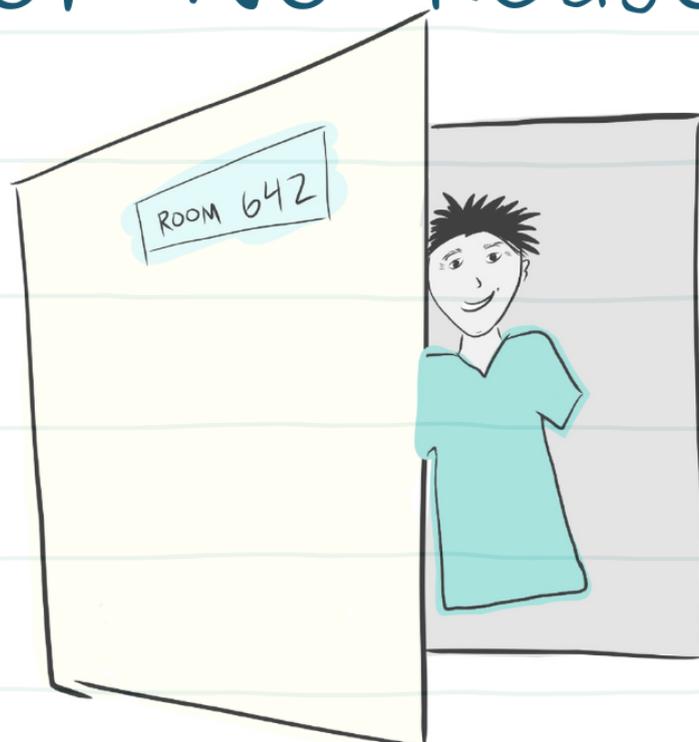


# #381 LIVE! Patient Centered Things We Do For No Reason™

## Things We Do For No Reason



Live! with  
Monee & Meredith

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[disclaimer]

[Curbsiders theme]

**Monee:** Welcome back to Curbsiders. I'm Dr. Monee Amin, joined by my cohost, Dr. Meredith Trubitt. On tonight's show, we're doing something a little different. We were recently invited to give a talk at Southern Hospital Medicine Conference in October on the *Things We Do For No Reason*. This is a live recording, so we get straight into the case. If you'd like to follow along with Ms. Becky's journey, please check out our show notes. But first, Meredith, will you please tell the good people in the audience what it is we do on this show?

**Meredith:** Sure, Monee. Did you know we are The Internal Medicine Podcast. We use expert interviews to bring you clinical pearls and practice-changing knowledge. However, tonight we didn't interview anyone. It was just the two of us talking about some high yield, patient centric, *Things We Do For No Reason*. So, thank you to Lenny Feldman and Tony Breu for letting us use the *Things We Do For No Reason* tagline. Without further ado, should we do this episode for a reason?

Today we're going to be talking a little bit about *Things We Do For No Reason*, a patient centered edition of *Things We Do For No Reason*. We're going to go through a few different things. And like we just said, I'm Meredith Trubitt.

**Monee:** I'm Monee Amin, and please follow us on Twitter. We love that stuff.

**Meredith:** We have no relevant disclosures, and we'll go ahead and jump into our first case because we don't have the poll everywhere, we're going to do just like by hand raising. So, there's multiple answer choices. I'm going to go through the slide or the question. So, we got a patient today. Her name is Ms. Becky, and she's a 69-year-old. She comes in with bright red blood per rectum, and all she really says is, "Doc, it's a lot of blood." She has past medical history of hypertension, diabetes, HFpEF. Her pertinent labs when she comes in is that she has an H and H that's 10 over 30, but we don't have a baseline. She's never been into our ER before, and the ER had already called GI, and they're planning on maybe doing a scope. They call you to admit her to the hospital, and you're doing your admission order set.

By a show of hands, "What do you want as her diet on your admission order set?" So, option one, who wants a low sodium diabetic diet? Oh, man. No hands. Okay. Who wants B, clear liquids? Okay, I got a few. Okay C, NPO at midnight? Got a lot more. Or D, who wants to just give her all the food? No one? How rude. B? Okay. I think the resounding popular answer was C, NPO at midnight.

