

## MILLIONS PAID FOR SERVICES WITH NO NET HEALTH BENEFITS <sup>1</sup>

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A UCLA-led study showed that physicians frequently order preventive medical services for adult Medicare beneficiaries that are considered unnecessary and of “low value” by the U.S. Preventive Services Task Force (USPSTF) – at a cost of \$478 million per year. National survey data were analyzed over a 10-year period looking specifically at seven preventive services given a “D” rating by the Task Force. They discovered that these services were ordered more than 31 million times annually.

The USPSTF, an independent panel appointed by the Department of Health and Human Services, makes recommendations on the value of clinical preventive services. Services rated D are considered to have no likely health benefit to specific patients and may even be harmful to them. Overall, utilization of a variety of services considered unnecessary by the Task Force drives up spending by billions of dollars each year.

Researchers examined data covering the years 2007-2016 from the annual National Ambulatory Medical Care Survey to determine how often, and at what cost, seven specific grade D services were utilized:

- Vitamin D supplementation for fracture prevention for post-menopausal women.
- Prostate cancer screening in men 75 and older (prostate-specific antigen test).
- Chronic obstructive pulmonary disease screening in asymptomatic patients (peak flow or spirometry).
  - Colorectal cancer screening in those over age 85 (colonoscopy or sigmoidoscopy).
  - Cervical cancer screening in women over 65 (Papanicolaou or HPV test).
  - Cardiovascular disease screening in low-risk adults (rest or stress ECG).
  - Asymptomatic bacteriuria screening in non-pregnant women.

The researchers noted some limitations to the study. For instance, their method of estimating

Medicare spending on these services may lack clinical details and therefore might misclassify some instances of appropriate care as low value.

Medicare could save nearly \$500 million per year and protect patients against potential harm by no longer providing reimbursements for these services. Under the Affordable Care Act, the Secretary of Health and Human Services is authorized to prohibit payment for services rated D by the USPSTF. In February 2021, the U.S. Office of Personnel Management’s Federal Employees Health Benefits Program stopped covering grade D services.

### APPROPRIATE USE OF SHORT-COURSE ANTIBIOTICS IN COMMON INFECTIONS <sup>2</sup>

This study is considered best practice advice from the American College of Physicians.

Antimicrobial overuse is a major health care issue that contributes to antibiotic resistance. Unnecessarily long duration of antibiotic therapy in common bacterial infections is the main reason for this problem. The practice is prevalent for conditions such as exacerbations of acute bronchitis with chronic obstructive pulmonary disease (COPD), community-acquired pneumonia (CAP), urinary tract infections (UTIs), and cellulitis.

The authors conducted a narrative literature review of published clinical guidelines, systematic reviews, and individual studies that addressed these infections. It was not a formal systematic review, but based on best available evidence. Guidance was prioritized to the highest level of synthesized evidence.

#### BEST PRACTICE ADVICE 1:

Clinicians should limit antibiotic treatment to 5- to 6- days when managing patients with COPD exacerbations and acute uncomplicated bronchitis who have clinical signs of a bacterial infection (presence of increased sputum purulence in

addition to increased dyspnea, and increased sputum volume).

#### BEST PRACTICE ADVICE 2:

Clinicians should prescribe antibiotics for community-acquired pneumonia for a minimum of five days. Extension of therapy after five days of antibiotics should be guided by validated measures of clinical stability, which include resolution of vital sign abnormalities, ability to eat, and normal mentation.

#### BEST PRACTICE ADVICE 3:

In women with uncomplicated bacterial cystitis, clinicians should prescribe short-course antibiotics with either nitrofurantoin for five days, trimethoprim-sulfamethoxazole (TMP-SMZ) for three days, or fosfomycin as a single dose. In men and women with uncomplicated pyelonephritis, clinicians should prescribe short-course therapy either with fluoroquinolones (5-7 days) or TMP-SMZ (14 days) based on antibiotic susceptibility.

#### BEST PRACTICE ADVICE 4:

In patients with non-purulent cellulitis, clinicians should use a five- to -six -day course of antibiotics active against streptococci, particularly for patients able to self-monitor and who have close follow-up with primary care.

#### AMERICAN COLLEGE OF GASTROENTEROLOGY (ACG) PRINTS FIRST-EVER IRRITABLE-BOWEL SYNDROME (IBS) CLINICAL-PRACTICE GUIDELINES<sup>3</sup>

The ACG developed these guidelines thanks to advances in diagnostic testing and therapeutic options. It's felt that these can be used effectively in daily practice to help expedite care and improve symptoms in patients with this syndrome.

