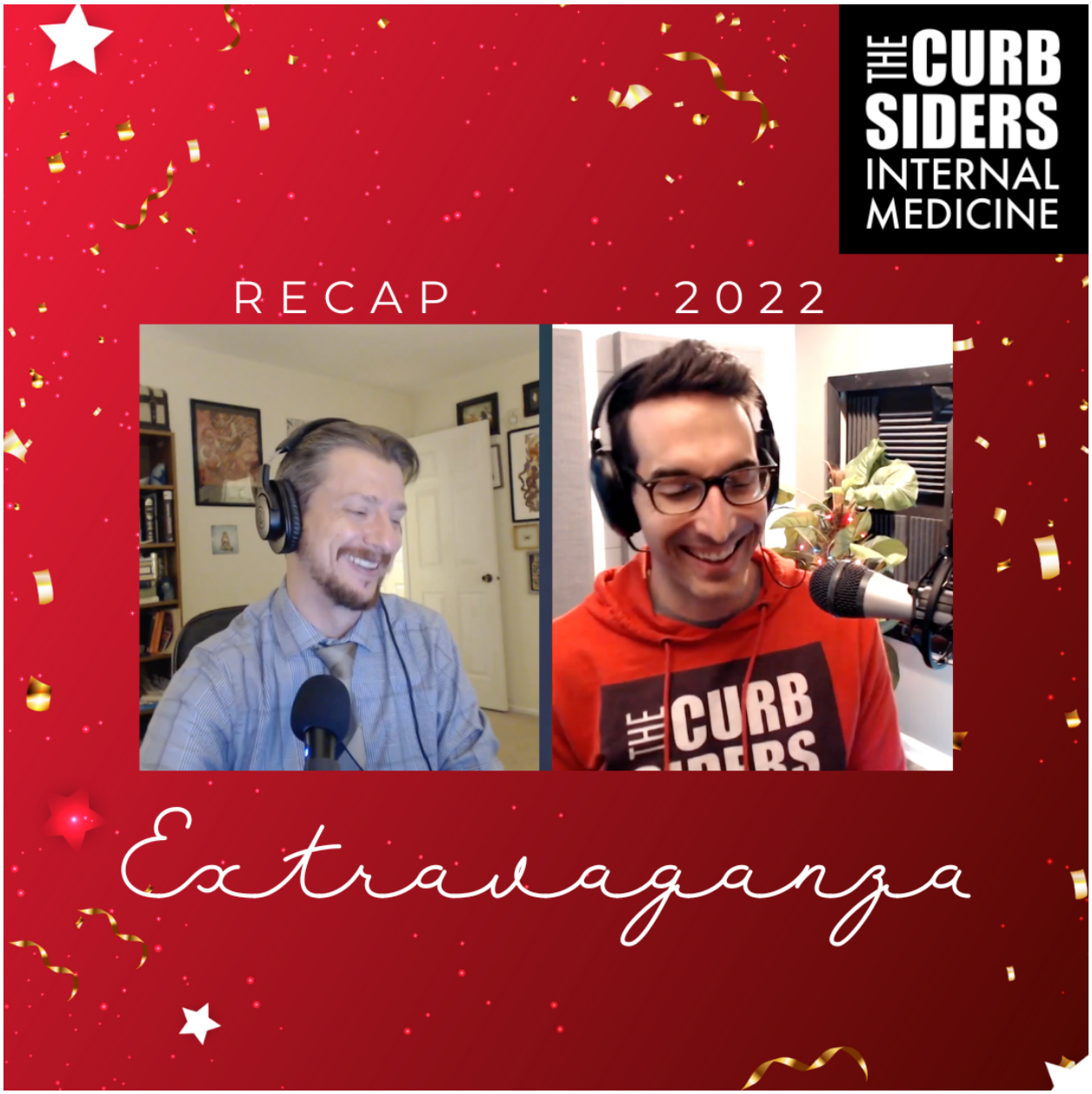
#373 Recap Extravaganza 2022



[Curbsiders Podcast theme]

Matt: So, one, two, three. [claps] Well, Paul.

Paul: [laughs] We you scared my cats.

[laughter]

Paul: Just two black cats shot off into the distance after we clapped.

Matt: Audience, for those who are joining us, this is our recap extravaganza. Paul and I, before we start the recording, we have to clap to sync things for our audio editor and I guess it sent Paul's cat scurrying. So welcome back to the Curbsiders. I'm Dr. Matthew Frank Watto, joined tonight by my great friend and everyone's favorite primary care doctor, Paul, I think we're calling you America's Favorite Primary Care Doctor or America's Primary Care Doctor, it's Dr, Paul Nelson Williams. Paul, how are you doing tonight?

Paul: I'm great, Matt. I think no one is saying that except for you. I don't think this is going to catch on much like a national treasure, but I appreciate the thought. How are you doing?

Matt: I need to just put it in more intros and I think it's going to start to trend on Twitter, Paul.

Paul: [laughs] Well, the way [crosstalk] Twitter is going, it doesn't count much, but we'll see.

Matt: On tonight's show, Paul, we're going to recap a bunch of episodes that aired in 2022, Paul, before we get to that, will you remind people what is it in general that we do on The Curbsiders?

Paul: Sure, Matt, in general. We are The Internal Medicine Podcast. We use expert interviews from your clinical pearls and practice changing knowledge. As you mentioned, this is our end-of-the-year recap spectacular or something along those lines, there's probably some more words in there where it's just basically the two of us talking about these great episodes that already kind of came and went. The experts aren't with us, except in our hearts and souls. We'll be talking about the episodes that really were impactful to us and maybe sharing some of our favorite clinical pearls from each one.

Matt: I should mention that conspicuously absent from this is the great Dr. Chris “The Chiu Man" Chiu. Chiu Man, we love you. This year, we just-- this is kind of a last-minute decision to record this. For scheduling, we're doing it without Chris. Chris conceived of the idea for this show way back like five, six years ago when he first joined Curbsiders. So, shout out to him. He's now spending a lot of time doing The Cribsiders, our pediatric medicine podcast. Paul, before we get to some of these pearls, I wanted to just quickly say a few things. I mean, this has been an amazing 2022. We made about 60 new episodes this year, Paul, which is-

Paul: That's many--[crosstalk]

Matt: -too many.

Paul: [laughs] Yeah, it's a lot, that's a lot of content.

Matt: I think the audience appreciates it, Paul but it's a lot of work.

Paul: [crosstalk]

Matt: We made over 40 hours of CME, Paul, between and that's just this show. If you count the miniseries, it's probably more than 50 hours, maybe 60. We did 24 issues of the Curbsiders Digest, or I should say Nora Taranto, Alyssa Mancini, Alex Chaitoff, and a bunch of other people have contributed to that consistently. Great job by them. The show has now been downloaded, Paul, in the history of the show, over 35 million times. But, Paul because of the rate of growth of the show, has almost 11 million downloads in just this year alone.

Paul: Incredible.

Matt: Which is insane. So, like almost a third of our-- yeah, so I guess we're still growing and it's really still moving, Paul. Sometimes, much to our surprise.

[laughter]

Paul: That just may, what have you.

