Choosing Wisely®:
Applying the Campaign to Practice

Rebecca Parker, MD, FACEP
Chair, ACEP Board of Directors

Disclosure

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* Dr. Parker does not have a significant financial relationship to report.

Choosing Wisely®

* History
* The Story of Emergency Medicine and ACEP
* ACEP's Recommendations
* Implementation efforts

www.choosingwisely.org

The Cost of Care

- Cost of healthcare unaffordable
  - U.S. spends 20X more compared to other countries
- Estimated 30% of spending wasteful
  - Lack of communication between physician and patient one reason for waste
- Less waste, more resources for all

CTPA for Pulmonary Embolism

- ~ 2 million per year in U.S.
- 2012 CMS reimbursement ~ $446
- $446 X 2 million CTPA: ~ $892 million/year
- Est 33% CTPA done on low risk pretest probability
- $892 million X .33:~ $300 million/year (savings)

Venkatesh AK, et al. Evaluation of pulmonary embolism in the emergency department and consistency with a national quality measure. Arch Intern Med. 2012; 172 (13): 1028-1032

Choosing Wisely
An initiative of the ABIM Foundation

Starting the conversation

- Piloted in 2009 by National Physician Alliance through *Putting the Charter in to Practice* grant
  - List of "5 Things You Can do in Your Practice"
  - 3 primary care specialties
  - Published in Archives of Internal Medicine

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American College of Emergency Physicians
ADVANCING EMERGENCY CARE

The JAMA Network

From: **The "Top 5" Lists in Primary Care: Meeting the Responsibility of Professionalism**

Arch Intern Med*. 2011;171(15):1385-1390. doi:10.1001/archinternmed.2011.231

Table. Field Testers Who Agreed or Strongly Agreed on the Importance of the Clinical Activity

Practice Activity	Testing Group	Field Testers Who Agreed or Strongly Agreed on Importance, %: Frequency Encountered	Quality of Care	Economic Impact	Strength of Evidence	Ease of Implementation
Family Medicine						
Imaging for low back pain	Alpha	55.5	51.8	85.1	100.0	70.3
	Beta	38.2	41.9	81.8	96.4	83.6
Routine laboratory studies	Alpha	74.1	37.0	59.2	70.3	48.1
Antibiotics for sinusitis	Beta	38.2	63.6	60.0	94.6	70.9
Annual ECGs	Alpha	44.4	40.7	48.1	92.6	88.9
	Beta	29.0	40.0	54.5	92.7	96.3
Pap test for patients <21 y	Alpha	40.7	74.1	59.2	96.3	74.0
	Beta	36.4	51.0	50.9	96.3	89.1
DEXA scans younger patients	Alpha	40.7	55.5	66.7	85.1	81.4
	Beta	25.4	32.7	60.0	90.9	83.7
Internal Medicine						
Imaging for low back pain	Alpha	65.5	75.8	82.7	100.0	75.8
	Beta	40.0	49.0	74.0	90.0	80.0
Routine laboratory studies	Alpha	72.1	51.7	62.1	68.9	44.8
	Beta	54.0	40.0	54.0	78.0	60.0
Annual ECGs	Alpha	58.6	69.0	62.0	89.7	89.6
	Beta	26.0	40.0	42.0	84.0	88.0
Generic statins	Alpha	75.9	79.3	86.2	89.7	93.1
	Beta	70.0	46.0	78.0	82.0	94.0
DEXA scans for younger patients	Alpha	58.6	58.6	44.8	65.5	75.8
	Beta	22.0	22.0	50.0	74.0	86.0
Pediatrics						
Antibiotics pharyngitis	Alpha	42.9	85.7	61.9	90.5	81.0
	Beta	53.6	46.5	53.6	96.5	89.3
Head injury imaging	Alpha	9.5	90.5	85.7	95.3	71.4
	Beta	10.7	35.7	71.5	96.5	89.3
OME referral	Alpha	23.8	52.4	66.6	85.8	90.5
	Beta	21.4	21.4	39.3	78.6	85.7
No cough medications	Alpha	90.5	71.4	47.6	71.5	42.8
	Beta	82.1	60.7	35.7	92.9	78.0
Inhaled steroids for asthma	Alpha	71.4	90.5	81.9	95.2	47.6
	Beta	67.8	78.5	71.5	89.3	85.7

Abbreviations: ECG, electrocardiogram; DEXA, dual energy x-ray absorptiometry; OME, otitis media with effusion; Pap, Papanicolaou.