**Monee:** Yeah. We want people to starve, apparently. So that's great. It's easy to scoff at the fact that we tend to starve our patients. Seems reasonable, but I think it's important to kind of step back and think about why it is that we feel like we need to do that. I'm going to quote a study, very recent study from 1946 in which they studied 66 pregnant patients who aspirated during delivery under general anesthesia. Two of these women had eaten a full meal six to eight hours prior. So, this is the study we all turn to. We didn't know it, some of us. I didn't before we did this. But that's actually the history of why it is that we do this to begin with. The other part that gets lost in this, I think, is that's a high-risk population. The stuff we're going to talk to you about today is actually just low risk populations. We'll hopefully do a pretty good job of telling you what those high and low risk populations are.

**Meredith:** Yeah, valid point. High risk, low risk, pros, cons.

**Monee:** [laughs] Yes. Taking the history a little bit further, what's one of the good things potentially about keeping someone NPO at midnight? They won't aspirate and die. So that's good. The thing is that we really worry about, if you're thinking about this, maybe from the other perspective, the other side, electrolyte abnormalities, dehydration, and hypoglycemia, all of which are bad news bearers. Some of the practical implications of this, in my QI work we talk a lot about, is the problem actually a problem? They've actually studied how much people are kept NPO. So, there's a study from the Mayo Clinic in which they found that the median duration of NPO orders was 12.8 hours. 23.3% of the patients were completely avoidable NPO orders, and some of them were unavoidable. Bottom line is we are keeping them NPO longer than they need to be.

**Meredith:** Kind of piggybacking off of that, I think the other interesting one that you and I have talked about in the past is length of stay. Does putting someone NPO increase their length of stay? There's really no great studies on this question, but there's one that's not totally applicable to medicine, but it at least is an interesting commentary that might be at least something to let sizzle in your head, I guess. There was in 2017, a bariatric surgery patient population, and their policy had instituted for a water ad-lib up to two hours pre-operatively. And while they didn't show any statistically significant data, the trend was towards a decreased length of stay. So, it is hypothesized that possibly this also is impacting something as valid as length of stay. So, brings us to the next question. What can we do to think about reducing NPO time for patients?

**Monee:** So, we mentioned this earlier. Low risk are the patients that most of us take care of. These are the specific situations in which people are considered high risk. Gastroparesis, pregnancy, lower esophageal sphincter incompetence and gastric or bowel obstructions. Things that hopefully we don't see too much of. The vast majority of other patients would be considered low risk, which is hopefully what we get to. And thinking about it from that perspective, the American Society of Anesthesiologists actually give us guidelines, which I love guidelines, because I don't have to think about it. This includes general, regional and procedural anesthesia. And it's pretty simple, guys, it's two, four, six, eight, who do we appreciate without the four, I guess. Up until two hours before the procedure you can get clear liquids, six hours light toast, so toast and clears. And then eight hours you can go and get a nice steak dinner or something.

**Meredith:** Yeah, sounds like you were watching *Bring It On* a little too much. Then I think the question is what is a clear liquid? I've always wondered what actually counts as a clear liquid. I think I've actually been lying to my patients for a long time.

**Monee:** And my residents.

**Meredith:** Yeah.

**Monee:** So, water, as we all know. Coke, carbonated beverages. This was not a commercial. Juice, but it has to be pulp-less juice. So, my dad would be very sad. And coffee, no cream, no sugar, so super jittery and nothing sweet.

**Meredith:** So, as a recap to this part of this talk, I think the take on point for *Things We Do For No Reason* is NPOs at midnight. We should really be reconsidering our patients that actually fall into a low-risk category and who we could be giving them clears up to two hours before to prevent some of these downside risks such as the dehydration hypoglycemia that can come. With that, and only for those higher risk populations, your gastroparesis patients or things like that should you really be considering your NPOs at midnight. So, with that, we'll continue with Ms. Becky.

**Monee:** Ms. Becky looks sad.

**Meredith:** She does. She's bummed.

**Monee:** She's hungry.

**Meredith:** Yeah. So, Ms. Becky, she is now status post her EGD. And it showed a clean based ulcer. So, she's hospital day two. You come in and see her and she's like, "Doc, I have of lower extremity swelling actually." She's like, "Oh, and by the way, I ran out of my Lasix three days before I came into the hospital."

**Monee:** This never happens, does it?

**Meredith:** Never. Only every day of my life. And her physically also, you notice that she has two plus lower extremity edema, and you do a much more thorough exam as well to notate all the other findings. But her labs are really unrevealing. And just for the purpose of where we're going to go, her imaging also showed no bilateral lower extremity DVTs. So, now we're curious about, again, show of hands, what fluid restriction would you choose for Ms. Becky? So, by show of hands, who wants choice A, two liters? All right, it got, like, five. Who wants choice B, one and a half liters? Again, three to five. Who wants choice C, one liter?