Matt: I think the reason for that is, Paul, is because we are internists. Our audience are internists, or they're interested in internal medicine. We have questions that are just legit questions that you would have, doing this job every day. I think that's why the show hits home because all the people that make this show are clinicians that want answers to these questions. And that's how we choose our topics. We have 35 team members. These range from medical students all the way up to attending physicians. We have a Slack channel where all of us are contributing ideas. We have people that are doing artwork, infographics, they're writing, producing. They're helping to co-host and edit the show. It's a whole production. Without all their work, Paul, none of this would happen. Because you and I, we are no longer capable of doing this-

Paul: No.

Matt: -by ourselves. I would also like to just say that in the past one and a half years, we've really launched a couple of new shows. We just started a hospital medicine series this year, which Monee 'Got Money' Amin and Meredith Trubitt have been heading up with lots of contributions from Cyrus Askin, Adam Barelski, who often appear as co-hosts on that. With the two miniseries, The Curbsiders Teach that did two seasons, Paul. That's Molly Heublein and Era Kryzhanovskaya, which is I'm getting good at saying that name, Paul.

Paul: Nicely done.

Matt: So, they finished two seasons of that one. The Curbsiders Addiction Medicine, brand new this summer. If you haven't heard it, check it out.

Paul: Amazing series.

Matt: May go over all the addiction medicine topics led up by Carolyn Chan, with friends Kenny Morford, Shawn Cohen, Natalie Stahl, and Katherine Mullins. Kat Mullins helped review a lot of the episodes there. So much exciting stuff happening at Curbsiders. I can't believe Paul, that we started this 7ish years ago at September 2015.

Paul: Crazy.

Matt: It took like six months to get off the ground, but it's going. [Paul laughs] Paul, any thoughts? I know, Paul, you're usually well-spoken. I can't say the same for myself.

Paul: Thanks.

Matt: Any reflections on 2022?

Paul: It feels haunting, like 2021. I will say, as you mentioned, we're both, I don't think we like to admit it, but like, we're like mid-career faculty, pretty solidly now like, we're in the middle of our career. We're screaming towards death is what I'm saying that and I don't know that I have the energy to maintain any kind of expertise or be excited or curious without being inspired by our team, at least in the same way that I am now. I think being surrounded by you and the rest of the team that just are really interested and excited about medicine every single day and are really passionate about things. It keeps me excited, interested. I just cannot, on an individual level, be so grateful to our team and our listeners, and the show for making me care about medicine, because I think it's easy to kind of take your foot off the cast at some point in your career.

In large part, because this show has required, I've been able to continue to pay attention and keep current. I'm very grateful for that. I will also say, and I don't want to take too much time, but the joy of seeing our individual team members continue to progress in their own careers and make these new things, like the new series and seeing even some of our team members kind of go into fellowship this year. There's just been a lot of really exciting transitions and it's great to even perfectly be involved in that kind of thing. It's just been gratifying all the way around. I will lastly thank all the people who are doing those downloads. Maybe it's my mom 30 million times. [Matt laughs] I would like to thank our listeners who are so engaged and so excited and are always reaching out to us and encouraging us and thanking us for what we do and also keeping on us ominous. I'm eternally grateful for the show and for the listeners and the community we've created.

Matt: Yeah, I echo all of that. Paul, it's the New Year, So, not to brag, but I already have, Paul, I already have a date for New Year's Eve.

Paul: [laughs] I hate this so much.

Matt: Yeah, Paul, it's December 31st.

[drum rimshot]

Paul: Great.

Matt: All right. [Paul laughs] If you want to add a drum noise in there, that would be great. Paul, New Year's Eve is a big drinking holiday. [Paul laughs] Right?

Paul: [Paul laughs] Sure. Yeah. That's all I heard.

Matt: Paul, I just worry about you, so try not to make any poor decisions, Paul.

[drum rimshot]

Paul: With a you?

Matt: Yeah, with a you.

Paul: Great. This year, you can't stay poor without you. Excellent.

Matt: All right, [Paul laughs] there's some more, Paul, but if people can check out 33 *newyearspuns.com*, if you want to--[crosstalk]

Paul: That's a dotcom?

Matt: [laughs] Maybe it's a dotcom.

Paul: There's a website devoted just to New Year's puns? Tell me that's real?

Matt: Actually, yes, Paul. You type in any topic and puns, there's a website for it.

Paul: Amazing.

Matt: Yes, it seems that's the case.

Now that we're bleeding listeners, let's get on to our first episode. A lot of these episodes are ones that aired earlier in the year just because we've recapped a lot of the more recent episodes on Tales from the Curbside, so swinging back here. The first episode, Constipation #314. Our guest was Dr. Xiao Jing, Iris Wang, and was produced by Elena Gibson. Paul, one of the main things that I remember from this is that most patients are going to be okay with just like a laxative trial. You don't have to go through all that fancy testing. Every patient with constipation doesn't need a colonoscopy. In fact, that's often not even part of the workup at all. The way that you can recognize patients that have defecatory dysfunction or pelvic floor dysfunction is the patient that says that they're straining a lot and that you need to describe it as doing toilet yoga. They're saying they always have this sense of incomplete evacuation. Those are patients who might benefit from actually pelvic floor physical therapy, or more simply, Paul, the Squatty Potty. I know it's a brand name. If they want to sponsor the show, that would be fantastic.

Paul: [laughs] We are open.

Matt: Paul, the Squatty Potty, any of your patients, are you recommending that? Was this practice changing for you?

Paul: It was not, as much as it probably should have been, I will say that patients have actually come to me and said they tried it and it was life-changing. They volunteered on their own. I think the positioning stuff is incredibly valid and important and easy or at least easier than the pathway we missed down. It's a nice low-key intervention before we kind of proceed all the way to defecography and some of the fancier tests that we might actually have. This feels like a nice immediate first step.

Matt: Yeah, absolutely. I think with the constipation trial of the laxatives, we talked all about that on the episode. Senna and bisacodyl, the PEG polyethylene glycol or milk of magnesia, she

said, are some of the ones. And then Paul, the kiwis, two kiwis a day without the skin. That works pretty well, too. I think that was more of a blockbuster from 2021.

Paul: [laughs] [crosstalk]

Matt: So, we talked about on that episode too, on this episode as well. Any other things about the constipation episode that you wanted to talk about there? I think those were the ones just not missing the defecatory disorder, the pelvic floor dysfunction, which I think is probably more common than we recognize. Any other thing from that one, or should we move on?

Paul: I think so to speak, it is probably time to move on.

Matt: Okay, so #317, erectile dysfunction, this was featuring Dr. Ashley Winter with production by Hannah Abrams and graphics by Kate Grant. Paul, I know you have a favorite pearl for this one, so I want to give this up to you. How will we use this device that I've developed? This is my patented teaching methodology, Paul, if someone has erectile dysfunction, I should not at all worry about cardiovascular disease. There's no relationship, correct?

Paul: Oh, this is pedagogical wizardry. That is actually incorrect, Matthew, this is a tip that we talked about, I think, a couple of times, and I think it's usually important we're talking actually off the air that we both really emphasize this as well. Erectile dysfunction can precede cardiovascular disease or another more scary cardiovascular disease by up to five years. This is something I talk to my patients about all the time, and there's a great body of literature to support this that if someone presents erectile dysfunction, that really should prompt you to evaluate their cardiovascular risk factors. It is a great time to have that conversation about tobacco cessation. It's always a good time for that conversation. It's a great time to emphasize lipid control and blood pressure control and controlling diabetes and really optimizing cardiovascular health, because this might be the harbinger of say coronary artery disease or, God forbid, stroke or something along those lines.