Date of download: 4/12/2014

**Now JAMA Internal Medicine*

Choosing Wisely
An initiative of the ABIM Foundation

The Campaign

- Sponsored by ABIM Foundation
- 9 Medical Societies in Feb 2012
- More than another dozen joined Feb 2013
- To date (April 2015) 65+ Medical Societies released at least one set
  - 325+ recommendations

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ABIM FOUNDATION
American College of Emergency Physicians
ADVANCING EMERGENCY CARE

The Campaign

- *Choosing Wisely*® aims to promote conversation btw physician and pt by helping pts choose care that is:
  - Supported by evidence
  - Not duplicative of other tests or procedures already received
  - Free from harm
  - Truly necessary

ACEP's Journey

- ACEP initially declined participation in 2012
- ACEP Cost Effective Care Task Force (CEC) work extended
- In Feb 2013, after October 2012 ACEP Council discussion, review by an expert panel of EPs, the ACEP Board of Directors elected to participate using the CEC process
  - Letter sent to ABIM Foundation and meeting occurred
- First 5 recommendations submitted June 2013 from CEC/Delphi panel process, released October 2013

Joining Choosing Wisely® February 2013 ACEP Letter

Concerns included:

1. Unique nature of EM vs office based
2. Recommendations should have significant financial impact
3. Evidence based
4. Specialty specific
5. Explore liability related reform/safe harbor

JAMA IM Editorial February 2014

How Should Top-Five Lists Be Developed? What Is the Next Step?

Development of ACEP CEC Strategies

- Board formed the CEC Task Force in 2012
- CEC TF debated the methodology to identify CEC strategies. Also debated whether to join Choosing Wisely®
- Survey sent to ACEP members
- 1,193 individual cost effective care suggestions submitted from survey.
- Delphi Panel formed to prioritize strategies.

Development of ACEP CEC Strategies

* Delphi Panel Evaluated all Proposed Strategies Utilizing Three Criteria

1. Contribution to cost savings
2. Risk/benefit to patients
3. Actionability by emergency medicine providers

Measure	TOPIC	Member Vote Vote for 10 with an X	#Round 1 Votes
		RANK 10 ITEMS	
Don't use urinary cathethers for patient or staff convenience. Use HICPIC (CDC) guideline indications for placement.	Procedure		7
Don't order CT Pulmonary Angiography in low-pretest probability patients with suspected pulmonary embolism and a negative D-dimer (or no D-dimer performed)	Imaging		4
Do non-invasive mechanical ventilation in adults with CHF with respiratory distress to reduce intubation	Procedure		8
Don't do CT head in adults with minor trauma outside of ACEP/CDC clinical policy recommendations	Imaging		8
Do utilize palliative care services, if available, for those patients most likely to benefit.	Dispo		8
Don't do CT head in children with minor head injury who are low risk from PECARN studies	Imaging		7
Do use a checklist when inserting a central line	Procedure		3
Do not prescribe antibiotics in URIs in uncomplicated patients.	Med/Blood		6
Don't order CT of the cervical spine in trauma patients who do not meet Canadian C-Spine Rule criteria	Imaging		8
Do not prescribe antibiotics routinely in sinusitis.	Med/Blood		7
Do use techniques in ED to reduce ventilator associated pneumonia	Procedure		5
Do not cotinue futile resusciatative efforts.	Procedure		4
Do use oral rehydration instead of IV for mild to moderate dehydration.	Procedure		5
Do not use D-Dimer in nurse-driven protocols	Labs		3
Don't order any imaging for adults with atraumatic back pain without high risk features (needs to be defined: age>60, active cancer, ???)	Imaging		8
Do use oral medications instead of IV whenever possible.	Med/Blood		7
Do use a trial of oral disintegrating tablet (ODT) anti-emetic and PO hydration prior to intravenous fluids in uncomplicated cases of mild to moderate dehydration	Procedure		8
Don't give oral or IV antihypertensives to patients with isolated hypertension and no end organ damage.	Med/Blood		7
Don't order urine cultures for healthy adult females with uncomplicated UTIs	Labs		6
Don't do CT of the head in adult patients with syncope and a normal neurological exam	Imaging		6