IBS is a common chronic disorder of bowel function affecting an estimated 4.4% - 4.8% of the population, and leading to reduced quality of life. More research is needed to completely understand the role of the gut microbiome in patients with IBS and to understand the genesis of visceral pain.

Among the 25 recommendations contained in the guidelines, here are 11 of the most significant:

- For global IBS with diarrhea (IBS-D), options include bile-acid sequestrants, rifaximin and opioid agonists/antagonists; in women with severe refractory IBS-D, try alosetron.

- For global IBS with constipation (IBS-C) symptoms, use chloride channel activators and guanylate-cyclase activators.

- For treating IBS symptoms, options to consider include soluble (not insoluble) fiber, peppermint, tricyclic antidepressants and gut-directed psychotherapies. Don't use anti spasmodics, probiotics, polyethylene glycol (PEG) products, or fecal transplant.

- Consider a limited trial of a low-FODMAP diet to improve global symptoms.

- Do tests of anorectal physiology in patients with IBS and symptoms suggestive of pelvic floor disorder and/or refractory constipation.

- Don't test for food allergies and food sensitivities in all patients with IBS unless they are reproducible symptoms that cause concern for a food allergy.

- Use a positive diagnostic strategy (as opposed to a diagnostic strategy of exclusion) for patients with IBS symptoms to improve time to treatment and reduce cost.

- Don't do routine colonoscopy in patients with IBS symptoms younger than age 45 who do not have warning signs.

- Don't do routine stool testing for enteric pathogens in all patients with IBS.

- In patients with suspected symptoms of IBS and diarrhea and without alarm features, check fecal calprotectin or fecal lactoferrin and C-reactive protein to rule out inflammatory bowel disease (IBD).

- Do serologic testing to rule out celiac disease (CD) in patients with suspected IBS and diarrhea.

#### FISH OIL SUPPLEMENTS LINKED WITH HEART RHYTHM DISORDER<sup>4</sup>

This study concluded that omega-3 supplements are associated with an increased likelihood of developing atrial fibrillation (AF) in people with high blood lipids. Due to the high prevalence of elevated triglycerides in those with increased cardiovascular risk, fish oil supplements are often prescribed. Also, these supplements are available over the counter in a low-dose form. Patients with AF have a five times greater likelihood of having a stroke, so this is an important study.

A comprehensive meta-analysis of randomized controlled trials was performed to determine if

fish oils were consistently related to an increased risk of AF. The analysis included five randomized controlled trials that investigated the effects on cardiovascular outcomes of supplementation with omega-3 fatty acids. Participants had elevated triglycerides and were either at high risk for cardiovascular disease or had established cardiovascular disease. A total of 50,277 patients received fish oils or placebo and were followed up for 2 to 7.4 years. The dose of fish oils varied from 0.84 gm to 4 gm per day.

The analysis showed that omega-3 fatty acid supplementation was associated with a significantly increased risk for AF compared with placebo, with an incident ratio of 1.37 (9.5% confidence interval 1.22-1.54;  $p < 0.001$ ).

Although one clinical trial indicated beneficial cardiovascular effects of supplementation, the risk for AF should be considered when such agents are prescribed or purchased over the counter, especially in individuals susceptible to developing AF.

As an added comment, I know that the Mayo Clinic online has an article from their website dated December 8, 2020, stating that “while

research shows that people who eat dietary sources of fish oil at least twice a week have a lower risk of dying of heart disease, taking fish oil supplements seems to have little to no benefits to heart health.”

There are also some significant possible interactions, which include:

- Anticoagulant and antiplatelet drugs, herbs and supplements. It’s possible that taking fish oil supplements with them might increase the risk of bleeding.

- Blood pressure drugs, herbs and supplements. Taking fish oil supplements might slowly lower blood pressure. Taking these supplements with blood pressure drugs might increase their effect on blood pressure.

- Contraceptive drugs. Some contraceptive drugs might interfere with fish oil’s typical effect on triglycerides.

- Orlistat (Xenical, Alli). Taking fish oil with this weight-loss drug might decrease absorption of fish oil fatty acids. Therefore consider taking the supplement and the drug at least 2 hours apart.

- Vitamin E. Taking fish oil can reduce vitamin E levels.

## REFERENCES

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