**Monee:** This is getting mean.

**Meredith:** Yeah. No one. And so, I'm guessing everyone else wants the 800 milliliters? No, no, okay. [laughs] Sort of in between this two liter and one and a half liters I guess.

**Monee:** Is where the group was.

**Meredith:** Yeah, I guess since we're not doing this, anyone not want a fluid restriction? Oh, man. Okay, three or four. So, we're pretty split across those three.

**Monee:** Yeah. All right. So, little pattern here. We're going to go back to the history and why it is that we do this. I'll be honest, I didn't really look into the actual history, like a study, but I think about my very crude understanding of pathophys, and crude is the only way to describe it. So, if someone has heart failure and we're trying to get volume off, I think in my head, "Okay, well, if we just give them less fluid and then make them pee, then together, it should be fine. That should really take care of everything." So that's how I think of it. And then Meredith drew the short end of the stick, and she has to tell you the real pathophys is.

**Meredith:** Your brother is so disappointed.

**Monee:** Very disappointed.

**Meredith:** Dr. Amin's brother is a nephrologist, so he lives and breathes this.

**Monee:** He's going to be really excited that you just told everyone that he's a thing.

**Meredith:** We're going to talk about RAS pathway, because it's going to make, I think it helped me understand why we're going down this pathway a little bit. So, when you're fluid restricting someone, you start actually on the dehydration pathway in their RAS activation, and you're going to thereby increase renin, angiotensin, aldosterone and this will actually thereby increase sodium retention, and therefore, increase fluid retention as well. So, if your goal in these patients is really to diurese them and get that fluid off, then it's possible that this pathway is suggesting that by doing all this extra fluid restricting, you're limiting what your overall ability is to do.

**Monee:** Meredith, please, please tell us, what does the data show [crosstalk] stuff.

**Meredith:** I think out of all of the four different things that we're going to talk about today, this topic probably has some of the most data, I think. There's one study by Traverse and it's really the first randomized control trial for fluid restriction and acute decompensated heart failure. What they did is they actually limited people to one liter. So, even less than what anyone in this room wanted to do in one group. And then in the other group, they gave them a completely liberalized fluid option for the hospitalized patient. What they showed was there was actually no difference in duration or daily dose of IV diuretics, time to symptomatic improvement, total daily fluid output, or average hospitalization weight loss between the two groups. And notably, there's more patients who are actually withdrawn from the fluid restricted arm due to a rise in their creatinine suggesting harm although that wasn't statistically significant. But it's a small study, so it's like, how valuable is this.

**Monee:** Well, I don't know, but I guess say one liter seems pretty aggressive. And I can't say that I've ever done it because again, it seems pretty aggressive, not very nice, but it's not statistically significant necessarily. It seems like aggressive food restrictions, maybe not the best of plans.

**Meredith:** Yeah. So, I've actually never done this either. I will say I recently had a patient on service who had been instructed to do this as an outpatient. When he told me about it, my jaw dropped because I was like, "Oh, my God, aren't you thirsty all the time?"

**Monee:** Did you tell him not to do it?

**Meredith:** No, was too scared. Too scared. All right, so following with the Traverse study, then there was another one by [unintelligible [00:13:26] and their group, and they were like, guys, 1 liter was not enough, so we need to restrict them even more and do 800 milliliters.

**Monee:** That is beyond mean.

**Meredith:** Yeah, and again, what they did is they were comparing the two groups to a completely liberalized diet. Again, they showed there's no difference in the weight loss, use of diuretics or rehospitalization between the study arms. Theirs did show a statistically significant increase in perceived thirst values that they measured as a quality standpoint for the two groups. While that's not always like the most clinically significant measure, we're talking about something that we're not overly sure has that much benefit and now is making your patient uncomfortable as well. It feels like not awesome.

**Monee:** Definitely not awesome and also not patient centered, which is what we're going for. And that's a theme that you'll notice as we go along, actually. So, to recap fluid restriction, don't do it. It's not a good plan. Actually it might be contributing to worsening the RAS activation system and just making the problem even worse. So, yeah, that's a bad plan. All right. Ms. Becky just looks more and more sad.

