

Take 3 – Practical Practice Pointers® August 5, 2019 Edition

Gallbladder Disease, HTN Diagnosis, HTN Treatment

Follow-up: Screening for HIV in high risk groups

As a follow-up from the 7/22 “Question from a Colleague” Pointer regarding HIV screening in high risk groups, I received thoughtful e-mail from one of our colleagues, John Epling, who is regularly in these conversations nationally through his work with the USPSTF. Here are John’s reflections, shared with permission.

When I was doing press for the HIV screening and PrEP recommendations, we handled the "for whom" question differently. While the populations you and the CDC list are absolutely affected disproportionately by HIV, we thought it would be a bad idea to talk about those demographics as risk factors. Instead we emphasized the behaviors:

- *Having a sex partner who is HIV positive*
- *Having sex without a condom with a partner whose HIV status is unknown and who is at high risk for HIV*
- *Sharing drug injection needles and syringes*
- *Exchanging sex for money or drugs, also known as transactional sex*
- *Having a sexually transmitted infection in the past 6 months*

They don't exactly roll off the tongue, but, for instance, men who have sex with men (MSM) but who are monogamous, use condoms and are HIV negative probably don't need PrEP or more frequent screening.

I spent a lot of time saying - "that's why primary care clinicians are essential to the process and need to be skilled in asking sexual and drug use histories"

Thanks John. Well said. We should and need to be experts in providing contextual care, not only for these populations, but for all of our patients. Afterall, we’re likely all in a high risk group for something!

A Three-fer From Choosing Wisely and the SAGES

1) Three Things Physicians Should Question About GB Disease

The Society of American Gastrointestinal and Endoscopic Surgeons (SAGES) recently released a list of practices that should be questioned. These included some regarding gallbladder disease.

1) Avoid routine cholecystectomy for patients with asymptomatic cholelithiasis: 10-20% of people in Western countries have gallstones and 50-70% of these are asymptomatic. Incidental discovery of gallstones on imaging performed for unrelated reasons is common, often prompting surgical consultation. Treatment with observation alone is indicated for asymptomatic patients with incidental cholelithiasis, unless diagnosed with related hematologic disease. Cholecystectomy for patients with asymptomatic cholelithiasis is too aggressive. For asymptomatic cholelithiasis patients undergoing an unrelated abdominal operation, such as gastric bypass, concomitant cholecystectomy may be considered.

2) Avoid other imaging tests apart from ultrasound (US) for the initial evaluation of patients with suspected gallstone disease.

The diagnostic workup of acute right upper quadrant pain is informed by risk factors for cholecystitis. When acute cholecystitis is suspected the initial imaging modality of choice is US based on availability, examination time, lack of ionizing radiation, morphologic evaluation, confirmation of the presence or absence of gallstones, evaluation of bile ducts, and identification or exclusion of alternative diagnoses. When the clinical features, examination, laboratory and US findings are congruent, no further imaging is required.

3) Don't discharge patients presently emergently with acute cholecystitis without first offering a laparoscopic cholecystectomy.

Surgeons often debate the timing of cholecystectomy in patients with acute cholecystitis. Evidence suggests that cholecystectomy during the index hospitalization is both safe and cost effective. Interval cholecystectomy may be associated with higher chance of requiring open surgery or readmission, increasing costs. Finally, acute cholecystitis patients that are discharged without undergoing surgery may have a higher risk of presenting with complications of cholelithiasis, which can be more morbid than the initial presentation.

My Comment:

I've become aware of two physician colleagues who over the past few months have personally had cholecystectomies so I thought these brief updates from Choosing Wisely were timely.

Reference:

Choosing Wise and the SAGES, January 9, 2019: [Link](#)

A Hypertension Two-fer: From the Literature

2) Measurement of High Blood Pressure

Ambulatory blood pressure (ABP) monitoring is now recognized as the best method for predicting the risk of cardiovascular events in relation to an individual's blood pressure (BP) level. The association between ABP and the risk of cardiovascular events is continuous, consistent, and independent of other risk factors. Although the accurate measurement of BP is the cornerstone for appropriate diagnosis and treatment of hypertension, recent guidelines have questioned the accuracy, and consequently the role, of manual BP measurement in routine clinical practice.

