recommendations are based on evidence that screening and early treatment can improve health outcomes. However, the USPSTF found no evidence on appropriate or recommended screening intervals for either anxiety or depression. For anxiety screening, the USPSTF recommends using the Screen for Child Anxiety Related Disorders or the Patient Health Questionnaire–Adolescent.[9] For depression screening, the USPSTF recommends the Patient Health Questionnaire–Adolescent or the Patient Health Questionnaire–9.[10] In contrast, the USPSTF states there is insufficient evidence to recommend screening for eating disorders in adolescents or adults.[11]

The World Federation of Societies of Biological Psychiatry and the Canadian Network for Mood and Anxiety Treatments have provided a summary of nutraceuticals and phytoceuticals for which there is evidence of therapeutic value in treating psychiatric disorders.[12] For depression, the authors recommend St John's wort for monotherapy (MT) (600-1800 mg/day) and omega-3 fatty acids (eicosapentaenoic acid with or without docosahexaenoic acid) for adjunct therapy (AT) (1-2 g/day). They give a provisional recommendation for probiotics (MT or AT) (1-10 billion colony-forming units/day); saffron (30 mg/day of the stigma of *Crocus sativus*; MT or AT), curcumin (500-1000 mg/day; MT or AT), lavender (80-160 mg/day of a specialized oil; MT or AT), and zinc (25 mg/day elemental; AT). Finally, for depression they give a weak recommendation for 1500 IU to 4000 IU per day of vitamin D (MT or AT) and 800 mg to 3200 mg per day of *S*-adenosyl-L-methionine (AT). For generalized anxiety disorder, the authors provisionally recommend ashwagandha (300-600 mg/day; MT or AT) and lavender (80-160 mg/day of a specialized oil; MT or AT), and make a weak recommendation for galphimia (350-700 mg/day; MT). For patients with obsessive compulsive disorder, this guideline weakly recommends *N*-acetylcysteine (2-3 g/day; MT or AT). For patients diagnosed with bipolar disorder, the authors make a weak recommendation for omega-3 supplementation (1-2 g/day of eicosapentaenoic acid with or without docosahexaenoic acid; AT). For patients with a diagnosis of schizophrenia, authors provisionally recommend *N*-acetylcysteine (1-3 g/day; AT) and weakly recommend ginkgo (120-360 mg/day; AT). Finally, for patients with attention deficit hyperactivity disorder, authors provide a weak recommendation for a broad-spectrum micronutrient formula (8-12 capsules/day of vitamins and minerals; MT) and vitamin D (1500-4000 IU/day; MT or AT).

The Canadian Centre on Substance Use and Addiction states that patients who consume 2 or fewer standard drinks of alcohol per week are likely to avoid alcohol-related consequences.[13] This guideline update moves away from concrete recommendations and instead outlines a risk continuum tied to alcohol consumption with a key takeaway message: For enhanced health outcomes, less alcohol is invariably better. The guideline also highlights the increased risk of cancer with 3 to 6 alcoholic drinks per week and increased risk of cardiovascular disease with 7 or more alcoholic drinks per week. Consuming more than 2 standard drinks on any occasion elevates the potential for harm (eg, injuries, acts of violence). When considering pregnancy, there is no recognized safe level of alcohol intake.

Conclusion

This article concludes a 3-part series summarizing guideline updates from 2022.

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Competing interests
None declared

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