**Meredith:** Yeah.

**Monee:** I don't know why are we doing this to her.

**Meredith:** I know. She's like, "Get me out of this hospital."

**Monee:** It's hospital day three, and the nurse comes in with the AM meds and Ms. Becky, she wants to talk to her doctor before she takes this enoxaparin shot, which just got ordered because we've confirmed she's not bleeding. Just out of curiosity, what is your current

practice regarding VTE chemical prophylaxis in low-risk patients? Are you guys into A? It's the order set, so I'm going to do it. Is it B? I'm sorry A, any takers?

**Meredith:** I saw a couple of hands. Don't be shy.

**Monee:** Yeah, it's okay to admit it. Order sets are a thing. B, it should never be ordered.

[laughter]

**Monee:** And anyone for C? You should talk to your patient about it before you order it.

**Meredith:** All right, a few more.

**Monee:** Got some panderers here.

**Meredith:** Yeah, I love it.

**Monee:** Well, again, we're going to do the why. And the history of the why in this situation or really just the reason that I think a lot of us do. VTEs account for up to 5% to 10% of hospital deaths. I should point out that we don't know if all of those VTEs were developed in the hospital. It's very possible that the patients had them when they came in. Appropriately, we do not screen every single patient for VTE, but there's no real way to know. But in the vein of not wanting to do harm--

**Meredith:** Such a good pun. I'm so proud of you. [chuckles]

**Monee:** You're rubbing off on me and I do not like it. Anyways, it seems like [chuckles] we have swung the pendulum way too far in favor of chemoprophylaxis, even in low-risk patients. I think we all know some of this is guideline driven, quality measures driven and kind of stuff. So, just keeping that in mind.

**Meredith:** So, we're going to poll the room here. In y'all's hospital systems, wherever you're working, do you use a scoring system to re-stratify who warrants VTE chemoprophylaxis? So, by a show of hands, who does? Three, okay. Who does not? All right. That's way more. So, I think that was probably like 8 to 10. Who has no idea?

[laughter]

**Meredith:** We appreciate the honesty.

**Monee:** Yeah, I got to say that I had to think about it for a second.

**Meredith:** Yeah. So, I think the resounding winner was no's, followed by I'm not sure's, and then the lowest were yes, that they do use one. So, one of the common ones that you can use, and I don't know what you guys are using in y'all's hospital systems, but it's the PADUA, which we have up on the screen right now. One of the things actually that is very striking about the PADUA is just how easy it is to get to your score of four to warrant prophylaxis, especially when you think about who's coming into the hospital. A lot of us have patients who are coming in who are already over the age of 70 and how many of you have active cancer, so that already gets you your four points. It is a fair amount of patients that may not meet that low risk category, scoring less than four. But it's also possible that you do have someone who's, I don't know, like Ms. Becky, and she's less than 70.

**Monee:** Somehow.

**Meredith:** Yeah. And she doesn't have any cancer or other things. So, I think her score is really a three. And so, that's someone who might fall into that low-risk category.

**Monee:** All right, so there's some not great things about giving a VTE prophylaxis to those potential downsides, I guess, to giving people prophylaxis when they maybe are lower risk than you would worry about. So obviously, pain shots kind of stink. There's obviously blood involved. It costs and I'll come back to that here in a second. And then I would be remiss if I didn't shout out to all the inter-med student, all of us, for hit. So, it's very exciting when you get to diagnose that. Have you ever diagnosed it?

**Meredith:** Way back in the day when I was in training, [laughs] which wasn't actually that far. Yeah, once.

**Monee:** That's pretty cool. I think I got to order the test once, but it didn't come back positive. Okay. Again, I'll come back to the cost here in a second. But the most fun fact of all of this is that enoxaparin shots are the most refused medication in the hospital, and it's not even close. I remember it was like at least double the next or whatever. So, I mean, we don't always make decisions because of patient's comfort, but in this situation, there's enough risks I think that it should be something that you think may be a little harder than we always do. I mentioned that I would talk more about cost.

I think in all the talks that we've been seeing the last couple of days, cost of healthcare is not the most transparent thing. These studies are a few and far between, but they've shown studies where over \$75,000 a year are spent unnecessarily on the cost of just the enoxaparin. This does not account for any of the shenanigans that come after that. So, if you get enoxaparin and you get a bleed, that's not counted in this. If you get enoxaparin and get cellulitis from the infection site, injection site, it's not counted in this.

**Meredith:** You [crosstalk] count all of the unnecessary hit orders either.

**Monee:** Okay, fine. That's actually [laughs] probably the most expensive, [chuckles] if we're being honest. Okay, well.

