

Take 3 – Practical Practice Pointers[®] March 18, 2019 Edition

Choose Wisely Derm, Journal for Weight Loss, Statin Intensity in T2D

Follow-up – Screening Pelvic Examination “PS”:

As follow-up to the Pointer in the March 11 Take 3 regarding the screening pelvic examination, the AAFP and Choosing Wisely also recommend the following:

“Don’t require a pelvic exam or other physical exam to prescribe oral contraceptive medications.” (September 2013).

Explanation: Hormonal contraceptives are safe, effective and well-tolerated for most women. Data do not support the necessity of performing a pelvic or breast examination to prescribe oral contraceptive medications. Hormonal contraception can be safely provided on the basis of medical history and BP measurement.

A Twofer From Choosing Wisely/American Academy of Dermatology

1) Antibiotics for Common Dermatological Problems

Do not routinely prescribe antibiotics for inflamed epidermal cysts (August 2015).

Explanation: The overwhelming majority of red and swollen epidermal cysts (ECs) are inflamed but not infected. It is important to confirm infection before treating these cysts with antibiotics. Appropriate treatments for inflamed ECs include incision and drainage or an injection of corticosteroid directly into the cyst.

Don’t routinely use topical antibiotics on a surgical wound (June 2017).

Explanation: Any possible reduction in the rate of infection from the use of topical antibiotics on clean surgical wounds compared to the use of non-antibiotic ointment or no ointment is quite small. Risk reduction may be overshadowed by the risks of wound irritation or contact dermatitis. When topical antibiotics are used in this setting, there is a significant risk of developing contact dermatitis, a condition in which the skin becomes red, sore, or inflamed after direct contact with a substance, along with the potential for developing antibiotic resistance. Only wounds that show symptoms of infection should receive appropriate antibiotic treatment.

My Comment:

The recommendation regarding epidermal inclusion cysts highlights what appears to be a common misconception. Both recommendations serve as an ongoing reminder that antibiotics are tools that can be quite useful when used appropriately (though are not without risks), but can also cause harm when not used appropriately or overused. We all “know” this, but don’t always act on this knowledge. Thanks for being thoughtful as to how you use this “tool.”

Reference:

Choosing Wisely and the American Academy of Dermatology [Link](#)

From the Literature

2) “Write It When You Bite It” for Successful Weight Loss

Previous studies have shown that dietary self-monitoring is consistently related to successful short- and long-term weight loss. In fact, the Diabetes Prevention Program suggested that a month of self-monitoring diaries increases the odds of achieving a 7% weight-loss goal by 32%. Daily dietary self-monitoring consists of recording all foods and beverages consumed as well as the portion size and preparation method. Weight-loss program participants are often instructed to record foods as soon as they are consumed, or to “write it when you bite it,” although there is little research supporting this recommendation. The advent of nutrient analysis websites and smartphone applications allows for easier tabulation of total calories and fat consumed, thus lowering the burden of numerical calculation.

Evidence has suggested that the accuracy and completeness of self-monitoring diaries are not as important as the frequency with which they are completed. Daily diary completion for a typical 24-week weight-loss intervention is perceived by participants as onerous and can represent a significant time commitment. Little is known, however, about exactly how much time individuals successful at weight loss actually spend self-monitoring. Moreover, it is not clear whether individuals become more efficient with practice, thus becoming able to decrease the time they spend self-monitoring in order to get the same result.

Electronic self-monitoring options now provide opportunities to continue to evaluate the details of self-monitoring behavior without relying on self-report. Therefore, the purpose of this study was to quantify the time spent and the daily frequency of dietary self-monitoring for participants engaged in an online 24-week behavioral weight-control intervention using a Web-based dietary analysis program.

In this study, participants ($n = 142$; BMI average 36; 90% women) were encouraged to adhere to a reduced-calorie and low-fat diet and do 200 minutes of moderate to vigorous exercise a week. They were also taught self-monitoring, goal setting, problem-solving, and relapse prevention strategies to help them change their eating habits. The self-monitoring also included documenting beverage intake, food portion size, and preparation method.

