WCHQ’s Top 10 *Choosing Wisely* Recommendations

**American Academy of Allergy, Asthma & Immunology**

*Don’t order sinus computed tomography (CT) or indiscriminately prescribe antibiotics for uncomplicated acute rhinosinusitis.*

Viral infections cause the majority of acute rhinosinusitis and only 0.5 percent to 2 percent progress to bacterial infections. Most acute rhinosinusitis resolves without treatment in two weeks. Uncomplicated acute rhinosinusitis is generally diagnosed clinically and does not require a sinus CT scan or other imaging. Antibiotics are not recommended for patients with uncomplicated acute rhinosinusitis who have mild illness and assurance of follow-up. If a decision is made to treat, amoxicillin should be first-line antibiotic treatment for most acute rhinosinusitis.

**American Academy of Family Physicians**

*Don’t do imaging for low back pain within the first six weeks, unless red flags are present.*

Red flags include, but are not limited to, severe or progressive neurological deficits or when serious underlying conditions such as osteomyelitis are suspected. Imaging of the lower spine before six weeks does not improve outcomes, but does increase costs. Low back pain is the fifth most common reason for all physician visits.

*Don’t screen women older than 65 years of age for cervical cancer who have had adequate prior screening and are not otherwise at high risk for cervical cancer.*

There is adequate evidence that screening women older than 65 years of age for cervical cancer who have had adequate prior screening and are not otherwise at high risk provides little to no benefit.

**American College of Cardiology**

*Don’t perform stress cardiac imaging or advanced non-invasive imaging in the initial evaluation of patients without cardiac symptoms unless high-risk markers are present.*

Asymptomatic, low-risk patients account for up to 45 percent of unnecessary “screening.”
Testing should be performed only when the following findings are present: diabetes in patients older than 40 years-old, peripheral arterial disease; or greater than 2 percent yearly risk for coronary heart disease events.

Don’t perform stress cardiac imaging or advanced non-invasive imaging as a pre-operative assessment in patients scheduled to undergo low-risk non-cardiac surgery.

Non-invasive testing is not useful or patients undergoing low-risk non-cardiac surgery (i.e. cataract removal). These types of tests do not change the patient’s clinical management of outcomes and will result in increased costs.

The American College of Obstetricians and Gynecologists

Don’t schedule elective, non-medically indicated inductions of labor or Cesarean deliveries before 39 weeks 0 gestational age.

Delivery prior to 39 weeks 0 days as been shown to be associated with an increased risk of learning disabilities and potential increase in morbidity and mortality. There are clear medical indications for delivery prior to 39 weeks 0 days based on maternal and/or fetal conditions. A mature fetal lung test, in the absence of appropriate clinical criteria, is not an indication for delivery.

Don’t schedule elective, non-medically indicated inductions of labor between 39 weeks 0 days and 41 weeks 0 days unless cervix is deemed favorable.

Ideally, labor should start on its own initiative whenever possible. Higher Cesarean rates result from indications of labor when the cervix is unfavorable. Health care practitioners should discuss the risks and benefits with their patients before considering inductions of labor without medical indications.

American College of Radiology

Don’t do imaging for uncomplicated headache.

Imaging headache patients absent specific risk factors for structural disease is not likely to change management or improve outcome. Those patients with a significant likelihood of structural disease requiring immediate attention are detected by clinical screens that have been validated in many settings. Many studies and clinical practice guidelines concur. Also, incidental findings lead to additional medical procedures and expense that do not improve patient well-being.

American Gastroenterological Association

Do not repeat colorectal cancer screening (by any method) for 10 years after a high-quality colonoscopy is negative in average-risk individuals.

A screening colonoscopy every 10 years is the recommended interval for adults without increased risk for colorectal cancer, beginning at age 50 years. Published studies indicate the risk of cancer is low for 10 years after a high-quality colonoscopy fails to detect neoplasia in this
population. Therefore, following a high-quality colonoscopy with normal results the next interval for any colorectal screening should be 10 years following that normal colonoscopy.

Society of Thoracic Surgeons

Patients who have no cardiac history and good functional status do not require preoperative stress testing prior to non-cardiac thoracic surgery.

Functional status has been shown to be reliable for prediction of perioperative and long-term cardiac results. In highly functional asymptomatic patients, management is rarely changed by preoperative stress testing. It is therefore appropriate to proceed with the planned survey without it. Unnecessary stress testing can be harmful because it increases the cost of care and delays treatment without altering surgical or perioperative management in a meaningful way. Furthermore, low-risk patients who undergo perioperative stress testing are more likely to obtain additional invasive testing with risks and complications. Cardiac complications are significant contributors to morbidity after non-cardiac thoracic surgery, and it is important to identify patients preoperatively who are at risk for these complications. The most valuable tools in this endeavor include a thorough history, physical exam and resting EKG. Cardiac stress testing can be an important adjunct in this evaluation, but it should only be used when clinically indicated.