Routine office BP measurement is not only more susceptible to a "white coat effect" (when BP measured in the office is higher than ABP), but is also less accurate, correlating relatively poorly with the awake ABP, and is more likely to be associated with digit preference (rounding off readings to the nearest zero value). Automated office blood pressure (AOBP) measurement involves recording several blood pressure (BP) readings using a fully automated oscillometric sphygmomanometer with the patient resting alone in a quiet place. Although several studies have shown AOBP measurement to be more accurate than routine office BP measurement and not subject

to a “white coat effect,” the cumulative evidence has not yet been systematically reviewed.

This systematic review and meta-analysis examined the association between automated office blood pressures (AOBP) and office BP readings measured in routine clinical practice and in research studies, and ambulatory BP recorded during awake hours, using the ABP as a standard for predicting future cardiovascular events.

The authors found that automated office blood pressure readings, when recorded properly with the patient sitting alone in a quiet place, are more accurate than office BP readings in routine clinical practice and are similar to awake ambulatory BP readings, with the mean AOBP being devoid of any white coat effect. They concluded that based on the evidence, AOBP should now be the preferred method for recording BP in routine clinical practice.

My Comment:

There has been some reluctance among clinicians to adopt this technique because of uncertainty about its advantages compared with more traditional methods of recording BP during an office visit. This study advances the science of BP measurement and should increase our confidence in AOBP, which removes both the “white coat” and human error components from BP measurements. Sounds like it might be time for a change ...

Reference:

Roerecke M, et al. Comparing automated office blood pressure readings with other methods of BP measurement for identifying patients with possible hypertension. JAMA Intern Med 2019;179(3): 351-362. [Article](#)

From the Cochrane Database

3) Treatment of Hypertension (HTN)

It is known that HTN increases with age and in particular for persons > 60. Systolic HTN is more strongly associated with cardiovascular disease than is diastolic HTN, and it occurs more commonly in older people. It is important to know the benefits and harms of antihypertensive treatment for HTN in this age group, as well as separately for people 60 to 79 years old and people 80 years or older.

This is the second substantive update of this review, originally published in 1998 and previously updated in 2009. The primary objective was to quantify the effects of antihypertensive drug treatment as compared with placebo or no treatment on all-cause mortality in people ≥ 60 with systolic and/or diastolic HTN. Secondary objectives were to quantify the therapeutic effects of antihypertensive drug treatment as compared with placebo or no treatment on cardiovascular-specific morbidity and mortality in people ≥ 60 with systolic and/or diastolic HTN and to quantify the rate of withdrawal due to adverse effects in this same population. HTN in these studies was defined as a blood pressure > 140/90.

Over 25,000 patients with moderate to severe systolic and/or diastolic hypertension (average 182/95 mmHg) met the inclusion criteria. Most of these trials evaluated used

thiazide diuretics as first-line therapy for a mean treatment duration of 3.8 years. Outcomes assessed were all-cause mortality; cardiovascular morbidity and mortality; cerebrovascular morbidity and mortality; coronary heart disease morbidity and mortality; and withdrawal due to adverse effects.

The authors concluded that treating healthy adults ≥ 60 with moderate to severe systolic and/or diastolic HTN with antihypertensive drug therapy reduced all-cause mortality, cardiovascular mortality and morbidity, cerebrovascular mortality and morbidity, and coronary heart disease mortality and morbidity. Most evidence of benefit pertains to a primary prevention population using a thiazide as first-line treatment.

My Comment:

Though this study in many ways confirms what we “already know,” it and the previous Pointer highlight the importance of our “getting this right” when it comes to the diagnosis and treatment of HTN. This is particularly true given the cumulative toll of morbidity and mortality that vascular disease in its many forms takes for our patients.

Though not specifically addressed, this study also appears to support a higher systolic threshold for defining HTN in this population. This would be consistent with the present recommendations from both the AAFP and the ACP.

Reference:

Musini VM et al. Pharmacotherapy for hypertension in adults 60 years or older. Cochrane Database Syst Rev. 2019 Jun 5. [Review](#)

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

Mark

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