#396 Recap, Top Pearls from #SGIM23

[Disclaimer]

[The Curbsiders theme]

Matt: Welcome back to the Curbsiders. I'm Dr. Matthew Watto, here with two great friends, Dr. Paul Nelson Williams and Chris “The Chiu Man" Chiu. This is part one of two recap sessions. These will be released as one mega episode. We're at SGIM 2023. Paul. Is it SGIM or SGIM?

Paul: I was going to ask you, well, I'd go SGIM.

Chris: Coz it says SIGM.

Matt: SIGM.

Chris: People say SGIM.

Matt: Okay. I'm a fan of SGIM and SGIM, but not SIGM. But I like the organization as a whole, no matter what you call.

Paul: I see it.

Matt: Yeah.

Paul: That's the incorrect opinion, but in terms of the pronunciation but I agree, it is a special organization for sure.

Matt: All right, so we'll have a second session where some other friends will join us later.

Paul: And wait, when did you ask them how they pronounce it too? I think this is now.

Matt: Yeah, maybe they could tweet at us or tweet at Paul because I'm not on Twitter.

Paul: A SIGM pronunciation podcast.

Matt: Yeah. So, Paul, why don't you remind people what is it that we do on the Curbsiders?

Paul: Sure, we are *the* Internal Medicine Podcast. We use expert interviews to bring you clinical pearls and practice-changing knowledge. But of course, our format is a little bit different this time around. Matt, we're recapping some of the sessions that we've been to. Some of them have been standard lectures, clinical update presentations, some have been workshops that have been more interactive, but in any case, loaded with pearls and actionable stuff to help us take better care of patients and teach better.

Matt: That's right. We're going to start with, I guess well, which pearls do you want to start with Paul? I know you have a lot of sessions that you've been attending and let's go to you first.

Paul: I think why don't we start with the plenary because I think Chris has some thoughts on some of the stuff here too. I'm not going to focus on the big 10 speeches, but I thought some of the oral presentations at the beginning were fascinating and really compelling and I think may impact practice, maybe policy more than practice to some extent. But one of the talks that was given was the effect of basic income on healthcare utilization given by Sumit Agarwal at Brigham and Women's with his team. And so, basically what this was was a study of a neighborhood called Chelsea in Boston, which is economically poor. It is majority/ minority. The average income is about one $1500 a month and basically they put on a lottery for patients or for these folks to get debit cards for $400 a month, no strings attached. They could do whatever they wanted to with it. It was just all you had to do is be in this neighborhood and sort of meet those qualifications that way, but they could spend it however they liked.

And the outcomes they were looking at is how did this impact their healthcare utilization? I won't go through all of this in terms of the background demographics, since we've got more actual pearls to talk about, but it significantly decreased ED visits by about a third in the group that actually got the cash benefit. A lot of that was driven by decrease in visits for behavioral health. It almost completely eliminated ED visits for substance use disorder fascinatingly. There was an increase in outpatient utilization driven largely by subspecialty care, which is also interesting. It's hard to know if that meant that money was being used for transportation or to facilitate and coordinate that kind of care. It was fascinating and it's self-evident. If people have more money, they live better, but it looks silly to how they use healthcare. I thought it was a really fascinating and compelling, hideously expensive pilot. I think $9 million was the number I heard Chris.

Chris: Yeah, it was sort of interesting. How they were able to somehow pair all these patients with their electronic medical records in this retrospective way. People were talking about apparently, I think there were like two major healthcare systems, so that allowed them to get maybe captured, I think like two-thirds or 75% of all the patients there. But it was fascinating. Seeing the dichotomy or the response of decreased ED visits, but increased outpatient visits, and I think a lot of people really did talk about that. It'd be really interesting to see the cost-benefit change there because obviously ED visits are much more expensive. Would that offset the cost of the 9 million for sort of this basic wage? Hard to say, but still, I thought it was a great study.

Paul: Yeah, interesting. I think we will hopefully lead to further funding to look even more at them.

Matt: When AI puts everyone out of jobs, we'll just give everyone will have a basic income and will--[crosstalk]

Paul: UBI and Universal Healthcare and then the world will be okay.

Matt: Yeah, that's the vision. What else about the plenary, Paul? Did you want to talk about any Curbsiders presenting at the plenary?