Development of ACEP #1-5

- CEC Delphi Panel
- Multiple Conferences
- Analyzed existing pertinent literature
- Reviewed pertinent ACEP Clinical Policies
- 3 rounds of formal voting
- 12 strategies submitted to the Board
- Board picked the final 5 sent to Choosing Wisely®
- Released October 14, 2013

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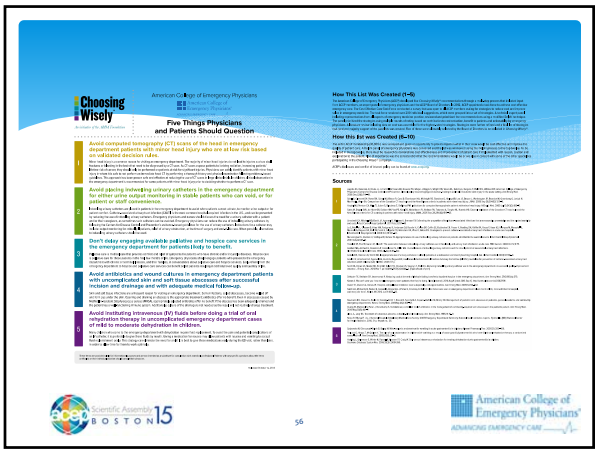
American College of Emergency Physicians' ADVANCING EMERGENCY CARE

CEC Strategies are not Evidence-based Guidelines But… Still May Help to Reduce Practice Variability

Physician Variability in the Approach to a Given Clinical Condition

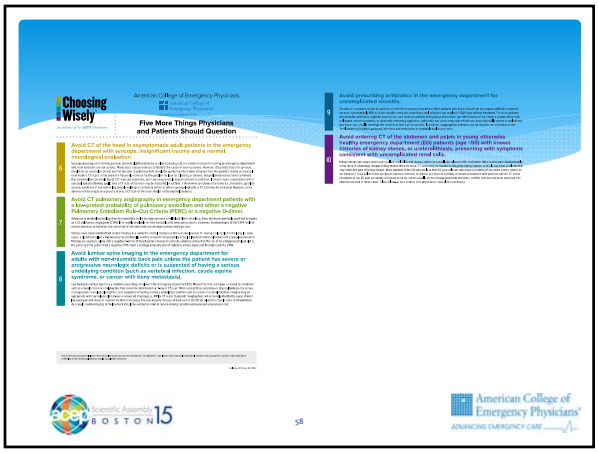
In patients with a traumatic headaches, emergency physician ordering of CT ranged from 15-61% in a single ED practice.

Prevedello LM, Raja AS, Zane RD. et al. Variation in the use of head computed tomography by emergency physicians. *American Journal of Medicine* (2012) 125, 356-364.



Development of ACEP #6-10

- Member survey-cost effective and improve care
- Delphi panel reconvened
- 12 strategies submitted to the Board
- Board picked the final 5 sent to Choosing Wisely®
- Released October 24, 2014



ACEP's Recommendations

Case 1: Mrs. Lee
82-year-old woman to ED for SOB

- Mrs. Lee was started on diuretics. She appeared frail. In the ED, the physician and nurses asked for a urinary catheter (UC) for comfort.
- On the 4th day of admission, started complaining with chills, fever 102°F, and BP dropped to 90. Blood cultures and urine cultures grew *Escherichia coli*.
- Jane was diagnosed with urosepsis due to symptomatic CAUTI and had to be treated with intravenous antibiotics.

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ACEP Recommendation #2

Avoid placing indwelling urinary catheters in the emergency department for either urine output monitoring in stable patients who can void, or for patient or staff convenience.

* Catheter-associated urinary tract infection (CAUTI) is the most common hospital-acquired infection.
* Clinical Study
  * http://onlinelibrary.wiley.com/doi/10.1111/j.15532712.2009.00677.x/full
* 2009 CDC Guidelines for Prevention of CAUTI
  * http://www.cdc.gov/hicpac/pdf/cauti/cautiguideline2009final.pdf

Courtesy ACEP's QIPS Section

Catheter Associated Urinary Tract Infection (CAUTI)

* Most prevalent hospital-acquired infection: 95,483 to 387,550 annually
* Development of a CAUTI is associated with:
  * frequency of urinary catheter (UC) placement,
  * cleanliness of placement,
  * ongoing maintenance, and duration of catheterization.
* ½ of all non-obstetrical hospitalizations are admitted through the ED

Catheter Associated Urinary Tract Infection (CAUTI)

* 20-23% of admitted patients had a UC placed (30-36% for elderly)
* 91% of UCs placed within 24 hours of admission originated in the ED
* 33-50% of UCs placed in hospitalized ED patients lack documented physician orders and nearly half are inappropriate.