This is your chance to really partner with the patient, to work on things that are important to you both to address all of your concerns. It's a point that I raised over and over again. It's a great chance to have a broader conversation about preventive care and health maintenance.

Matt: Yeah. I did not know these statistics before we did this episode. Now I do have a bunch of patients that are in their 40 to 60 range with erectile dysfunction, and they are not metabolically well, and I'm being more aggressive about talking to them. And this is a good bargaining chip. It gets people's attention, let's say that. I do find it to be helpful in counseling people. The other thing, Paul, every late-night comedy would lead me to believe that if anyone takes sildenafil, tadalafil that they will immediately have an erection, that is a problem for them if they're in a public place. Is that true?

Paul: It's apparently wrong on a couple of fronts, which is reassuring. Dr. Winter informed us that these PDE5 inhibitors, they're only helpful in the setting of arousal. It's not like you take them and then you're walking around with priapism, which is the other point that she made that priapism is actually probably a far less common side effect than we give her credit for, I think. I'm not sure about your practices, Matt, but I was counseling patients about that, about the erections lasting more than 4 hours ago to the emergency department every time I prescribed it. I still mention it, but I'm now much less concerned about it because evidently, it's not nearly the concern that I was worried about.

Matt: Yeah, and that's the big joke. Patients all remember that one, too, because they say it on the TV commercials, and patients are like, "Well, I'm not having any erection, so if I could have one that lasts 4 hours, it doesn't sound like a problem.

Paul: No one's ever, Matt.

Matt: [laughs] Yeah, exactly. She made the point that it's more the injectable medications where that seems like it would be more of a risk factor. Speaking of the PDE5 inhibitors, tadalafil, it wasn't as much on my radar. She was very enthusiastic saying that her patients have had good results if they have both BPH and erectile dysfunction, that the daily tadalafil has been a good medication for a lot of them. I have since used it in a couple of patients and had some success as well. Maybe if people didn't hear this episode, haven't tried that, that does work and it's a good option for those patients.

Matt: Anything else on this topic, Paul, or should we move on to an episode produced by you, #320 Palpitations?

Paul: I love the Palpitations episode. Let's talk about it.

Matt: So, our guest was Dr. Josh Cooper, and production and graphics were by Edison Jyang, and of course, production was helped by Paul Williams. So, Paul, how do you go about deciding when someone says they have palpitations? How do you go about deciding, picking out which type of monitor you're going to get the person, how long they're going to wear for?

Paul: Yeah, it's a golden age, I think you'll agree. I think when we're in training, we didn't have really a whole lot of short-term options. The options that we had were bulky and really, they're like, honest to God best that you actually had to wear, as opposed to now, where you have these patches and devices that kind of stick on your chest and you can kind of set it and forget it that are not so bad. To get to your question, the way that you would choose a device or a monitoring device really depends on the frequency of symptoms. If someone's having symptoms four or five times a day, 24 to 48 hours of like, short-term monitoring with one of those patches is probably sufficient. There are 30-day patches that you can wear, which would certainly be appropriate for someone who has symptoms say once a week or once every couple of weeks or so. For those patients where you're suspicious for some arrhythmia, but it's habits relatively infrequently, but it's also scary.

Like, so, for instance, your patient with unexplained syncope. That's probably more when you're having conversations about the implantable loop recorders, more so than, like, one of the shorter-term monitoring devices. It's just we've got a lot of great options that I think you pick and choose from, largely dependent on how frequently the symptoms are occurring. Is that consistent with your practice?

Matt: Yeah, absolutely. Some of the articles that I was going through and prereading suggested that a two-week monitor is often the sweet spot for-- you'll pick up a lot of things on a two-week monitor. If the patient is having symptoms every day, 24 to 48 hours should be sufficient. I agree with what you were saying. Then the patient that has PVCs, because a lot of the times you'll get this report back, sometimes it won't have been interpreted yet by the cardiologist. If the PVC burden is greater than 10%, those are patients that really should be seeing cardiology electrophysiology because they might need some intervention, because I think they're just more at a higher risk group. The other group, he said, is people with frequent PVCs. If they have underlying Ischemic disease or structural heart disease, those patients as well would be at a

higher risk than say, like, a 25-year-old who's healthy, who has 1% or 2% PVCs, that's not necessarily somebody that needs anything to be done about it.

Paul: Right.

Matt: Paul, has this changed how you talk to people about, let's say someone has, like, AVNRT, like a supraventricular tachycardia, has this changed the way you talk to patients about that? He gave us a couple of options. I don't know if that's changed your conversations at all.

Paul: It is not so much because, to be honest, partially because I work with Dr. Cooper, who's amazing, and if they're at the point that they're having a conversation, they're probably having it with him if we're being perfectly honest. I think after that diagnosis has been made, a lot of the time that conversation is being had with electrophysiology. But it was a helpful framework.

Matt: Yeah. He basically said he gives them three options, he'll say, and I think it's useful to know, like, if you send someone to EP that they'll probably have some version of these three options, which is like, "Okay, if they're having supraventricular tachycardia, the option is or just PVCs, that maybe they're feeling them, but they're not frequent enough 2% PVCs." Not necessarily you have to do anything. But If it's bothersome to the patient, they see cardiology, cardiology may say, "Well, we could do nothing. You could just know that you're going to get that or we could try putting you on a medication, like a beta blocker or something." Or, option three would be, "We could try to do an ablation or take you to the lab for a study and see if we can figure out where this thing's coming from." It's kind of a shared decision with the patient and the electrophysiologist at that point.

Paul: I think the success rate for the ablations, especially for the SVTs, is extraordinarily good, if I remember correctly, depending on who you ask, but we're talking upwards of 90%, so if you choose to go through it, I think those procedures are fairly effective.

Matt: The other thing that surprised me that Dr. Cooper said is that because I asked him about the wearable devices, just expecting that he'd be like, "Oh, those are the bane of my existence," he's like, actually, I don't mind them. He goes, if the patient has that, they can print out the rhythm and they can show it to me. I can either say, "Oh, this is junk, or it might be some useful information." I think that's an interesting area we're going to get into. I think we will know more precisely when people are having arrhythmias I think going forward. I imagine cardiac monitoring is going to be pretty standard for probably lots of people because most people are wearing smartwatches.

Paul: I think we'll touch on this in a different topic, but I also appreciate that we should not be dissuading patients from being invested and interested in their own health. I think if someone comes in, we should not be dismissed or be like, "Oh, that dumb thing." I don't think that's a helpful way to frame the discussion, especially since someone's being an active participant in their own health, I feel like it's good to be open to that and use the tools that they're bringing us.

Matt: The next episode is another cardiology topic number #321 Hypertension some frequently asked questions. This was featuring Dr. Jordy Cohen with production and graphics by Malini Gandhi. Malini Gandhi, Paul, breakout star on the show this year, Wizkid. [crosstalk]

Paul: One of my many future bosses. But, yeah, I look forward to working under her benign reign whenever it happens, which will be just a matter of time at the point.