Paul: We have to hype up Carolyn Chan and then a brief guest appearance by our own Kenny Morford too. She was poised and she was really impressive. She gave her talk on her development of a medical improvisation-based interviewing curriculum. So, basically using improv to learn motivational interviewing skills with I believe it was medical residents, if not mistaken. I don't want to eat her lunch. I'll let her talk more about it if she so chooses to. They basically used improv that was well received. The residents felt more comfortable doing it. They were more effective at doing it and they actually didn't mind that modality as much as the idea of

role playing and going through that stuff might be hideous to someone who's introvert like me. The residents seem to overall enjoy it. An impressive novel way to teach a really important skill. So, yeah, impressive work and she did a great job.

Chris: Yes, and-- [crosstalk]

Matt: There you go, Chris. That's right.

Chris: Maybe Carolyn can talk about it later.

Matt: Okay, Paul, what about clinical sessions that you went to? I think Era is going to talk about Trauma Informed-Care. I know you went to that one, but anything that you took home from that that you really wanted to highlight for the audience?

Paul: It had been some time since we'd had our Trauma-Informed Care Episode with Megan Gerber. So, this was Trauma-Informed Care, A Hands-On How-to for Clinical Practice with Rebecca Gold, Adelaide McClintock, Susan Nasr, apologies if I mispronounced that, Amy Weil and Meagan Williams. And they went through, again it largely used the SAMHSA framework for Trauma-Informed Care. There are the three Es of trauma. There is the actual invent, which may be the threat of physical or psychological harm or actual harm itself. And it can also be events, too. It can be ongoing, which is important to recognize. But even more importantly, I think the takeaway point I took is that the event almost doesn't matter. One of the speakers said it's how the patient experienced the event is the more important thing. So, the specific gory details don't matter. It's how the patient internalized it and the impact that they had on them, which leads to the effects of the event on the patient.

The other mnemonic is the four R's realizing that trauma is widespread and understanding past recovery, recognizing signs and symptoms, responding by integrating knowledge and resisting retraumatization, which is not an easy thing to say. Then they also talked a little bit about resiliency as well, which is not classically part of that framework. But the things for you, I would reemphasize as universal precautions. So, many of our patients have been through trauma. It's just worth recognizing that it exists and is out there being very sensitive to it.

So, part of the recognition can be if someone is having frequent no-shows to your visit or if they have uncontrolled chronic disease or substance use disorder, or depression. That might not be happening in isolation. That might be a manifestation of a trauma that they've experienced that might be worth pursuing if you have that type of relationship with the patient that you're able to.

And then the physical exam pointers, I always think are amazing in terms of I think these are things that we've talked about before. Always asking permission, offering a chaperone at every single physical examination, which sounds burdensome, but most of the time no one's going to want a chaperone. The more practical things like always remaining in the patient's line of sight when you're doing an examination, announcing what you're going to do and why you're doing it, being mindful of draping, and then being mindful of language. I think you've talked about this before, Matt.

Instead of saying, "I'm going to listen to your lungs, I'm going to listen to the lungs, really depersonalizing it and sort of not making it about a specific organ that you're supposed to be looking at or a specific body system." And then the other thing is and I still catch myself doing this and I'm so glad to hear this over and over again, is avoiding the term for me, which can also be very traumatizing for patients. Move your gown for me or take a deep breath for me. You

don’t have to, you can just stop--[crosstalk]. Please take a deep breath is perfectly fine and removing it as a coercion thing. I thought just a helpful reminder of a lot of stuff that we've talked about.

Matt: All right, Chris. You went to a clinical update in cardiovascular risk factors talk. Tell us a little bit about that, what you think is useful for the audience to know.

Chris: Yeah, so I always think about going to these clinical updates. Here at SGIM you can't see a lot of the slides ahead of time, so you don't know what you're going to get when you come in. Sometimes, especially working for the Curbsiders, we read a lot of stuff. We're pretty up to date and I was very pleasantly surprised. I enjoyed the session a lot. It was called clinical updates and cardiovascular risk factors. It was with Jennifer Cluett, Kelsey Bryant, Allison Crawford, Benjamin Gallagher, and Eva Tseng.