2009 CDC Prevention of CAUTI Guidelines (HICPAC)

Table 2.
A. Examples of Appropriate Indications for Indwelling Urethral Catheter Use [1,4]
Patient has acute urinary retention or bladder outlet obstruction
Need for accurate measurements of urinary output in critically ill patients
Perioperative use for selected surgical procedures: • Patients undergoing urologic surgery or other surgery on contiguous structures of the genitourinary tract • Anticipated prolonged duration of surgery (catheters inserted for this reason should be removed in PACU) • Patients anticipated to receive large-volume infusions or diuretics during surgery • Need for intraoperative monitoring of urinary output
To assist in healing of open sacral or perineal wounds in incontinent patients
Patient requires prolonged immobilization (e.g., potentially unstable thoracic or lumbar spine, multiple traumatic injuries such as pelvic fractures)
To improve comfort for end of life care if needed
B. Examples of *Inappropriate* Uses of Indwelling Catheters
As a substitute for nursing care of the patient or resident with incontinence
As a means of obtaining urine for culture or other diagnostic tests when the patient can voluntarily void
For prolonged postoperative duration without appropriate indications (e.g., structural repair of urethra or contiguous structures, prolonged effect of epidural anaesthesia, etc.)

Note: These indications are based primarily on expert consensus. [65]

Appropriate Indications:

- Accurate Measurement of Urinary Output in Critically Ill
- Acute Urinary Retention or Obstruction
- Assist Healing of Perineal and Sacral Wounds in Incontinent Patients
- Perioperative Use in Selected Surgeries
- Required Immobilization for Trauma or Surgery
- Hospice/Comfort Care/Palliative Care

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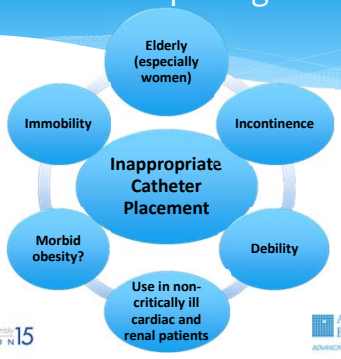
Think twice before placing a catheter



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Case 2: Ms. James
55-year-old woman to ED for weakness

- Ms. James presents by EMS complaining of weakness. She has breast cancer with metastasis to the brain and spine a few months ago causing her to be bedridden.
- Quick assessment shows sepsis most likely from a stage 4 bed sore.
- On speaking with the husband hospice was discussed, but radiation for the metastasis is the next plan.

Choosing Wisely®
ACEP Recommendation #3

Don't delay engaging available palliative and hospice care services in the emergency department for patients likely to benefit.

- Summary Paper
  - http://onlinelibrary.wiley.com/doi/10.1197/j.aem.2003.07.019/abstract
- Summary Paper
  - http://www.annemergmed.com/article/S01960644(10)01202-3/fulltext
- 2012 ACEP Palliative Care Information Paper
  - http://www.acep.org/uploadedFiles/ACEP/Practice_Resources/issues_by_category/administration/Palliative_Care_IP_Final_June2012_edited.pdf
- Palliative Care in the ED Toolkit
  - http://www.capc.org/ipal/ipal-em/monographs-and-publications

How do people die?