Matt: [laughs] One of the things that just stuck out of my head as she described this casual office blood pressure, which is where the patient is, like, sitting on the exam table, so there's no back for them to rest against. Their feet aren't on the floor. And the blood pressure reading there. Maybe they're talking to the MA as the blood pressure is being taken. We don't base our blood pressure targets on blood pressures that were measured that way. Those would not stand up for a clinical trial and really making sure that you're getting good blood pressure readings before you're making changes. Paul, how are you getting blood pressure readings outside the clinic? Are you rechecking them in there? Give the audience some tips.

Paul: Great question. Everyone's practice flow is going to be different. I think we often offload much of prework on our medical assistants since our frontline staff. I think patients are going to be talked to other getting the blood pressure because we're just giving our medical assistants and other support staff a lot to do. I just think it's just the way things are optimized. I think the casual office blood pressure is going to be a fact of life because what we do is relatively high volume. To get around that my practical technique in the office, I will look at the reading, and frankly, if it's normally tensive, I'll say "Shoot, that's good," and then I really don't worry about it so much. If it's elevated, I'll have my visit, we'll have the conversation, we'll talk about the plan and then my move is, "All right, I'm going to go get your papers and get some things together. What I like you to do is please make sure that you have your arm out of your sleeve and I'd like you to sit there quietly. Do you need to use the bathroom? No. Okay, wonderful."

I use the end of the visit after I know they've been sitting and talking like I know they've been sitting peacefully; they haven't been moving around and give them a chance to kind of equilibrate. I'll go, get the paperwork together, come back and do a recheck myself with their feet supported, with their back against the chair, with their arm at heart level, not talking and really give myself my best chance. Outside of the office, we talked a little bit about this. I think you probably do a better job with the than I do. I think we're starting to appreciate the role of home blood pressure monitoring or out-office blood pressure monitoring.

A liberal use of cuffs which are not frequently covered by insurance but aren't usually probably expensive and there are websites that you can look at to actually find ones that are decent and do a little counseling about when to take it and how often. I will tell patients first thing in the morning before they eat, after they empty their bladder, before the cigarette. And the same rules apply. Make sure that you're seated, make sure that your feet are flat on the floor, make sure you're back supported, don't let anyone talk to you. If you can do that a couple of times a week, that's great. If you can do it twice a day, first thing in the morning and after dinner, that's even better. Or before dinner, that's even better still. More often than not, if I get just a few sporadic home readings, I'm still happy. It sounds like you have a better success rate in terms of getting your patients to do, home blood pressure monitor.

Matt: I give this similar counseling. Dr. Cohen said she likes to get six readings over the course of a week, at least six readings. I usually ask patients, check it once or twice a day over the next week, and send me at least six readings. If you have a patient portal that works, a lot of my patients will send me the readings through the patient portal, and then I can message them back whether or not I want to make any changes to their pressure or if I need to call them. You can also set reminders in the chart because, especially if I'm really worried about someone, I will sometimes set a reminder. Remind me in a week to call this person, so I make sure they get their blood pressure readings, because it was, like, too high for me to be comfortable that they just go home.

I didn't want to send them to the ER, but I want to make sure that I closed the loop on that. So those are some tips. But, yeah, I do think home blood pressure monitoring is great and *validatebp.org* is a website where people can go to look and see which cuffs are recommended by the experts in blood pressure.

Now, Paul, for me, I want to tell you one thing that changed my practice, then I want to ask you something else. The low-dose combination pills, those were upfront in the International Society for Hypertension Guidelines from, I believe, 2020. Dr. Cohen said she's also a fan of those because the low dose combination, you're less likely to get side effects, and also, better chance that you will hit the mechanism of their hypertension if you give them agents that work by different mechanisms. So, I like that and I've been using a lot of the low dose combination, and usually, your choices are they have the calcium channel blockers diuretics or ACEs or ARBs in combination pills. Now, Paul, I know it's easiest to get a combination pill probably with an ACE inhibitor and hydrochlorothiazide, and that's okay. Paul, why is an ACE inhibitor not your first choice?

Paul: I love that framing. Thank you for setting me up, Matt. I will say I do struggle with the combinations because they don't tend to include ARBs as commonly, and ARBs are my first-line choice if we're talking about either ACE versus ARBs. I think most recently there's a meta-analysis this year, I want to say that actually combined that they looked at both the benefits of ACEs versus ARBs compared to the potential harms, and it turns out that ARBs do all the things that ACEs do. Like, they are renoprotective, and they help with systolic heart failure, and they do all the stuff that we like. They are great for patients who have diabetes and on and on and on. We know these things. ARBs tend to have a much more favorable side effect profile compared to ACEs, so you're not going to see angioedema nearly as much. You're not going to see a cough. I think cough is, astronomically lower with ARBs than are there with ACEs.

GI bleeding, which was nowhere on my radar, is less common with ARBs than they are with ACEs. I think given the choice, I'm going to go ARBs 10 times out of 10. I think even for most of the guidelines you're allowed to use the first line. I reach for much of the time when I have the option, but unfortunately, they're not really available in many forms, at least on formula is that I deal with in combination.

Matt: Yeah, there are some ARB calcium channel blocker combinations that I've been using. Telmisartan-amlodipine is one of the ones out there. I know Dr. Cohen said there's an olmesartan amlodipine version that she likes. There's a lot of them out there that you can try. One of the other things, she differentiated, and we're going to spend a little more time on this one because it's such a common topic. Losartan, Paul, this was something I really thought all the ARBs were created equally. I didn't really differentiate them. She gave us a couple of pearls about that. So, what about losartan? How should we be dosing that?

Paul: Yeah, so losartan, again, I'm sure this varies by geography, but it's the one that's invariably available and covered by most insurances, so it's the one I tend to reach for. And then Dr. Cohen is kind of casual throw at there, but that really should be a twice-daily medication, which immediately made me feel stupid. I am now actually being more for patients that I think it can be adherent with it, I'm now actually prescribing it twice daily when that's the ARB that I reach for because it does tend to have more consistent coverage over the course of the day, and it is what people can also afford. Losartan is now probably one of my preferred ones. Valsartan has some availability, but it tends to be less potent. The longer acting ones, I think,

are very formulary dependent in terms of, like, the telmisartan and olmesartan and that kind of stuff. What are you reaching for when it's ARB time, Matt?

Matt: No, I run into the same thing. Valsartan less potent, but it is long-acting. It tends to be cheaper and in combination with hydrochlorothiazide, that's one of the ones you can get. Losartan or valsartan are often the workhorse ones. You just need to know that for patients, some patients might need a more potent one and some patients might need twice daily dosing of the losartan, especially if the once daily is not cutting it, especially if they're on the 25 milligrams, the lower dose losartan, I will often add that second dose--[crosstalk]

Paul: Just increase it twice daily?

Matt: Yeah. We talked about CKD4, because once the EGFR drops below 30, I'd get very scared about prescribing ACEs, ARBs, diuretics. I was thinking, thiazides won't work, so I have to use loop diuretics. And Dr. Cohen really opened that up there. She actually encouraged us. She said, "Actually, ACEs and ARBs can still be protective and help prevent the progression of renal disease." So, you can still use them in patients with CKD4. You do have to watch for that bump in creatinine. If it goes up more than 30%, you have to worry about bilateral renal artery stenosis and maybe it's not a great choice for them. The other parameter was potassium up to 5.5, she was okay with. But you really do have to monitor the creatinine, the potassium, and make sure that you're not having any wild swings there. The other thing, Paul, the CLICK trial that was with chlorthalidone.