They did a great job and they brought some really fun and interesting articles, a couple that I knew. But I think it's really important to us to talk about again and some other ones that I'd never even heard of. So, I sort of cherry-picked three of that I want to share with you guys today. I guess the first one we can talk about is chlorthalidone versus hydrochlorothiazide for hypertension. This came out like right before the New Year and I could have sworn that we had talked about it on Digest or one of our hotcakes and stuff-- [crosstalk]

Matt: I know like back in the day, I think we talked about with multiple experts. Joel Topf, of course, like talking about how we like chlorthalidone better for-

Chris: CKD, yeah.

Matt: -like blood pressure control and just if someone's not responding or they've labile blood pressure on hydrochlorothiazide because it's shorter acting that chlorthalidone is a better choice. And I think Dr. Jordy Cohen also brought this up in a recent episode because it was like is chlorthalidone better? We expected better outcomes with chlorthalidone than hydrochlorothiazide.

Chris: Yeah, so this was a great study because it was from, I think the diuretic comparison project. It was in the VA with over 65-year-old patients with hypertension already and they're already on hydrochlorothiazide and basically, they're randomized to either stay on the hydrochlorothiazide or an equipotent dose of chlorthalidone. The median fall-up was 2.4 years. Incidence of the primary outcome events, which were all cardiovascular events, actually didn't differ significantly in either efficacy or safety.

Obviously, there are some limitations to the study. Basically, a lot of the chlorthalidone were low doses of chlorthalidone. The study population because of the VA was overwhelmingly white and male. And apparently, there was a lot of cross over because it was open label. There are more in the chlorthalidone that switch back to hydrochlorothiazide than the other way around. I think the TLDR from this really is that switching patients from hydrochlorothiazide to chlorthalidone for just blood pressure control may be a little useful, but maybe it's probably not that useful overall.

Matt: Yeah.

Chris: Chlorthalidone is more expensive. You have more instance of hypokalemia and actually for people you're trying to do combo medicines for adherence reasons, like there's no chlorthalidone combinations.

Matt: So, I think what Dr. Cohen, Paul, tell me if this rings, I don't remember if this is the same exact study that she was mentioning, but the patients had well-controlled blood pressure. It's not like these were patients with resistant hypertension that were uncontrolled. You're adding chlorthalidone and replacing the hydrochlorothiazide. We don't know because that's largely on the show how we've talked about using chlorthalidone. I think what I would take away from this based on what you've said and what we talked about with Dr. Cohen is "If someone's well controlled, there's no added benefit to adding chlorthalidone. But if they're uncontrolled, you might still consider it an option Paul, what do you--

Paul: I think that's right. And there's a little bit higher potency but at the cost of hypokalemia and some of the other stuff. But yeah, you would not-- Everything you said sounds exactly correct.

Matt: And I would say to people, I checked this week, the $4 formulary at some of the big box retailers has Indapamide 1.25 or 2.5 milligrams. It's also a long-acting diuretic and so that is a good option if chlorthalidone is too expensive and we just don't think to use it. I think just because it's just not--[crosstalk]

Paul: Their marketing department fell down somewhere along the line.

Matt: They fell down, but I've used it on two patients and it's been great. So, take that for what you will. All right, Chris, what else from this cardiovascular risk factor reduction talk that you went to, whatever it was called?

Chris: [laughs] Yeah, so the next one staying with hypertension. I wanted to bring this one up because on previous episodes we talked about the Hygia study. So, a little bit of background is when we look at ambulatory blood pressure monitoring, people often dip at nighttime. Usually, 10% is pretty reasonable. In the morning you just have a small surge. We have patients who are non-dippers, so they don't dip at all or they actually go up. The question is, does nighttime dosing of blood pressure medicines make a difference? This Hygia study, which came out in 2019 in the European Heart Journal found there was a 45% relative risk reduction in cardiovascular death. MI, heart failure, and stroke. So, it was huge. I can't remember, I feel like it was an episode we had with like Tony Breu or someone else, and it was just like, "Well, if it doesn't cost anything just to do it at nighttime, there's possibly some added benefit, might be reasonable." Obviously with diuretics might be a little more difficult. But ever since then, apparently, there was a huge controversy with Hygia. There were a lot of weird things in terms of whether the methods were right, whether there was true randomization. There was like inconsistencies when you compare it to *clinicaltrials.gov* where people sort of pre-list what their methods are. And apparently, there's huge attrition rates too.

