Take 3 – Practical Practice Pointers© January 27, 2020 Edition

Deprescribing Statins, Connecting with Patients, Pap Interpretation

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From the Literature

1) Deprescribing Statins in Older Adults

The incidence of atherosclerotic coronary vascular disease (ASCVD) continues to rise in older adults past age 75 and is a significant contributor to mortality. However, there is little evidence to support the initiation of statins beyond age 75, principally because the studies of statin use for primary and secondary prevention of ASCVD so rarely include patients over age 75. The "deprescribing" movement has picked up a lot of steam recently in the care of older adults, given the known harms of polypharmacy and the unproven benefit of many of the medications we end up prescribing for this population. A review of guidelines in October 2019 looked specifically for direction about deprescribing from major cardiovascular disease prevention guidelines. Using a comprehensive search, quality assessment and selecting guidelines that gave at least some advice on deprescribing of statins for any indication, the authors found 18 guidelines that addressed the broader question of deprescribing. Unfortunately, the guidelines all addressed deprescribing in the context of statin intolerance and in cases of poor general health – and none provided any specificity about how to deprescribe.

An RCT published in 2015 examined the safety and outcomes associated with describing statins in the setting of life-limiting illness (frequently palliative care for cancer and dementia). The authors found that the deprescribed group showed "non-inferiority" in survival (they set up the trial to evaluate whether deprescribing was no worse than continuing statins), some improvements in certain quality of life outcomes and a reduction in total medication use. There were no study-related adverse events.

Other sources of information on this topic include:

- The Choosing Wisely Campaign has a recommendation from the American Medical Directors Association (nursing home medical directors) that suggests that starting statins over age 75 is only beneficial if the patient has diagnosed ASCVD, but not for primary prevention. Link
- The Pooled Risk Cohort equations used by several guidelines to assess ASCVD risk use age > 40 to calculate risk do not necessarily have a stopping age.
- The USPSTF recommends using this calculated 10-year risk over 10% plus hypertension, dyslipidemia, smoking or diabetes as the indication to start statins for primary prevention. Link
- The 2018 ACC/AHA guideline on the management of blood cholesterol recommends "clinical assessment and risk discussion" when considering initiating statins for primary prevention over age 75. Link

John's Comments:
There is increasing work in the area of deprescribing, and the RCT described above is an example of this good work, but more is needed. It seems reasonable to assess the current health and comorbidity status, indication for statin (primary or secondary prevention), history of statin tolerance and our patients' values and preferences related

to medications and cost when considering stopping statins. The two major reasons I would stop statins: 1) a healthy patient over 75 who is burdened by cost or side effects and 2) a patient with a life-limiting illness who wishes to be on fewer medications. The bigger lesson is to think carefully about starting statins in this age group – they will benefit most if they have clinical ASCVD and a reasonable life expectancy.

References:

- Ploeg MA et al. Recommendations for (Discontinuation of) Statin Treatment in Older Adults: Review of Guidelines. J Am Ger Soc PAP 30 October 2019. Link
- Kutner JS et al. Safety and Benefit of Discontinuing Statin Therapy in the Setting of Advanced, Life-Limiting Illness. JAMA Int Med 2015;175(5):691. Link

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From the Literature

2) Fostering Presence and Connection with Patients

The importance of the clinician-patient relationship has been recognized for millennia. There is pressing concern in recent times that this special relationship is threatened due to the increased demands of clinical practice, including time constraints, insurer demands, novel technologies, and documentation burdens.

This present study sought to identify evidence and narrative-based practices that promote clinician presence, a state of awareness, focus, and attention.

The authors performed a systematic literature review of studies examining effective interpersonal interventions in clinical care. After evidence synthesis, 13 promising interventions were reviewed in a 3-round modified Delphi process by a panel of 14 researchers, clinicians, patients, caregivers, and health system leaders. After the third round, panelists selected their "top 5" practices. Final recommendations incorporate elements from all highly rated practices.

Recommendations included:

- prepare with intention (take a moment to prepare/focus before greeting a patient);
- listen intently and completely (sit down, lean forward, avoid interruptions)
- agree on what matters most (find out what the patient cares about and incorporate these priorities into the visit agenda)
- connect with the patient's story (consider life circumstances that influence the patient's health; acknowledge positive efforts; celebrate successes)
- explore emotional cues (notice, name, and validate the patient's emotions).