Paul: Yeah.

Matt: Have you used chlorthalidone since that in any patients?

Paul: I am now more liberal with chlorthalidone in my more advanced CKD patients. I think we talked about this a fair amount, and I think that traditional teaching was just not as effective in patients with more advanced chronic kidney disease. It turns out that it seems to work just fine. It doesn't actually cause problems. It's nice to have a medication with which I have comfort for that patient population that often has harder-to-treat hypertension, so I do. I still respect chlorthalidone. I think like we talked about with Dr. Joel Topf years ago, I still tank potassium is you really have to watch the electrolytes and stuff pretty carefully with it but it is-

Matt: Absolutely.

Paul: -effective for patients with CKD 34.

Matt: Yeah. Before you reach for hydrazine, think about [Paul laughs] ACEs, ARBs, chlorthalidone in your patients with CKD.

Paul: Just put the--[crosstalk]

Matt: Yes.

Paul: -for a hot minute and you'll have options.

Matt: Yes. I thought that was all really great. The final point I wanted to make on this because we talked about resistant hypertension, and I do tend to see a lot of patients where they have this, I'm worried about primary hyperaldosteronism. I order an aldosterone and a renin, and the

renin comes back suppressed but the aldosterone is like, normal or even low in some sense. She mentioned this concept of salt-sensitive hypertension. Some of the agents you might want to use, Paul, have you used any of the mineralocorticoid or amiloride since learning this?

Paul: I am more likely to reach, in general, for spironolactone. That seems to be my go-to-ish choice. It's one of those things where if you've not prescribed something frequently, you're less likely to reach for it, so amiloride is not one that I'm just gunning for, though. God help us, the nephrologists are really trying to talk us into using it.

Matt: They are.

Paul: [laughs] It'll come one of these days. But I do reach for the MRAs. If I suggested someone hyperaldo, which as we've talked about before, is probably far more prevalent than we give her credit for.

Matt: Yeah.

Paul: Matt, when you're looking for it, though, what kind of investigations are you looking for, and what kind of parameters get you excited these days?

Matt: We have an adrenal episode coming up, and we're planning a NEF Madness episode, which may cover mineralocorticoid receptor antagonist. I'm still working this out because I generally look for an aldosterone above 15. Certainly above 20 would get me concerned for primary aldosteronism and a renin that is suppressed or undetectable. That's what I look at more so than the ratio, because the ratio, as was mentioned to us on a way, way back Curbsiders episode, there's certain renin assays, so you have to make sure, depending on the renin assay, that could affect the ratio. It's better to interpret them together, but not necessarily look at the ratio. So that's what I'm doing. That's the best answer I can give you for now, but I'm excited to learn more about this on some of our upcoming episodes.

Let's leave hypertension, and I think we can get on to H. pylori, this is Episode #322 with George Saffouri. This was produced with graphics by Beth Garbs Garbitelli. This was actually pitched by a listener in our "listener pitch contest," Paul, which happened way back. Ana Maria, Keilhauer Varona. And Paul, before you test people for H. pylori, I want to make sure patients are not taking proton pump inhibitors, not taking antibiotics, and if they can get by without them, even H2-receptor antagonist, Dr. Saffouri mentioned, reading about it. Some people say it's okay. His practice was he's like, "I'm not sure." Some of the literature has suggested maybe it's a problem, so he doesn't like to do it. At least one to two weeks, they should be off all these medicines, but a lot of the guidelines would tell you at least a month off antibiotics, H2-receptors, antibiotics, and PPIs. And then, Paul, are you confused about which regimens to treat for H. pylori? I mean, it's kind of dizzying.

Paul: Matt, I hate to say it, but even if we did 27 episodes about it, I would probably still have to look at the doctor up to the algorithm just to make sure I'm actually picking the right one. I will forever find it bewildering even though Dr. Saffouri did a great job of teasing things out and talking about what she uses preferentially, what's okay. It's something I'm going to have to look up every single time, because there are certain facts that I can't make sick of my brain, and this, unfortunately, is one of them.

Matt: Yeah. Let me give the audience if you're seeing some with H. pylori, just don't start with the clarithromycin-based triple therapy. I mean, there's lots of resistance to that. That's not

recommended anymore by the guidelines or by Dr. Saffouri. So, what Dr. Saffouri mentioned was that there's this Bismuth-based quadruple therapy. It can be tough for patients to tolerate, but that's often the first line that he's going for. If that doesn't work, the next line that he would use is often levofloxacin-based therapy. There was some other, we talked about this a little bit, Paul, at one of our ACP recap shows where actually levofloxacin did seem to perform well there, too. There are some newer things coming out in the future, so rifabutin-containing therapy, Paul, I probably won't be prescribing that without conferring with one of my gastroenterology colleagues or-

Paul: Yeah, or IDE even.

Matt: IDE colleagues. And then there's this new agent. It's potassium, let me bring this. I don't want to mess this up. It's a vonoprazan, it is a potassium-competitive acid blocker. It competitively inhibits the binding of potassium ions to the hydrogen potassium ATPase, also known as the proton pump, and can block that final step of gastric acid secretion. So, that actually seems very promising. It's a new therapy, apparently, they're already using it in Asia because I think probably H. pylori being more common there. They're running out of regimens faster than we are.

Paul: Yeah, it's true.

Matt: So, look out for that, this vonoprazan. Finally, there's a reverse hybrid therapy, Paul.

Paul: I'm so excited about this just because of the name. [laughs]

Matt: I just love the name. Reverse hybrid therapy is where you give a PPI and amoxicillin for 14 days, but on the second half of that 14 days, you add in clarithromycin and metronidazole, and apparently that works pretty well. So, lots of options out there. The last thing I'll leave you with on H. pylori, Paul, is don't forget to retest. You want to test for a cure, because if H. pylori goes untreated, there's a risk for gastric cancer and you really want to treat the patients, and especially if they were symptomatic from it.

And Paul. Next up, #324 Obesity featuring Fatima Cody Stanford, and production and graphics by Isabel Valdez, and Maddison McLellan. Now, Paul, correct me if I'm wrong, but obesity, it's not a chronic disease, [Paul laughs] and there's no way-- it's not something that we should think about chronically prescribing medication for. What do you think?

Paul: I think that is probably not the right way to think about it, as we've talked about before. I think that you've actually said far more relatively than I have, I think you could characterize it and conceptualize it as a chronic disease state, particularly when there are metabolic consequences. I think that's always the important thing to remember, is we're trying to prevent those things from actually impacting health. So, yes, that's right. Oftentimes for chronic disease states, you need chronic medications and chronic therapies above and beyond behavioral changes. I think that's probably the way they frame the discussion for a lot of the patients will be talking to recognize that we're trying to prevent downstream metabolic effects that may ultimately be harmful.