The journal did look back at it and they did not retract it, but apparently, it was a big controversy. Luckily, more recently, in October 2022, Lancet published this study called the Time Study, which had over 20,000 patients who completed the study. They randomized one-to-one to take either all blood pressure meds in the morning or in the evening. But the diuretic dose, you were allowed to be flexible if you had nocturia as a problem.

So, they found that the primary outcome was a composite of cardiovascular death or hospitalization for nonfatal cardiovascular events, and there was no difference at all. So, I thought that was really interesting, a much better study, and totally refutes a bad study, apparently. And the things to look forward to. There're apparently some big trials coming out of Canada called the BedMed and the BedMed-Frail Studies.

Matt: Wait, pause for Paul Williams' reaction to the trial name.

Paul: Ooh, I'm not even trying.

[laughter]

Matt: He is not in a mood to be trifled with today.

Paul: Canada, get your act together.

[laughter]

Chris: So, we do have those to look forward to. Maybe next year when we come back, we'll be able to give you some updates on that.

Matt: Based on the state of the evidence, what's going to be your practice is when patients ask, Dr. Chiu, what should I do with my blood pressure meds?

Chris: It's the same practice always has been. Take it whenever you can--

Matt: Whenever you can remember.

Chris: Best way for you to remember if it's morning or nighttime, then do it.

Matt: Okay. All right.

Paul: Just love cardiologists. Just curious to see each other. Is it a sleepy time or a wakey time? Do we get the medication like it is-- [crosstalk]?

Matt: Okay, so let's go. Chris, we're going to come back to you. I know you maybe have more from that, but let's flash to Paul Williams, which is a weird way to say things.

Paul: I don’t like that. Yeah.

Matt: Paul Williams.

Paul: Star wife.

[laughter]

Matt: Paul Williams. Paul, tell me you went to a talk about buprenorphine and chronic pain. I'm very interested in this because I wasn't sure if this was referring to patients who have opioid use disorder and chronic pain or patients who just have chronic pain and are taking chronic opioids and they're switching them over to buprenorphine. What do we make of this and who are they recommending chronic buprenorphine therapy for?

Paul: Great questions. Also, this is the chronic pain and buprenorphine talk with Stacy Charat, Elizabeth Cuevas, Deanna Hill, Aliza Norwood, and Galina Tan. Apologies again if I mispronounced anyone's name. This was a really 3000-foot view. I think the big takeaway is that this is complicated and it's going to be a lot of trial and error and talk to your pharmacy

colleagues and have a team in place to figure this out. You'll need a lot of patient check-ins. The overarching framework they did for this talk, which I found interesting because is I'd not heard about this before, is the spectrum of opioid use, ranging from opioid use disorder to physical dependence. In this gray space in between, there's this entity known as complex persistent opioid dependence. This is characterized by poor pain control where you keep escalating the dose. The patients don't seem to do all that much better with the higher doses but have bad outcomes if you try to dose reduce.

As they're explaining this, I feel like everyone in the same room have the same expression. Like I have ten patients that meet exactly what that is. So, they're not chasing euphoria. The patient's goal is mitigation of their pain and higher function, but you're just not getting there with your traditional modalities. It was with that framework that maybe buprenorphine might be a good option for these patients. Having said all that, they did the deep review and there're a lot of formulations available for buprenorphine, I think, which is one of the reasons why people are nervous about prescribing it.

But there are buccal films known as Belbuca. There's the transdermal patch known as Butrans notoriously difficult to get approved by insurance companies. There're the sublingual films, your buprenorphine, naloxone, your depot buprenorphine and Zubsolv. There're a billion names for these things. But in any case, their thought was that these are good options for patients who might be in the situation. So, the patients that we talked about were patients at least the one that was discussed in my group was someone who was already on chronic long-acting and short-acting opioids but was not achieving any kind of pain response and they wanted to come off these medications.

