

Asymptomatic Bacteriuria, Sleep Myths, Grief Myths for Clinicians

From the Infectious Disease Society (IDSA) and the Guidelines

1) Clinical Management of Asymptomatic Bacteriuria (ASB)

Asymptomatic bacteriuria is the presence of 1 or more species of bacteria growing in the urine at specified quantitative counts ($\geq 10^5$ colony-forming units [CFU]/mL), irrespective of the presence of pyuria and in the absence of signs or symptoms attributable to urinary tract infection (UTI). ASB is a common finding in some healthy female populations and in many women or men with abnormalities of the genitourinary tract that impair voiding. This recently published guideline updates the IDSA 2005 guideline, incorporating new evidence that has become available.

Notable recommendations include:

- In infants and children, recommend against screening for or treating asymptomatic bacteriuria (ASB) (*strong recommendation, low-quality evidence*).
- In healthy premenopausal, nonpregnant women or healthy postmenopausal women, recommend against screening for or treating ASB (*strong recommendation, moderate-quality evidence*).
- In pregnant women, recommend screening for and treating ASB (*strong recommendation, moderate-quality evidence*).
- In pregnant women with ASB, suggest 4–7 days of antimicrobial treatment rather than a shorter duration (*weak recommendation, low-quality evidence*). In older, community-dwelling persons who are functionally impaired, we recommend against screening for or treating ASB (*strong recommendation, low-quality evidence*).
- In older persons resident in long-term care facilities, recommend against screening for or treating ASB (*strong recommendation, moderate-quality evidence*).
- In older patients with functional and/or cognitive impairment with bacteriuria and delirium (acute mental status change, confusion) and without local genitourinary symptoms or other systemic signs of infection (eg, fever or hemodynamic instability), recommend assessment for other causes and careful observation rather than antimicrobial treatment (*strong recommendation, very low-quality evidence*).
- In older patients with functional and/or cognitive impairment with bacteriuria and without local genitourinary symptoms or other systemic signs of infection (fever, hemodynamic instability) who experience a fall, recommend assessment for other causes and careful observation rather than antimicrobial treatment of bacteriuria (*strong recommendation, very low-quality evidence*).
- For the bacteriuric patient with fever/other systemic signs potentially consistent with a severe infection and without a localizing source, broad-spectrum antimicrobial therapy directed against urinary and nonurinary sources should be initiated.
- In patients with diabetes, recommend against screening for or treating ASB (*strong recommendation, moderate-quality evidence*).
- In patients with a short-term indwelling urethral catheter (<30 days), recommend against screening for or treating ASB (*strong recommendation, low-quality evidence*).

- In patients with indwelling catheters, we make no recommendation for or against screening for and treating ASB at the time of catheter removal (knowledge gap).
- In patients with long-term indwelling catheters, we recommend against screening for or treating ASB (*strong recommendation, low-quality evidence*).
- In patients undergoing elective nonurologic surgery, we recommend against screening for or treating ASB (*strong recommendation, low-quality evidence*).

My Comment:

It is so very difficult for many of us to not test for, and having tested, to not treat someone with asymptomatic bacteriuria. This guideline is in line with other such recommendations, and hopefully will help provide confidence for us to resist the temptation to screen/treat those for whom doing so will likely cause much more harm than benefit.

Reference:

Nicolle, L et al. Clinical Practice Guideline for the Management of Asymptomatic Bacteriuria: 2019 Update by the Infectious Diseases Society of America. *Clinical Infectious Diseases*, Published online 21 March 2019. [Guideline](#)

From the Literature and the Popular Press

2) Sleep Myths

False beliefs about sleep can persist despite contradicting scientific evidence, potentially impairing population health. Identifying commonly held false beliefs lacking an evidence base (“myths”) can inform focused efforts to promote population sleep health.

The authors of this study compiled a list of potential myths using Internet searches of popular press and scientific literature. They then asked 10 experts from the field of sleep medicine to rate the myths on 2 dimensions, falseness and public health significance, using 5-point Likert scale.

There were 20 predominant “sleep myths” identified. Out of these, some were rated to have the most public health significance. They included:

Myth: Adults need five or fewer hours of sleep

Reality: Most adults require between 7-10 hours of sleep each night, depending on age and other personal characteristics. The CDC estimates that at least 1/3 of adults get fewer than 7 hours of sleep/night. There is evidence that both acute and chronic poor sleep contributes to multiple adverse health outcomes.

Myth: Your brain and body can adapt to less sleep

Reality: Our body requires four phases of sleep to become fully restored, including REM sleep and deep stage sleep. Any “adaptations” will lead to poorer health indices.