Matt: The medications we talked about in this episode where we didn't talk much about GLP-1 agonists or the new fancy GIP/GLP-1 agonist, tirzepatide, which is probably going to be approved at some point, but is not yet FDA approved for obesity. It's not yet FDA-approved for obesity. I looked just before we came on, there's a fast-track application, and probably sometime

in 2023, the second surmount trial is going to finish, and they're expecting that will have enough data for them to get it approved for obesity. I believe it's already approved for type 2 diabetes.

Paul: Correct, that's right.

Matt: I know we've been getting calls from patients asking about that because it's--

Paul: Oh, wow.

Matt: These agents, the GLP-1 agonists and the GIP/GLP-1 agonist, they're in the news because I think celebrities are taking them more for vanity reasons than for obesity, health-[laughs]

Paul: For health promotion and--[crosstalk]

Matt: -health-related reasons, at least a lot of them. They are in the news, but we focus more on some of the lower-cost generic medications. There are some of these combination pills that are branded medications for obesity, but Dr. Stanford said she actually likes to prescribe them sequentially. She'll prescribe one of the agents at a time. So, Paul, do you want to talk about any of those agents? How about phentermine? Because this is one that I've always been afraid of.

Paul: Yeah, same. I mean, this is probably the part that's been most practice-changing for me. There's good evidence for phentermine, and actually, patients do well on it, but I've always been squirrely about its potential impact on blood pressure and heart rate. Those are always the things. Again, as we talked about before, if you don't prescribe something often, you're less likely to prescribe it, and that just perpetuates itself. But Dr. Cody Stanford let us know that actually the risk for hypertension and for I think even tachycardia is higher with bupropion, which I will prescribe with wild abandon.

[laughter]

Paul: [unintelligible [00:40:12] Well, that's the case, and I can be much more comfortable prescribing phentermine. You should still watch. Like, I don't know that we give it to someone who has really uncontrolled hypertension. Certainly, I'm not sure I would prescribe to someone who couldn't come back for follow-up blood pressure checks, or at least if I didn't have a way to kind of monitor parameters and just make sure they were doing okay. Especially if you can monitor and then, especially around dose increases, that's probably the most important time to kind of check-in. It's probably less impactful than bupropion, which I think a lot of us do have comfort with. I personally change my own habits, and that much. I don't fire off the topiramate all that, to be honest with you.

Matt: If someone has migraine headaches and obesity, it's a good choice. As long as--[crosstalk]

Paul: Yeah, for sure, absolutely. [crosstalk] I do find the side effects from that are actually more bothersome for patients than for phentermine.

Matt: Yeah, I have used so there's phentermine-topiramate. Those come in a combination but she says she usually will start one or the other and then titrate up, see how the results are, and then she may or may not add the second one, but she's prescribing two generic pills instead of

the branded combination. The other branded combination is bupropion and naltrexone. Again, she said she prescribes bupropion up to she might give 150 twice a day, and then she might add a second 150 in the morning, so 450 total daily. For naltrexone, she said she actually asked the patients to cut the pill into quarters and they'll take a quarter of a pill twice a day and then eventually half a pill twice a day. She taught us how she goes up on that. So, these are just some options. She even said metformin is sometimes she'll try and for some patients that does seem to help them with weight loss.

These are just other tools you can use because not everyone's going to be able to afford or access the GLP-1 agonists or metabolic surgery, which is, using her analogy, lifestyle, diet, and exercise, are like using a teaspoon to shovel your sidewalk if you have snow on your sidewalk. If you're from the Northeast, like Paul and I, she said that the medications are like using a shovel to clear snow from your sidewalk or your driveway. The metabolic surgery is like using a snow plow to clear snow from your driveway. It's looking like as we get some of these more sophisticated agents, the medications may be more closer to approximating metabolic surgery, which is exciting.

Paul: The newer data are really remarkable, and I have a couple of folks just describe it like, "Life changing." So, they're nothing.

Matt: I think we're going to get to a point, Paul, where like with blood pressure, like with diabetes, the vast majority of patients, once they start medications, they will need a chronic medication to help control the condition. Thinking of obesity with the chronic disease model, they may need to be an agent for the unforeseeable future. I think that's something that we need to wrap our heads around as do patients, and we need to do a better job about talking to them about therapies beyond just the diet and exercise which are not really cutting it for most patients.

Paul: I do think, I'm not sure what your thoughts on this, but I think even having a discussion about medications or metabolic surgery just also shows that it's something that we are concerned about and think that it is worth discussing. Diet and exercise often feel pro forma as a discussion with it be like, okay, I think we should actually consider medication or to have a consultation with the surgeon that seems to at least highlight like this is something that we should continue to discuss, that I think is important and I think that's even valuable in just that.

Matt: Paul, up next, #326 Cardiorenal Syndrome. This was a NephMadness episode. This is part of our NephMadness PodCrawl, Paul, and I think we're going to do another PodCrawl for NephMadness 2023. So, let's tease that now, we've been emailing Joel. So, a little behind the scenes for people.

Paul: Looking forward to failing just aggressively in the first round. Just like wiping out of my brackets immediately and not weighing anything. It's a fun yearly tradition for me at this point.

Matt: Yeah, NephMadness is great. So, audience, keep your ears out for that one. So, the cardiorenal syndrome, Paul I was a physiology major in college, and so, I love this stuff. Elevated venous pressure and venous congestion are actually believed to be the pathophysiology of cardiorenal syndrome, because I had always been taught, it was poor forward flow was the cause of cardiorenal syndrome, but it actually seems like it's venous congestion. Which makes sense that we spent most of the episode talking about diuretics and how to get the volume off of the person.

Paul: [laughs] How to decongest, yeah, absolutely.

Matt: How to decongest. So, Paul, let me give you a hypothetical. If I'm admitting someone to the hospital, they have heart failure, their creatinine is up a little bit. I should always stop the ACE, the ARB, the SGLT2 inhibitors that they're on for their heart failure. What do you think of my practice there?

Paul: I think that your practice would be consistent with what a lot of people would do. I will say that our experts did not think that they need to be stopped necessarily, as long as the patient wasn't hypotensive, they weren't hypertrophic, and didn't have electrolyte disturbances that warranted discontinuation. I think the prevailing wisdom right now is it's probably okay to continue those things as long as those parameters are okay. Yeah, I think in actual practice, I wouldn't be surprised. A lot of people are still stopping them relatively routinely just to make sure they have room to do other stuff.

Matt: The key point is they need to restart them when the person leaves the hospital.

Paul: [laughs] Yes, right, but it's important to- [crosstalk]

Matt: I think that was a big risk.

Paul: -continue fully directed medical therapy, you're [crosstalk] guideline directed.

Matt: Yeah, we did talk about on the episode, this concept that when someone is volume overloaded, they're expanded as you use the diuretics, you're doing your diuresis. You may see this bump in creatinine. Part of that may just be that you're removing the fluid, and that is their--you're unmasking what their creatinine really is. That's this concept of permissive hypercreatininemia, which is hard to say, and we spend a lot of time talking about-- people often are getting discharged too early, probably, or we're stopping too early because you start the diuretic, you start to see the creatinine rise, then you go, "Oh, I'm done." You really have to say, "What's the exam like?" "How's the patient feeling?" "What's their weight?" All these parameters we have for saying, "Am I done with the diuresis?" Creatinine should not be your only parameter. If the creatinine doubles, yeah, that's one thing. Consult your friendly neighborhood nephrologist, but if it goes up by 0.2 or 0.3, depending on what they're starting from, you can have this concept of permissive hypercreatininemia. And don't under-diuresis your patients. I think that was one of the big take-home points from this episode.