Perhaps buprenorphine would be a good option for them. The big takeaway and I'd love to hear, Chris, if you heard it, the pearls that you got from this is that for patients who are on relatively low morphine equivalents, it's starting with one of the medications for pain, so the buccal film or the transdermal patch because those tend to have lower doses, they tend to be dosed in micrograms as opposed to milligrams. If someone's already on full agonist therapy, like, say, someone who's on MS Contin, long-acting morphine, and then the short-acting pain control, that's someone for whom the sublingual formulations, like the buprenorphine and naloxone, like your brand name suboxone might be a better choice because those are dosed to milligrams and tend to be more potent.

They did talk about initiation protocols and you can sort of do things that I was familiar with from treating opioid use disorder. There's the stop-start method where you just make someone go into withdrawal and then you start the buprenorphine versus cross-tapering low-dose initiation, which we've talked about at length on the show before, is a very reasonable option for someone even when you're just using it for pain. Those are the big takeaways I took from it. The overarching theme is that this is complicated and you'll need to talk to your friends and do trial and error before you feel comfortable doing it.

Matt: Yeah, so it sounds like we're still pretty early on in this, and so you could use it. Anybody that's on chronic opioids and is not doing well, you could think about doing this.

Paul: I blew past this because we've covered it on the show before, but buprenorphine, by its very nature, does not have the same respiratory depression as full agonist therapy or sedation or euphoria. There's a lot of safety considerations that we like you for.

Matt: Okay, Chris, anything else to add to that session?

Chris: Well, I mean, there are a lot of things that-- the session was packed, it was standing room only. It was crazy, and there are a lot of primary care docs in there trying to figure out how can I get chronic pain a little better controlled? I think they were just looking for anything. Some of the things that they brought up, I thought was interesting was this revised Opioid Risk Tool to help us figure out their risk for the patient. What was interesting is the way workshops work is you sit with a bunch of other people, and during these workshops, I find the people you sit next to actually might give you more information than you get from just the people putting on the workshop. He was just like, "Hey, you know this Opioid Risk Tool isn't actually very good." And he brought it up in a session. But "Yeah, we just wanted to give you an example of one of the tools that are out there." So, I thought it was interesting that maybe we don't have a lot of good ways to assess, but really you need to think about the patient and what are the things you have to worry about.

Our case had, like, a very elderly lady who had failed pain medicines in the past, currently off medicines, but she was like 89, but still needed better pain control. We were trying to figure out where she was on the spectrum of opioid use disorder versus the [unintelligible [00:20:39] or whatever the other spectrum was and whether she would be a good candidate for that. And also talking about, again, as Paul said, all these really sort of low-dose versions and having those as availability, I thought it was great.

Matt: Yeah, it'd be nice if they were more available. I feel like they would be helpful because they're much, much lower doses. Like 2 mg of buprenorphine for somebody who's on 5 mg of oxycodone is like, it's a huge step up in dose. It really has to be patients that are on higher doses of opioids that are going to get the milligram. In my experience, at least in Pennsylvania, the 2 mg, 4 mg films, or tablets are much cheaper than the transdermal or the buccal formulations.

Chris: All right, but imagine if you had the transdermal, like a 5-microgram patch, it's so much lower. If you can get good control, you wear it once a week. I mean it seems fantastic.

Matt: Yeah, I guess more to come on that. I know our addiction medicine group is doing a full episode on that, so I think we'll have a lot more detail. I wanted to present guys some pearls. The NAMS, The North American Menopause Society I believe that's what it stands for, in 2022, updated their guidelines specifically for using hormone therapy for treating some of the vasomotor symptoms of menopause. We had a great session with some wonderful experts. The speakers at this were Dierdre Bashir, Andrea Carter, Melissa McNeil, Sarah Merrriam, and Holly Thomas. As I said, they did a fantastic job. This is a topic I know we've done episodes on this way back, Paul, but I always just feel uncomfortable. There're cardiovascular concerns, there's VTE concerns, there's breast cancer concerns.

So, it's just like this session which I can try to put some version of it into the show notes but they had an algorithm for talking about how should you go about this and what do they recommend. Let me pull up my slides, which now I lost place for. Okay, some of the key points is that basically, like, who are you going to select for this? People should have at least moderate vasomotor symptoms before you consider this. Really the main group is going to be women under 60 or less than 10 years from menopause because that's where the risk-benefit is much more favorable in terms of benefits to risks. Are you guys using much of this in your practice or you guys as of the same fear of using it as I do? [laughs]

Chris: I agree.