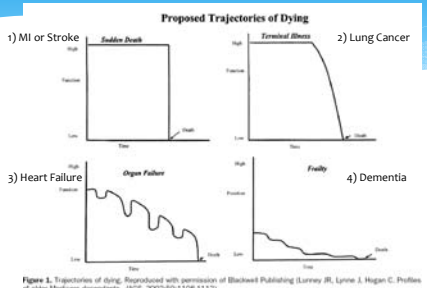
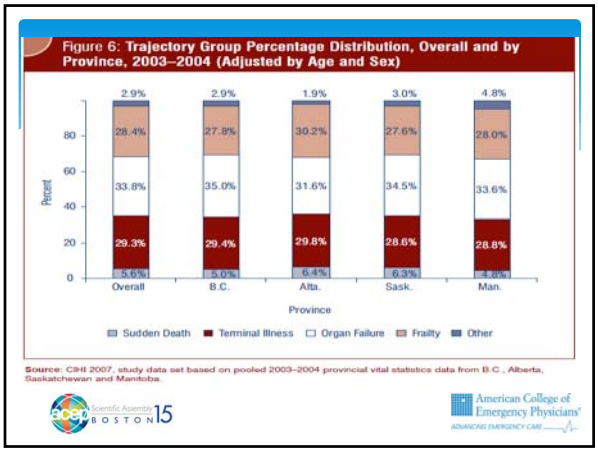


Figure 1. Trajectories of dying. Reproduced with permission of Blackwell Publishing (Lunney JR, Lynn J, Hogan C. Profiles of older Medicare decedents. JAGS. 2002;50:1108-1112).

Courtesy Dr. Mark Rosenberg



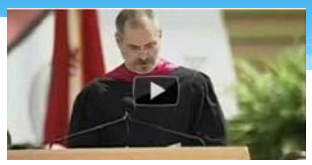
Where do you want to die?

1. Home or Familiar Surroundings
2. Nursing Home
3. Hospital
4. Car Accident

Where People Die and Why They Come to the ED

100% Want to Die at Home
17% Die At Home
>70% Die In HealthCare Facility
Most Admitted Through the ED
Unmet Palliative Needs

The Conversation



Remembering that I'll be dead soon is the most important tool I've ever encountered to help me make the big choices in life. Because almost everything — all external expectations, all pride, all fear of embarrassment or failure - these things just fall away in the face of death, leaving only what is truly important. Remembering that you are going to die is the best way I know to avoid the trap of thinking you have something to lose. You are already naked. There is no reason not to follow your heart.

http://www.youtube.com/watch?v=UFBxR6Z6KLc&feature=player_detailpage#t=539s

Key Elements for Palliative Care in the ED

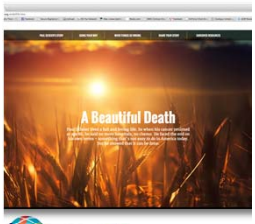
- Identify the patient
- Have the conversation
- Symptom management
- The Role of Hospice

Palliative Care ED Program

https://www.capc.org/ipal/ipal-emergency-medicine/

Consumer Reports Choosing Wisely®

http://web.consumerreports.org/endoflife.htm



- How We Want to Die
  - Easing suffering
  - Coping with bumps
  - Learning lessons of a good death
- Going Your Way
- When End of Life is Messy

Case 3: Mr. Brown 19-year-old man to ED for pain

- Mr. Brown presents with three days of lower back pain. He does not recall any trauma. It hurts worse with movement and he cannot bend over.
- Normal vital signs, no fever or other symptoms at home. Normal exam.
- No medical problems.

Choosing Wisely® ACEP Recommendation #8

Avoid lumbar spine imaging in the emergency department for adults with non-traumatic back pain unless the patient has severe or progressive neurologic eficits or is suspected of having a serious underlying condition (such as vertebral infection, cauda equina syndrome, or cancer with bony metastatis).

Back Pain Education

Courtesy Dr. Al Sacchetti

PEDIATRICS/ORIGINAL RESEARCH

Randomized, Controlled Trial of Antibiotics in the Management of Community-Acquired Skin Abscesses in the Pediatric Patient

Minh Duong, MD, MS
Stephen Markwell, MA
John Peter, MD
Stephen Barenkamp, MD

SEE EDITORIALS, P. 406 AND 412.

INTRODUCTION

Case 5: Jessica
2-year-old girl to ED for vomiting/diarrhea

- Jessica presents with two days of vomiting and diarrhea, each more than five a day. Intermittent crampy abdominal pain. Low grade fever. Siblings and parents are sick with same at home.
- Both slowing down, but ?decreased urine output.
- Normal vital signs, abdomen non tender. Mildly dehydrated on exam.
- No medical problems.

Choosing Wisely®
ACEP Recommendation #5

Avoid instituting intravenous (IV) fluids before doing a trial of oral rehydration therapy in complicated emergency department cases of mild to moderate dehydration of children.