The authors concluded that evaluation and validation of the outcomes associated with implementing the 5 practices is needed, along with system-level interventions to create a supportive environment for implementation.

Mark's Comments:

These recommendations are fundamental to effective communication skills and serve as a good reminder for all of us. At the same time, for some of this to even seem consistently possible in the midst of a hectic clinic day, the medical system as it is presently designed and evolving will need to change to decompress clinician workflow and allow for the preparation, thought, and reflection that would support these critical

relationships. In talking with many colleagues, that's not an excuse, but rather their present reality. I call this "survival mode."

At the least in the midst of these demands, I would encourage each of us to look for opportunities to implement these opportunities for deeper connection as often as possible within a busy day. Doing so will keep you connected with the Soul of the work that we do. And this will greatly enhance their (and your) life.

Reference:
Zulman DM et al. Practices to Foster Physician Presence and Connection With Patients in the Clinical Encounter. JAMA. 2020 Jan 7;323(1):70-81. Link

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From the Peer Review Committee and Question by a Colleague

3) Interpreting Pap Smear Results

Question:
I sometimes get confused when reading pap smear results. The interpretation will often say "satisfactory for evaluation" but will then sometimes say "no endocervical component present" or something to that effect. Is a pap smear without endocervical cells considered an "adequate specimen"?

Answer:
Cervical cytology became the standard screening test for cervical cancer and premalignant cervical lesions with the introduction of the Papanicolaou (Pap) smear in 1941. Liquid-based, thin-layer preparation of cervical cytology specimens was a subsequent modification in technique. Terminology for reporting cervical cytology was standardized by the Bethesda System in 1988. This system has been revised several times, and the current system was updated in 2014. Standards include:

- Terminology must communicate clinically relevant information from the laboratory to the patient's health care provider.
- Terminology should be uniform and reasonably reproducible across different pathologists and laboratories and also flexible enough to be adapted in a wide variety of laboratory settings and geographic locations.
- Terminology must reflect the most current understanding of cervical neoplasia.

Evaluation of specimen adequacy is considered by many to be the single most important quality assurance component of the Bethesda system. Twenty years ago, the significance of an endocervical component was considered an indicator of specimen adequacy. During the Bethesda Workshop of 2001, experts downplayed the significance of endocervical cells in the Pap smear, with their recommendations no longer deeming Pap collections lacking endocervical cells as "unsatisfactory."

Bethesda 2001 designated specimen adequacy as "satisfactory" or "unsatisfactory." Specimen quality indicators such as the presence or absence of a transformation zone component, or of obscuring inflammation or blood, are reported after the adequacy designation. It is not necessary to have the presence of endocervical cells in order for a specimen to be considered "adequate for evaluation," and indeed, in post-menopausal patients (and certainly those post hysterectomy), there will often be no endocervical component noted.

Additionally, the most recent 2014 Bethesda update provided additional guidance for special situations, such as assessing cellularity in specimens obtained from post radiation patients, interfering substances (e.g. lubricant, blood), and the effects of adequacy on HPV testing.

Present screening guidelines recommend the following:

- All women should begin cervical cancer screening at age 21.
- Age 21-29: Pap testing done every 3 years. HPV testing only if the Pap is abnormal.
- Age 30-65: Pap testing and HPV testing (co-testing) OR HPV testing alone every 5 years. Alternatively, a woman could have a Pap test alone every 3 years.
- Over age 65: women who have had normal Pap results can stop testing.
- Women over age 65 who have a history of a serious cervical pre-cancer should continue to be tested for 20 years after that diagnosis, even if this is after age 65.

My Comment:
To provide perspective, in talking with the Pathologist who is the Medical Director of our lab, he shared that our departmental "no EC" % is usually around 20% overall. It can be challenging to break our “scripting,” so depending on when you did your residency training, you may still have the belief that “no endocervical component” is consistent with an inadequate specimen. While this is no longer the case, it may be worthwhile for you to do a personal experiment and note what your percentage of “no EC” is, particular with women for whom you can visualize an endocervical transformation zone during the procedure. Of course, as we move toward more HPV testing alone (and perhaps with more home testing), much of this may also become a historical remnant!

Reference:
Nayar R and Wilbur DC. The Pap Test and Bethesda 2014. Acta Cytologica 2015;59:121-132. https://www.karger.com/Article/Pdf/381842

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Mark

Carilion Clinic Department of Family and Community Medicine