Myth: Snoring is mostly harmless

Reality: Snoring can be one sign of sleep apnea, which is estimated to effect up to 30% of the adult population, carries substantial morbidity, and is significantly underdiagnosed.

Myth: Drinking alcohol before bed helps you fall sleep

Reality: Alcohol may help you fall asleep, but significantly reduces sleep quality, including the deeper stages of restorative sleep.

Myth: If one is having difficulty falling asleep, stay in bed and continue to try

Reality: It takes a healthy sleeper about 15 minutes to fall asleep. Beyond that, it is better to change the environment and do something non-stimulating in a low-light setting.

Myth: It doesn't matter what time of day you sleep

Reality: A regular sleep schedule controls the body's circadian rhythms, which among other things control hormone release, digestion, and sleep-wake cycles.

Myth: Watching TV in bed helps you relax and fall asleep

Reality: The blue light from television and computers effects the release of melatonin and negatively impacts both sleep latency and REM sleep.

Myth: Hitting snooze is a great way to wake up slowly

Reality: The sleep you attain after the initial alarm is light sleep, but waking up in the middle of it can actually cause one to feel more groggy.

The authors concluded that there are areas that may benefit from public health education to correct myths and promote healthy sleep.

My Comment:

For an activity which comprises at least 25% of our lives, it is remarkable how little is actually known about sleep AND how little of what is known is actually put into practice.

One thing that is becoming more evident: There's a lot of important, restorative things happening to our bodies and minds when we sleep, and the cumulative effects of these things not happening is harmful to our physician and mental health, both individually and as a society. How's your sleep?

References:

- Robbins R, et al. Sleep myths: an expert-led study to identify false beliefs about sleep that impinge upon population sleep health practices. Sleep Health published online April 16, 2019. [Abstract](#)
- CDC – Tips for Better Sleep: [Link](#)

From the 4th Aim – Caring for Those Who Provide the Care

3) Why Clinicians Grieve Differently

How do you grieve? Western society doesn't talk much about grief, and even less within the medical community. The author of this piece has spent time studying grieving and "doctoring" and has made the following observations. For those readers who are non-physician clinicians, please replace "physician" with your own profession. There are close similarities.

1. Most physicians know death more intimately than the general population:

Some of us encounter death quite regularly. While some patients' deaths tug a little more strongly at the heartstrings, we become skilled at maintaining "professional distance." Even as we convey genuine care and connection, we are expected to readily

disengage from that experience and start fresh with the next patient. The more we do it, the better we become at it. The professional veneer is possibly an impediment to leaning into the experience of grief, as our usual relationship with death is geared to be disengaged from any emotional buy-in.

2. Physicians develop a keen understanding of the limitations of modern medicine and the fickleness of life: We know that not everything can be explained or understood. We know that sometimes bad stuff just happens with there being no good reason. It is unclear if this depth of knowledge helps or hinders the grieving process for physicians, but it often allows for greater peace/acceptance.

3. Physicians are often high-achievers, driven, and controlling: While these are generalizations, they are often true. Indeed, we are selected out because of these abilities, as they help us achieve medical school admission. This adds a complexity to grief when it so clearly reflects an event mostly out of our control.

4. Physicians spend most of our time observing: We might seem present in the moment but often in a disassociated way rather than fully engaged. We are constantly weighing options and possibilities, causing us often to be “there but not there.” This is not generally a useful skill in personal grief. Grief is a reflection of the depth of our love for that which is lost. Unless we have loved in a dispassionate, dissociated way, we do not give our grief a fair chance if we do not live it.

5. Acute grief is painful, distressing, heart-wrenching: Having lived it and survived the early intense days, we will actively do our best to avoid revisiting the intensity of those feelings. For many, the idea of trying to recount details of such events is too painful to contemplate.

6. Physicians are masters of hiding our emotions, which is a useful skill in some consultations: We see patients at their most vulnerable, transparent, and “human.” Some things shared are sad, humorous, bizarre, embarrassing, shocking, or even horrific. Keeping a straight face is an important skill to help engender trust and create a “safe space” for such reality. This serves us well in the moment, but can also mute our emotions when we try to access them in situations of grief.

My Comment:

While there is no “right way” to grieve, that we grieve is vital. Finding a constructive way to do so is essential for our emotional and spiritual health. Sharing our stories with each other and connecting with someone else who has walked the path is one way to avoid isolation of emotion and the often negative consequences of this.

Reference:

Alison Edwards, MBBS. Why Physicians Grieve Differently (modified): Kevin MD: [Link](#)

Feel free to forward Take 3 to your colleagues. Glad to add them to the distribution list.

Mark

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