**Meredith:** One of the things that's come up and has actually recently come out too, and the hospital medicine recommendations was really that this should, in your low-risk patients, be a patient centered conversation that we're having. So, if they really are falling into that low-risk category to go and say, "We can do this, but our goal is to reduce your VTE risk potentially, is this something that you're agreeable to? Is it something that you are worried about?" Because oftentimes, sometimes those patients are the ones that are up walking about, they may not see a value to it and instead of getting into the fight the next day and spending a lot of time having that conversation, then you could just do it upfront. So, in summary, to kind of recap, *Things We Do For No Reason*, VTE prophylaxis and low-risk patients, probably something that we could have a patient centered conversation about more often.

**Monee:** Yeah. I think what I didn't I hadn't thought very hard about this before. But recently I've been thinking about all the things that we do to patients that we never tell them we're going to do. And this is probably really near the top of the list of things that definitely is not great and potentially very uncomfortable for them. So, yeah, now I think it's good to keep this in mind and talk to your patients about it instead of the morning surprise.

**Meredith:** So, we'll come back to Ms. Becky who's just getting more and more agitated at this point.

**Monee:** I mean, those eyes say everything.

**Meredith:** Yeah.

**Monee:** Just she looks miserable.

**Meredith:** I don't blame her, to be honest. So, at this point, Ms. Becky, she's feeling much better. We found she had the clean based ulcer on her EGD and she's not having any more bleeding. We've diuresed her, she's doing much better. She opted out of doing VTE prophylaxis because frankly, she's over it at this point. And she's now just got put on all of her oral medications and so she's tentatively planned to go home the next day if she's tolerating all of the oral meds all right. At this stage of her mission, does she warrant overnight vital signs monitoring? So, we got four options. By a show of hands, who would pick, yes, every four hours, vital signs for anyone who's admitted to the hospital? How many of you are not raising your hands, but this is what you order?

[laughter]

**Monee:** I think we should have put the orders set thing again.

**Meredith:** All right, so who would pick B, yes, it's easier for the nurses if they know they have to check on everyone? Oh, some honesty. Thank you.

**Monee:** That's interdisciplinary thinking.

**Meredith:** Yeah. C, no, she's low risk for decompensation. All right, maybe halvesies. I'm not sure, I've never once thought about my vital signs ordering practice. I honestly think when we're writing the question, that was the answer choice we came up with first.

**Monee:** It was a-- [laughs] just let me pause for a second.

**Meredith:** Okay.

**Monee:** I've been expressing a lot of concern for Ms. Becky. We starved her, we've water deprived her, we've stabbed her, and now we're talking about sleep deprivation. Stabbing aside, I feel like we might be just talking about a resident.

**Meredith:** Yeah, 100%.

**Monee:** Okay.

**Meredith:** Actually, we didn't tell everyone what her profession is. I'm just kidding. All right.

**Monee:** She's 69. I guess people can dream.

**Meredith:** Yeah. So, a little background on vital signs, like we've done for the other three topics. So why do we do it?

**Monee:** It's in the name.

**Meredith:** Vital signs are vital. At a time when we didn't have a whole lot of other information to help us navigate objective information about our patients, we've always had vital signs to navigate with. And so, I think there's an inherent fear for all of us if we're not checking them, because that's just always there. And it just is frankly a comfort to us to know that you had that objective data at whatever time.

**Monee:** Yeah, we don't like surprises.

**Meredith:** No. We could poll everyone in the room and see who's type A, but I'm pretty sure everyone would raise their hand.

**Monee:** Just a spectrum. One of the things we've been talking about the last couple of sections is the role of risk stratification. As far as I know, really aren't some great, great studies and scoring systems for vital sign decision making, but I think you found some pretty interesting points just to consider when we're thinking about this in particular.

**Meredith:** Yeah, so I think in terms of studies and support on this topic, this was probably the most sparse, but there are some interesting examples. There's a couple of studies that looked at an interdisciplinary role for nurses doing a nurse driven protocol to decrease vital sign monitoring, especially overnight. And essentially all they would do is, the nurses walk in when they do their evening rounds, like when they go and meet the patients and whatnot, and they eyeball them and they say, "This patient does not need vital signs tonight." In those studies, they actually did not show any increase in ICU transfers. They didn't show any increase in rates of decompensation for those patients either. It sort of suggests that maybe this is an avenue we could pursue in thinking about ways to decrease our vital sign checks, especially overnight. I think the other thing that you and I were talking about, because for the people in the room who know me well know that I'm a little detail oriented at times, and so.

