Rapid recommendations

Updates from 2022 guidelines: part 2

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Continuing professional development is crucial to enhancing patient care, yet the growing volume of medical literature can be overwhelming for clinicians. This article is part 2 in a 3-part series summarizing guideline updates published in 2022 that could substantially affect primary care in Canada.[1] The aim of this synopsis is to highlight interesting and novel changes in recommendations, allowing clinicians to explore these topics further and appraise the information. Family physicians should note that many of the recommendations are based on low-quality evidence or expert opinion and should be evaluated from a primary care perspective before implementation.

Guideline updates

An Obesity Canada guideline update and the American Gastroenterological Association recommend adding 2.4 mg of semaglutide weekly as a fourth medication option for the management of obesity (level 1a, grade A recommendation).[2,3] The other 3 medications approved in Canada for the management of obesity are 3 mg of liraglutide daily; 16 mg of naltrexone and 180 mg of bupropion twice daily; and 120 mg of orlistat 3 times daily.[2] This guideline highlights the impact semaglutide has on weight loss, with a mean placebo-subtracted weight loss of -12.5% at 1 year. This compares well with the mean placebo-subtracted weight loss achieved with the other 3 medications, ranging from -2.9% (orlistat) to -5.4% (liraglutide). Semaglutide is also indicated for patients living with non-alcoholic steatohepatitis and who are overweight or obese. The guideline also recommends considering metformin for prevention of weight gain in patients with severe mental illness who are taking antipsychotic medications associated with weight gain.

The American Academy of Neurology recommends consideration of sodium channel blockers such as oxcarbazepine, lamotrigine, or lacosamide as additional treatment options for diabetic neuropathy (level B evidence)[4] in addition to medications recommended by Diabetes Canada.[5] Diabetes Canada's 2018 update recommended consideration of pregabalin, gabapentin, valproate, amitriptyline, duloxetine, venlafaxine, topical nitrate spray, or, in refractory cases, opioid analgesics for treatment of diabetic neuropathy.[5] A typical medication trial for an individual with neuropathic pain should be considered a failure if it is ineffective after 12 weeks or if the medication cannot be tolerated.[4] The American Academy of Neurology authors also summarized findings from a randomized controlled trial (RCT) that supported the use of other interventions, such as capsaicin, *Citrullus colocynthis*, *Ginkgo biloba*, exercise, cognitive-behavioural therapy, or mindfulness.[3]

The American College of Physicians suggests considering elective surgery to prevent recurrent diverticulitis for patients with persistent, recurrent, or complicated diverticulitis (conditional recommendation, low-certainty evidence).[6] Patients who experience symptoms lasting more than 3 months, 3 or more episodes in 2 years, or complicated diverticulitis have a high likelihood of recurrence. Evidence suggests that elective surgery decreases recurrence and may improve quality of life compared with nonoperative management (absolute risk difference of -21.5%, 95% CI -27% to -11%), but evidence is uncertain regarding effects on mortality, length of hospitalization, and adverse effects of diverticulitis. Risks of surgery—including known perioperative complications such as anastomotic leaks, sepsis, and myocardial infarction—must be balanced against benefits.

The American Gastroenterological Association and the British Society of Gastroenterology have each updated their guidelines for the treatment of irritable bowel syndrome (IBS) to include tenapanor and plecanatide as second-line agents for constipation-type IBS (IBS-C) and rifaximin as a second-line agent for diarrhea-type IBS (IBS-D) (conditional recommendations, moderate-certainty evidence).[7-9] The 3 guidelines refer to US Food and Drug Administration (FDA) composite end points for IBS: a reduction of at least 30% in abdominal pain from the average baseline score and improvements in either the number of complete spontaneous bowel movements per week for patients with IBS-C or stool consistency scores for patients with IBS-D. For patients with IBS-C, those who received tenapanor in 3 RCTs had greater symptom relief than those who received placebo (relative risk [RR]=0.84, 95% CI 0.79 to 0.90) based on the FDA end points, as did those who received plecanatide in 2 large phase 3 trials (RR=0.87, 95% CI 0.83 to 0.92).[7] Among patients with IBS-D, those who received rifaximin in 2 RCTs had a significantly better response than those who received placebo (RR=0.85, 95% CI 0.78 to 0.94) based on the FDA end points for IBS-D.[8] The Canadian Association of Gastroenterology's 2019 clinical practice guideline for IBS had no recommendation regarding the use of rifaximin and did not comment on

tenapanor or plecanatide.[10] The 2019 Canadian guideline is consistent with the American and British guidelines in recommending the use of tricyclic antidepressants and eluxadoline for patients with IBS-D and the use of selective serotonin reuptake inhibitors, linaclotide, and lubiprostone for those with IBS-C.[10]

The Infectious Diseases Society of America and the Society for Healthcare Epidemiology of America now recommend fidaxomicin as the first-line treatment for initial* Clostridioides difficile *infection (CDI)[11] instead of vancomycin[12] (conditional recommendation, moderate-certainty evidence). This new recommendation is based on evidence showing low resistance to fidaxomicin and a narrow antibiotic spectrum while still being highly active against CDI.[11] As a result, pooled analysis has shown fidaxomicin has similar efficacy in initial clinical response (RR=1.00, 95% CI 0.96 to 1.04) and lower recurrence (RR=1.16, 95% CI 1.09 to 1.24) compared with vancomycin. This new recommendation may be particularly beneficial for patients at increased risk of recurrence (ie, those older than 65, those who are immunocompromised, or those with severe CDI). Consequently, for a first episode of CDI, 200 mg of fidaxomicin taken twice daily for 10 days is the preferred treatment, with 125 mg of vancomycin taken 4 times daily for 10 days an alternative; for nonsevere CDI when vancomycin or fidaxomicin are unavailable, 500 mg of metronidazole taken 3 times daily over 10 to 14 days is another option.

The Canadian Association of Hospital Dentists recommends against the use of antibiotics for toothaches or localized dental abscess (strength of recommendation and quality of evidence not provided).[13] Antibiotics do not add any benefit to definitive treatment of root canal or extraction. Exceptions to this include patients with systemic complications or who are immunocompromised. When antibiotics are prescribed, strategies to reduce antibiotic resistance—such as delayed prescriptions and shortened durations with reassessment—should be considered.

Conclusion

This article highlighting key recommendations related to obesity care, diabetic neuropathy, and gastroenterology is part 2 in a 3-part series summarizing guideline updates from 2022. Health care practitioners are encouraged to appraise these recommendations and explore these updates to advance their knowledge or confirm current clinical practices.

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Competing interests
None declared

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