* Clinical Study #1
  * http://archpedi.jamanetwork.com/article.aspx?articleid=485711
* Clinical Review
  * http://www.sciencedirect.com/science/article/pii/S0736467908005969

PEDIATRICS/ORIGINAL RESEARCH

The Role of Oral Ondansetron in Children With Vomiting as a Result of Acute Gastritis/Gastroenteritis Who Have Failed Oral Rehydration Therapy: A Randomized Controlled Trial

Gregory Reinert, MD
Toni S. Hoppe, MD
Kenneth V. McQuillen, MD

From the Department of Emergency Medicine, St. Joseph Regional Medical Center, South Bend, IN (Resident, Department of Emergency Medicine, Northwest Community Hospital, Arlington Heights, IL (Hoppe), and the Department of Emergency Medicine, Grand Rapids Medical Center, Grand Rapids, MI (McQuillen).

Study objective: We hypothesize that ondansetron will facilitate oral rehydration therapy in children with acute gastritis or acute gastroenteritis and mild to moderate dehydration who fail initial oral rehydration therapy. We hypothesize that subjects receiving ondansetron will tolerate oral rehydration and that a lower proportion will require intravenous hydration than subjects receiving placebo, with a clinically important difference of at least 30% when comparing 2 groups of patients presenting to the ED with acute gastritis/acute gastroenteritis. Secondarily, we hypothesize that subjects receiving ondansetron will have a lower proportion requiring admission, fewer episodes of vomiting and diarrhea, and fewer revisits.

Methods: This double-blind, placebo-controlled, prospective, randomized trial enrolled a convenience sample of subjects 3 to 10 years old, with acute gastritis or acute gastroenteritis, who failed oral rehydration therapy in the emergency department (ED). Subjects received a weight-based dose of ondansetron (0.15 mg/kg of the orally dissolving tablet) or placebo, and oral rehydration therapy was reattempted 30 minutes later. If a subject vomited or refused to drink, he or she was considered a failed oral rehydration therapy and received acute gastroenteritis. If a subject tolerated adequate oral rehydration therapy, he or she was discharged. Parents completed symptom diaries and were contacted by telephone for follow-up. We used the χ^2 test to compare the proportions of subjects requiring acute gastroenteritis in each group.

Results: We enrolled 106 subjects: 51 received ondansetron and 55 received placebo; fifteen of 51 (21.2%; 95% confidence interval [CI] 11.2% to 35.3%) of subjects who received ondansetron required intravenous hydration and 30 of 55 (54.5%; 95% CI 40.6% to 68%) of placebo subjects required intravenous hydration ($p < 0.001$) for a difference of 33.3% (95% CI 14.5% to 46.27%). Admission rates were 5.9% (3/51) with ondansetron and 12.7% (7/55) with placebo.

Conclusion: In subjects with acute gastritis/acute gastroenteritis and mild to moderate dehydration who failed initial oral rehydration therapy, the proportion of children who received intravenous hydration was smaller in the ondansetron group than in the placebo group. (Ann Emerg Med. 2008; 52:22-30.)

0196/0644/$-see front matter

doi:10.1016/j.annemergmed.2007.09.010

INTRODUCTION

Background and Importance

Oral rehydration is safe and effective and is the recommended therapy for acute gastritis/acute gastroenteritis with dehydration.[1] However, it is often complicated by emesis. In the emergency department (ED) setting, even 1 episode of emesis during the rehydration process may result in oral attempts being bypassed for intravenous hydration. Multiple medications have been used in an attempt to limit vomiting and facilitate oral rehydration but have not gained acceptance, because of their limited success and high rates of complicating adverse effects.[2-5] Specifically, in addition to extrapyramidal adverse effects, promethazine, prochlorperazine, and metoclopramide are associated with a degree of somnolence that interferes with the oral rehydration process and the assessment of lethargy. Additionally, promethazine has been associated with

Results

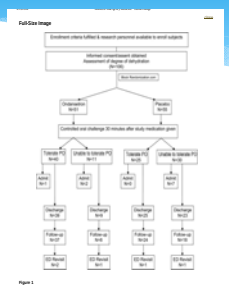


Figure 1
Patient progress through the trial. PO, Oral hydration.