**Monee:** I would have never self-described that.

**Meredith:** Yeah.

**Monee:** That's not the description I would provide.

**Meredith:** [laughs] So, in thinking about that, if you are really thinking about how many vital sign checks you're taking away when you let someone sleep, if you're doing Q4 on the floor, which is probably what you're doing, you're really only taking away one. You're probably taking away that 02:00 AM, midnight time and letting them sleep until, like, the morning. In terms of overall objective data, you're still getting an overall trend for what's happening to that patient. You're really only subtracting one data point over a total of six down to five or four down to three, but you would still have that information.

**Monee:** Yeah, I don't think I'd ever thought of it that way. And not just one. It's not really that many.

**Meredith:** Right. And your patients I think would appreciate the opportunity to sleep and that's something that I think in a way we might have some say over it. I think the last point, which actually dovetails nicely to one of the earlier talks today, but was a little bit on where are we talking about technology and continuous monitoring systems that could be set up into the patient's room that would be providing all of this, but wouldn't require waking up your patients to do that check. The question to that, though, is if we're really talking about low-risk patients, which is really what we're talking about here, are those types of continuous monitors really necessary for patients? And is that technology that's not necessarily in existence now in the hospital but maybe in upcoming years, something that we really [loud noise in the background] need or is that still providing too many data points? They're having too much fun next door.

**Monee:** Yeah, I'm curious to see how much the mic picked up of that when I go back to edit.

**Meredith:** So, it's going to be a real awkward.

[laughter]

**Monee:** Yeah, I think this is like you alluded to the talk from earlier this morning. Just because we have the technology, do we always need to be using it? I think in this situation it seems like the patients' telly is a great example. We have patients that are on telly or on their step down and they're on continuous pulse ox and sometimes will make me forget to turn off their telly when they don't need it, whatever. Just because we have it doesn't mean we necessarily need to use it. Being mindful of that I think helps obviously with the patient's comfort and also cost-conscious care and things like that. I think we're here to ready to recap this sleep dep-- sorry, overnight vital sign monitoring.

**Meredith:** [laughs] Nice Freudian slip.

**Monee:** To recap, sleep deprivation is bad. Waking patients up is not a good plan. It's not fun. And if they don't need it, they don't need it. I think really the overarching theme here is to think about engaging with the other staff and being mindful of how frequently you're ordering them and take every patient as a single patient and make the decision based on that patient and not all the other ones that you're admitting.

**Meredith:** So, let's go back and wrap up with Ms. Becky.

**Monee:** There it is. She's crying.

**Meredith:** Yeah, I would be too. [laughs]

**Monee:** This is terrible. What have we done?

**Meredith:** I don't know. I mean like you already said, we've done all the things to Ms. Becky and I think that it's a really good opportunity to remember there are plenty of things that we can do to our patients in the hospital which really affect their care and their experience. But maybe some of these are things we do for no reason and those are things that maybe we could not do as much especially to patients that fit into these low-risk categories. And maybe make their time in the hospital a little bit more bearable. So, had we been a little bit more mindful for Ms. Becky? Maybe we could turn her frown upside down.

[laughter]

**Monee:** I've been practicing this in my mind for the whole week.

**Meredith:** Yeah.

**Monee:** For the people that are listening, Ms. Becky was frowning and sad, and now she is smiling after that dramatic pause.

**Meredith:** All right, so we'll take any questions or comments.

**Monee:** Before we do that, a couple of thank yous. Lenny Feldman, who very generously allowed us to use *Things We Do For No Reason*, Choosing Wisely trademark, both VA hospital medicine and medical education for witnessing or talking and giving us feedback. And Dr. Malik who also gave us great feedback, and Caroline Coleman. Ms. Becky would not have come to life without Caroline Coleman's wonderful graphics. She's sitting right here in the front row. So, yeah, good on her, and questions?

**Meredith:** This has been another episode of The Curbsiders, bringing you a little knowledge food for your brain hole.

**Monee:** Yummy.

**Meredith:** Get show notes at *thecurbsiders.com* and 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 and internal medicine.

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**Meredith:** And I have been Meredith Trubitt. Thank you and goodnight.

[Curbsiders theme]

*[Transcript provided by SpeechDocs Podcast Transcription]*