Paul: Right, because otherwise, you send them home, they're not entirely decongested. They go back on their standing dose of diuretic, which is not to diuresis, but just to maintain. They are kind of slowly re-accumulate. Next thing, you're seeing them all over again. Better to get them as dry as you can.

Matt: Way back when we talked to Dr. Clyde Yancy about HFpEF Paul, remember he made a comment on the episode that has stuck with me. He said, "Yeah, when patients are in this congestion when they're in congestive heart failure, you really want to shut that cycle down as fast as possible because there's bad stuff going on." I don't know if he used the term negative remodeling or just inflammation, but just he said, "You want to get them out of that cycle as quickly as possible so they can recover. The longer you leave them in it, maybe the more damage is done in the long term." I think about that when we're treating heart failure.

Paul: Just relevant, not that we talked about this in the episode, actually, I can't remember if we did it or not. The other insanely, impressionate thing that Dr. Yancy had said was about the SGLT2 inhibitors. Do you remember this, Matt?

Matt: Yes.

Paul: Where he talked about, and this is years before these trials came out, and before this was anyone at his radar. He said, "I think at some point we're going to stop seeing the diabetes medications that have a cardiovascular benefit and start seeing them as cardiovascular medications that maybe help the blood sugar a little bit." I feel like, I'm not sure we're entirely there yet, but I think we're recognizing increasingly just how these are for things other than just diabetes, including sequential dialysis and that kind of stuff.

Matt: And this was totally an accident. They were just trying to make sure they were safe for the heart, and they found out that they were actually very good for the heart. You mentioned sequential nephron blockade. What does that mean? Well, we covered one of these episodes on a Hotcakes episode. We covered acetazolamide as helping to complement the diuretic therapy you're giving. Other things you can do are SGLT2 inhibitors, mineralocorticoid receptor antagonists like spironolactone and thiazide diuretics, of course, I think most people are familiar with those. So, think about that. Then, Paul, we even talked about this concept of hyperhidrosis where as like this Hail Mary passed. If the patient is just refractory to all the diuretic therapy you're giving, you actually can give them hypertonic saline along with your loop diuretic because apparently that giant load of sodium can shut down the renin aldosterone angiotensin signaling somehow, and maybe it even pulls water from the interstitium and helps the patient diuresis. I'm not going to try it, audience, [Paul laughs] but ask your friendly neighborhood cardiologist, nephrologist if they have the guts to do it and report back, please.

All right, Paul. #329 Curing Hepatitis C was the name of this episode with Dr. Christian Ramers. Production by Emi Okamoto and graphics by Lyan Chang. Paul, I wanted to ask, so if, let's say I was hypothetically seeing a person who injects drugs and they have hepatitis C, should I offer them treatment for hepatitis C? Because I'm worried about reinfection, which I know is a possibility. How should we handle that?

Paul: Great question, and I think you're even framing it from a less puritanical standpoint than I think it was often discussed in the past, like, why would I treat with these expensive medications if there's a chance this patient may become infected again? I think was the unkind and not accurate way that it was thought of before. I think people are recognizing. It's better to be not infected with hepatitis C [chuckles] [crosstalk] that you are, the better off you will be. Also, from a public health standpoint, the fewer people that are out with active hepatitis C infections who maybe are sharing needles or have a higher risk for for infection, it's better to have that population with a lower rate of hepatitis C in general. So, it is not a contraindication. In fact, nay-nay I would say there's probably an even stronger indication to offer treatment. I think for someone who injects drugs who does hepatitis C, they should, in the absence of other contraindications under semi-offered treatment because it also is absurdly easy compared to back when you and I were in training.

Matt: Since the hep C antibody can remain positive for life, how are you checking for reinfection, and how often?

Paul: Yeah, I think, and I can't remember whose recommendation this is at this point, but I believe it is to check a viral load on a yearly basis and patients continue to inject drugs who've had to treat it for hepatitis C, but I'd have to confirm who said that for sure.

Matt: One of the other things that I thought was just important for us to remember as internist seeing patients with hepatitis C is when you find someone that has hepatitis C, so you're ordering the hep C antibody with the reflex to PCR. If that PCR is positive and you confirm they have active viral copies or they have a high viral load, then you're going to want to stage the liver. Or I guess even if they don't have an active infection, you would still want to stage the liver. And what do we mean by that? There are some calculators you can use. There's the FIB-4 calculator, or the pre-calculator, which uses some lab tests, which you would just readily have available.

Paul: Right, [crosstalk] we should probably have anyway.

Matt: Those are very good at identifying people who are at low risk for fibrosis or people who are at high risk for fibrosis and cirrhosis. At the intermediate risk, they don't perform as well. Sometimes you might want to get elastography, which can be done with an ultrasound-type thumping machine, which we've described on other shows, or there's an MRI version of it. Then, Paul, I believe there are also some proprietary tests you can order, like blood tests.

Paul: Yeah, I think there's a FibroSure and a FibroTest. They all have fibro in the name, but I believe it's a combination of liver enzyme tests and inflammatory markers that they use to calculate a potential degree of fibrosis as well. You get this report that kind of gives you F0 through S4, and we'll characterize the degree of supposed fibrosis that is helpful and then also accepted by most insurance companies in terms of as you're navigating the prior authorization process for these medications.

Matt: Most of the patients are avoiding liver biopsy these days because of all this testing that we just mentioned. If you do find someone that has cirrhosis or you're worried about cirrhosis based on these tests, these are people you should be following for hepatocellular carcinoma, doing the ultrasound and plus-minus the AFP testing. So just remember to do that. Even after you've treated the patient for hepatitis C and cured them, you still would need to monitor if there's someone that has cirrhosis. That's mostly what I wanted to go through on this one. Paul, any other pearls on this topic before we move on? I know we're coming toward the end of the pearls here.

Paul: Yeah, there's a lot to say. I will say it's much easier, and I would just refer our listeners to the-- gosh, correct me if I'm wrong, the AAFLD and IDSA algorithm, is that right? [crosstalk]

Matt: AASLD.

Paul: AASLD. Thank you. IDSA simplified treatment algorithm. There's both with and without cirrhosis. It is one page that tells you really all you need to know that will actually get approved by most insurance companies. I will say we're talking at least, for me at least, but I'm not sure what your practice says but this is for the treatment of naive patients. If someone has higher treatment and then it needs retreatment. At that point, I will probably cheerfully have them see our colleagues, hepatology, or more likely infectious disease. I just wanted to make that point, clarification too.

Matt: Yeah, so let me give you the list for people who would qualify for simplified treatment or people who don't have cirrhosis, HIV, hepatitis B, they're nonpregnant. And, of course, they don't have hepatocellular carcinoma or liver transplant. I think most of us would just know to get other people involved with those patients, but just saying it out loud. Now, Paul, the last episode we were going to talk about, was USPSTF episode #345, talking about the vitamin and mineral supplementation recommendations. Now, Paul and our guest again was Dr. Michael Barry, who was also on our colon cancer screening episode. Of course, this was produced by Paul Williams with the great Elena Gibson helping to produce and coordinate and do the graphics. She's fantastic and thank you to her for all the work on those USPSTF episodes. Paul, correct me if I'm wrong, but I should just take as many vitamins as possible.