Case 5: Jessica
2-year-old girl to ED for vomiting/diarrhea

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Choosing Wisely®
ACEP Recommendation #5

Avoid instituting intravenous (IV) fluids before doing a trial of oral rehydration therapy in complicated emergency department cases of mild to moderate dehydration of children.

- Clinical Study #1
  - http://archpedi.jamanetwork.com/article.aspx?articleid=485711
- Clinical Review
  - http://www.sciencedirect.com/science/article/pii/S0736467908005969

Other Implementations

TCEP-TMA-ACEP Badge

Choosing Wisely
An initiative of the ABIM Foundation

AMERICAN COLLEGE OF EMERGENCY PHYSICIANS
Ten Things Physicians and Patients Should Question
For rationales, and to learn how this list was created, visit **www.choosingwisely.org**

1. Avoid computed tomography (CT) scans of the head in emergency department patients with minor head injury who are at low risk based on validated decision rules.
2. Avoid placing indwelling urinary catheters in the emergency department for either urine output monitoring in stable patients who can void, or for patient or staff convenience.
3. Don't delay engaging available palliative and hospice care services in the emergency department for patients likely to benefit.
4. Avoid antibiotics and wound cultures in emergency department patients with uncomplicated skin and soft tissue abscesses after successful incision and drainage and with adequate medical follow-up.

(continued on back)

5. Avoid instituting intravenous (IV) fluids before doing a trial of oral rehydration therapy in uncomplicated emergency department cases of mild to moderate dehydration in children.
6. Avoid CT of the head in asymptomatic adult patients in the emergency department with syncope, insignificant trauma and a normal neurological evaluation.
7. Avoid CT pulmonary angiography in emergency department patients with a low-pretest probability of pulmonary embolism and either a negative Pulmonary Embolism Rule-Out Criteria (PERC) or a negative D-dimer.
8. Avoid lumbar spine imaging in the emergency department for adults with non-traumatic back pain unless the patient has severe or progressive neurologic deficits or is suspected of having a serious underlying condition (such as vertebral infection, cauda equina syndrome, or cancer with bony metastasis).
9. Avoid prescribing antibiotics in the emergency department for uncomplicated sinusitis.
10. Avoid ordering CT of the abdomen and pelvis in young otherwise healthy emergency department (ED) patients (age <50) with known histories of kidney stones, or ureterolithiasis, presenting with symptoms consistent with uncomplicated renal colic.

TCEP

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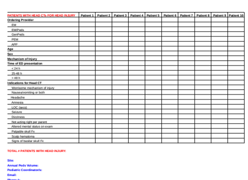
Pediatric Head Injury Study

- Goals:
  - Frequency of CTH in Peds
  - In compliance with PECARN/CW?
- Peds coordinator
- Chart review in 2014



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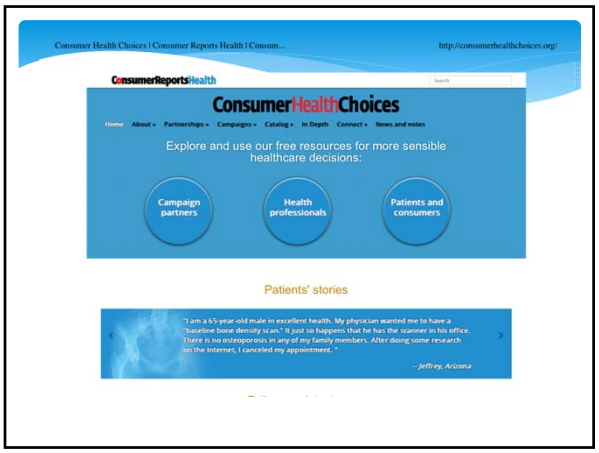
Courtesy Dr. Annie Soriano