Results showed that on average 23 minutes per day of self-monitoring was done in month 1 and 15 minutes in month 6. For those still recording any minutes self-monitoring by month 6 (66%), there were no significant differences in time spent based on weight loss; however, those losing either $\geq 5\%$ (50% of participants) or $\geq 10\%$ (26% of participants) logged in to the journal Web page significantly more times per day (1.6 vs. 2.4, $P < 0.001$ for $< 5\%$ vs. $\geq 5\%$; 1.7 vs. 2.7, $P < 0.001$ for $< 10\%$ vs. $\geq 10\%$).

The authors concluded that the frequency of self-monitoring is significantly related to weight loss, with the time needed to be successful diminishing during the intervention.

My Comment:

I choose to highlight this study due to its relative simplicity and the manner in which it highlights how technology can help us both better understand and guide human behavior. Smartphone apps such as Lose It, Calorie King, and My Fitness Pal are

some recommended platforms for this intervention. Given the prevalence of obesity among our patient population, every little bit certainly helps!

Reference:

Harvey J, et al. Log Often, Lose More: Electronic Dietary Self-Monitoring for Weight Loss. Obesity March 2019;27(3):380-384. [Link](#)

PPS: From the Guidelines and our Pay for Value Work

3) Statin Use in Persons with DM (SUPD) and Appropriate Dose

The American Diabetes Association (ADA), in alignment with the American College of Cardiology/American Heart Association (ACC/AHA), has provided very specific guidance regarding the use of statins in persons with DM for 2019. These include:

- For patients of all ages with diabetes and atherosclerotic cardiovascular disease (ASCVD) or 10-year ASCVD risk >20%, high-intensity statin therapy should be added to lifestyle therapy. **A**
- For patients with diabetes aged <40 years with additional ASCVD risk factors, the patient and provider should consider using moderate-intensity statin in addition to lifestyle therapy. **C**
- For patients with diabetes aged 40–75 years **A** and >75 years **B** without ASCVD, use moderate-intensity statin in addition to lifestyle therapy.
- In patients with diabetes who have multiple ASCVD risk factors, it is reasonable to consider high-intensity statin therapy. **C**
- For patients who do not tolerate the intended intensity, the maximally tolerated statin dose should be used. **E**
- For patients with diabetes and ASCVD, if LDL cholesterol is ≥ 70 mg/dL on maximally tolerated statin dose, consider adding additional LDL-lowering therapy (such as ezetimibe or PCSK9 inhibitor). **A** Ezetimibe may be preferred due to lower cost.
- Obtain a lipid profile at initiation of statins or other lipid-lowering therapy, 4–12 weeks after initiation or a change in dose, and annually thereafter as it may help to monitor the response to therapy and inform medication adherence. **E**

High Intensity: Daily dosage lowers LDL-C by approximately $\geq 50\%$ on average

- Atorvastatin (Lipitor) 40-80 mg
- Rosuvastatin (Crestor) 20-40 mg

Moderate Intensity: Daily dosage lowers LDL-C by approximately 30-50% on average

- Atorvastatin (Lipitor) 10-20 mg
- Rosuvastatin (Crestor) 5-10 mg
- Simvastatin (Zocor) 20-40 mg
- Pravastatin (Pravachol) 40-80 mg
- Lovastatin (Mevacor) 40 mg
- Fluvastatin (Lescol) 80 mg
- Pitavastatin (Livalo) 2-4 mg

My Comment:

Though I covered this in January, recent chart reviews indicate that there is appears to be confusion as to what constitutes “moderate” vs. “high” intensity doses for statins. As noted, there is convincing evidence for statin use for all patients with DM age ≥ 40 , and

in particular between the ages of 40 and 75. Since this is a measure on many insurer pay-for-performance programs with increasing incentives for 2019, effective implementation of this recommendation becomes even more compelling. If for whatever reason a patient is not tolerating a higher dose of a statin, I recommend documenting this clearly in the chart notes and/or problem list.

References:

- ADA Standards of Care 2019: Cardiovascular Disease and Risk Management. Diabetes Care. January 01 2019; volume 42 issue Supplement 1. [Link](#)
- Grundy S, et al. Guideline on the Management of Blood Cholesterol 2018. Journal of the American College of Cardiology. November 10, 2018. [Article](#)
- Stone NJ, et al. 2013 ACC/AHA guideline on the treatment of blood cholesterol to reduce atherosclerotic cardiovascular risk in adults: a report of the ACC/AHA Task Force on Practice Guidelines. Circulation. 2014;129(25 suppl 2):S13. [Article](#)

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Mark

Carilion Clinic Department of Family and Community Medicine