Paul: [laughs] Important always to think about who these recommendations are for, Matt. I don't know your medical history. We don't talk outside of work. [Matt laughs] This is specifically for people-- We're talking just for preventative, not for people with deficiencies or actually have a specific need for certain vitamins. I just want to say that point first. I will say for you, if I'm assuming that you're as healthy as you look, which is pretty healthy, you're probably not someone who's going to benefit from vitamin supplementation. There are a couple that seems to actually have known harms associated with them. Specifically, I believe it's beta carotene and vitamin E actually are associated with some worse outcomes. By and large, the data seems fairly wishy-washy for most stuff and it's just not going to make any real difference to you other than cost you a fair amount of money. I think that's worth noting.

The point that I really liked from this episode specifically was Dr. Barry framed this is not a way to tell patients to not do something. This is a way to have a conversation about all the things that we have available to us that can help preserve health and can actually help keep you feeling well throughout your life. Things like screening for hypertension, things like screening for diabetes and treatable infectious diseases and depression, and substance use on and on and on.

Matt: Getting them to sleep.

Paul: Yeah, exactly. All of it. There's so much that we can talk about that can keep you healthy and feeling good for the rest of your life. Even though this might not be the best way to do it, we have plenty of options to kind of optimize your health. I think framing that conversation that way, rather than just shutting the door was practice changing into itself for me. I just thought that's just a fabulous way to think about it.

Matt: Well, Paul, we've done some great work here. Upcoming in 2023, we have some really fun episodes. ADHD, adult ADHD, delirium, acute COPD, exacerbations, adrenal incidentaloma, that's been much, much requested topics. Hemochromatosis, Paul. As I said, there's another NephMadness coming. Hearing loss and tinnitus. Lots of great stuff, Paul.

Paul: Matt, I'm going to do it. Are you ready for this? This is Babe Ruth. I'm calling my shot. We don't have a guest lined up. I'm committing myself to hematuria this year. We're doing [Matt laughs] [crosstalk] urine. I don't have a guest. I don't have a script. By God, now I have to do it. So, we're going to make it happen. So, something else looking forward to.

Matt: Should I call one, too? I want to do a hypercoagulable workup, Paul. I'm going to produce that,

Paul: Oh, I love it.

Paul: All right. I'm excited.

Matt: I keep seeing people get this hypercoagulable work up. I want to find out when I should really do it.

Paul: And what do you do with-- [crosstalk]

Matt: Now, Paul, let's each leave the audience with a Pick of the Year. So, Paul, I know you have a pick of the year. No, you go first.

Paul: [laughs] Sure. It's something I picked before, which I guess is the idea of this. My pick of the year, because it's come up a bunch of times, is actually the 1991 David Cronenberg movie *Naked Lunch*, which is a science fiction kind of pretend biography of William S. Burroughs, but also based on the book by William S. Burroughs. It's this mélange of this person who kind of descends into addiction and madness after inadvertently murdering his wife. I feel I'm not selling it well, but the whole thing is so well-acted and atmospheric. The soundtrack is incredible. It is Peter Weller who is incredible in it as the lead character, William Lee. The whole thing, basically, it just feels like you're descending into madness with this person and there's talking typewriters. It's a beautiful, incredible movie that really makes you think, especially if the backstory of William S. Burroughs and have read *Naked Lunch*, which is not I would recommend, but I saw it in theaters the first time because it's a really important movie to me to actually play on the big screen near me. Huge.

I bought the Criterion Blu-Ray. Gorgeous, beautifully rendered. Matt. I'm going to share a peek behind the curtain. It was nice enough to get me a birthday present of a t-shirt from the movie, which is now my favorite article of clothing. It's been the year of *Naked Lunch*, so my Pick of the Year will be that very specific niche thing that no one is going to like it.

[laughter]

Paul: *Naked Lunch*, the 1991 David Cronenberg movie.

Matt: I'm very intrigued to watch this movie now. Now, Paul, my Pick of the Year is not a real pick of the year by your standards, [Paul laughs] but I just wanted to say, I had some tough times in the past few years, Paul. One of the things that have kept me sane, especially in this past year and I think dramatically increased my happiness. I have really been serious about my bedtime, and my wake-up time. Every morning I have a very strict morning routine. I wake up, I go for a two- or three-mile run. It doesn't take super long. I make coffee, I read something, and it's a great start to the day. Start the day with just a very peaceful, quiet run. It's often in the dark. I have one of those LED headlamps, and I would recommend that to the audience. Make some time. It doesn't have to be in the morning if you're not a morning person but have some time each day where you're just like you get to do what you want to do. That way you don't feel like you're just getting stuff thrown at you and drowning in emails and patient phone calls and all these things that we deal with in life. That was my Pick of the Year, Paul, which I know, it's like picking a jump rope, Paul.

Paul: No, I know. It's better for the show if I was mad about it or if I made fun of you. I think it's really nice. I agree with you. On those mornings when I get up, even when it's dark outside and I go out for my run when you get back, you are like, "Well, whatever else happens today, I have done this one good thing for myself." You can incorporate a couple of those things in the

morning so that no matter how your day goes, at least you got your run in, you made your bed, you're coming home into an empty sink, whatever it is. But it kind of takes a little bit of extra time in the morning so that the rest of your day, you have that sense of accomplishment going forward. I think that's terrific. Sorry, that I couldn't be mean about it.

Matt: That's okay. It's one of those things where because it is a decision that was made, it's already made. I don't have to think about it. I just get up, get dressed and go. Of course, I look forward to the coffee and sitting down and reading something afterward. It is nice to steal that time in the morning before the day gets going. I would recommend people try that out. Paul, with that, I think it's time to get to an outro.

Paul: All right, so watch a scary movie and go for a run, folks. [Matt laughs]

[show theme playing]

Paul: This has been another episode of the Curbsiders bringing you a little knowledge food for your brain hole.

Matt: Yummy.

Paul: Great. Last one for the year. Get your show notes at *thecurbsiders.com* and while you're there, sign up for our mailing list to get our weekly show notes in your inbox, plus twice each month, you'll get our Curbsiders Digest recapping the latest practice-changing articles, guidelines, and news in Internal Medicine.

Matt: We're committed to high-value practice changing knowledge, and to do that, we want your feedback. So, please subscribe, rate, and review the show on Apple Podcast or now on Spotify. You can also email us at *askcurbsiders@gmail.com*.

A reminder that this and most episodes won't be available for CME, because, hey, it's the end of the year and we need a break. Lots of our episodes from this year, including the ones we recap tonight are available for CME. So, check those out at *curbsiders.vcuhealth.org*. I wanted to give a special thanks to our whole team who keeps the show running, helps keep Paul and I sane, does all our beautiful cover art and infographics. Thank you to all of them. Too many people to name. As I said, there's over 35 people on our Slack channel.

The Curbsiders is produced and edited by the team at Pod Paste, Elizabeth Proto runs our social media, and Stuart Brigham composed our theme music. So, Paul, with all that, until next year, I've been Dr. Matthew Frank Watto.

Paul: And as always, I remain Dr. Paul Nelson Williams. Thank you and goodbye.

[show theme playing]

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