American College of Emergency Physicians
ADVANCING EMERGENCY CARE

ConsumerHealthChoices

Founding Partners

PBGH Pacific Business Group on Health · Greater Detroit Area Health Council, Inc. · AARP · Midwest Business Group on Health · Washington State Medical Association · national partnership for women & families · NBCH · alliance health · Healthcare Collaborative of Greater Columbus · Minnesota Health Action Group · Covered California · Oregon Health Care Quality Corporation · NCFH · SEIU · National Business Group on Health · Union Plus · The Leapfrog Group · National Hospice and Palliative Care Organization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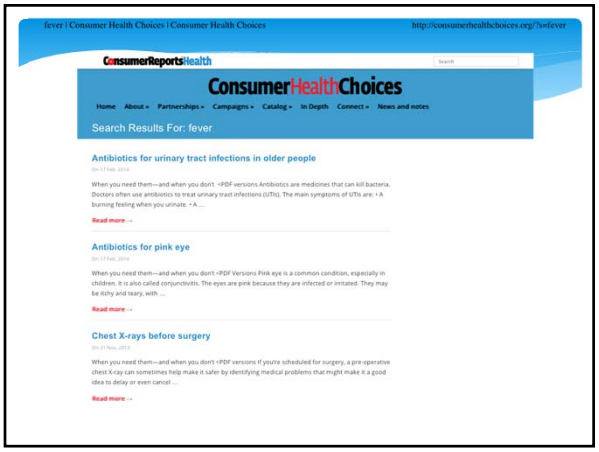
"I am a 65-year-old male in excellent health. My physician wanted me to have a "baseline bone density scan." It just so happens that he has the scanner in his office. There is no osteoporosis in any of my family members. After doing some research on the Internet, I canceled my appointment."
– Jeffrey, Arizona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When you need them—and when you don't: <PDF versions Antibiotics are medicines that can kill bacteria. Doctors often use antibiotics to treat urinary tract infections (UTIs). The main symptoms of UTIs are: • A burning feeling when you urinate. • A ...
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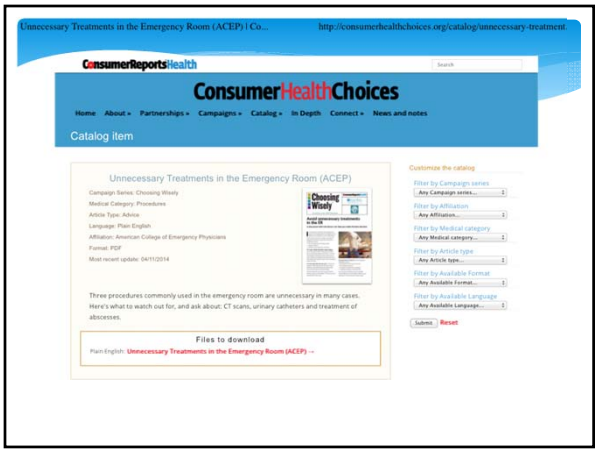
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Unnecessary Treatments in the Emergency Room (ACEP)
Campaign Series: Choosing Wisely
Medical Category: Procedures
Article Type: Advice
Language: Plain English
Affiliation: American College of Emergency Physicians
Format: PDF
Most recent update: 04/11/2014
Three procedures commonly used in the emergency room are unnecessary in many cases. Here's what to watch out for, and ask about: CT scans, urinary catheters and treatment of abscesses.
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Choosing Wisely
An initiative of the ABIM Foundation

ConsumerReportsHealth

Avoid unnecessary treatments in the ER

A discussion with the doctor can help you make the best decision

It can be hard to say "No" in the emergency department. But talking with your emergency room (ER) doctor may help you avoid costly testing.

That's why the American College of Emergency Physicians lists three common procedures you should know about:

- CT scans of the head for minor injury
- Urinary catheters
- Antibiotics and cultures for abscesses

CT scans of the head for minor injury. A CT scan uses X-rays to create a picture of the brain. If your head injury is not serious, a CT scan does not give useful information to the doctor. A medical history and physical exam help the doctor determine if your injury is minor. This can help you avoid a CT scan.

CT scans have risks and cost a lot. CT scans use radiation, which can increase the risk of cancer. Children, especially infants, have greater risks because their brains are still developing.

Services in the ER cost a lot, because of fees for doctors, services, and facilities. A CT scan can add over $2,000 to your costs.

You may need a CT scan if you have dangerous symptoms, such as:

- An injury your doctor can see or feel.
- Becoming unconscious.
- Changes in mental state or alertness.
- Ongoing vomiting or a bad headache.

If you take a blood thinner, such as warfarin (Coumadin®), you are more likely to bleed. So you may need a CT scan, even for a minor injury.

Thank you!

Scientific Assembly BOSTON 15

American College of Emergency Physicians' ADVANCING EMERGENCY CARE