Paul: I tend to favor that the medications I'm more comfort with the nonhormonal, so I'll do like gabapentins or venlafaxines before I will do the hormone replacement stuff.

Chris: Yeah, there used to be a great app that would go through that. I think that's out of date now and I can't even update it.

Matt: There are some things that I thought were useful. I mean, you might get patients asking, like, they think that their cognitive decline or brain fog and stuff like that is a good reason to prescribe it, but that's not necessarily recommended. If they have vasomotor symptoms, you can still try it and talk. That was one of the questions specifically, like, with testosterone for men, people think it's this panacea, they're going to feel great, all their symptoms are going to get better. That's not necessarily the case, but if they have vasomotor symptoms that are moderate and you want to try it and the risk-benefit matches up, you can try it.

Paul: It works. Yeah.

Matt: Yeah.

Chris: I heard there've been a lot of changes and updates in the risk for breast cancer and things like that when using hormonal therapy, and that's why it's not as risky as we used to think. Which is why when you're looking at the risk-benefit ratio, probably more people could be on it than you think.

Matt: Yeah, they said that the excess risk for breast cancer is with women on estrogen and progesterone, but it's about the same as if someone takes two drinks a day. It's not like a gigantic excess risk.

Paul: The absolute risk is probably relatively small. It's just the relative risk has increased.

Matt: The risk starts to go up around five years or so. One of the questions was about tapering. If someone does end up starting it around five years, you might start to taper the whole time. If you decided at some point you're going to start them on, it should be the lowest effective dose, and then you should try to taper them at five years because once you get beyond seven years, there's not really a lot of evidence for safety, efficacy, and then beyond 10 years, you're sort of evidence-free zone. So, that was part of it.

Paul: Yeah. And in Dr. McNeil's talk at ACP actually she made the point, "The vasomotor symptoms tend to abate with time, genitourinary symptoms do not. It's reasonable to try to taper if you're using for the vasomotor symptoms specifically.

Matt: Now, Paul, thank you for accidentally setting me up to make the point that there are such things as super flashers.

Paul: What?

Matt: These are women who may have symptoms beyond that 10-year point.

Paul: Terrific [crosstalk]

Matt: They said that there's a difference between starting hormonal therapy in a woman over 60 versus continuing it in a woman who was under 60. So, it's not an absolute. It's still going to be a conversation.

Chris: Any tips on those who really want to try to get off? Do they recommend, like, bridging with sort of the non-hormonals or what? Did they that anything there?

Matt: I didn't get that specific question answered, but it was a tapering down, I guess. If they're already on the lowest dose, you can't taper, but kind of tapering down.

Paul: Another question you may not know the answer to is you mentioned at least moderate symptoms. Is there a scale or like how is that determined? Do you know or is that just sort of by?

Matt: I'm sure there's a scale, but I did not know.

Paul: I think 6.10 scale. That's all right, I'm sorry.

Matt: That's okay. But-

Chris: Super.

Matt: -the one other thing that I wanted to-- and we probably should do a full episode on this, and I was also sort of there scouting for that. But part of the algorithm they said is like, okay, so the first thing, let's say you have women under 60 less than 10 years from menopause, you're going to be like, "Okay, does this person have known cardiovascular disease?" If they do, probably not a great candidate. Next thing you're going to do is if they don't have a known disease, you're going to assess what's their risk. If they've had a CAC score and their CAC score is above 100 that should probably consider them as having a disease.

Or you can calculate their ASCVD risk score. People who are high risk probably should avoid putting them on hormone replacement therapy. Low-risk patients would be good candidates. The intermediate risk is sort of like looking at other risk factors. Maybe they have an old CT scan that shows heavy coronary calcifications. They haven't had a formal CAC score or if they have a strong family history, maybe that would push you more against using it. It was interesting because they don't tell patients this when starting it. They were specific about this, that in women under 60 who start hormone replacement therapy, it does seem like there might actually be some reduction in cardiovascular disease. But I think it's not so clear that they would claim that and start it as a cardiovascular risk reducer.

Paul: Right. Well, when we talked with the USPS [unintelligible [00:27:54] about that specifically, indeed there is the risk reduction, but we also have things that don't have some of the risks with them, but that just works even better for risk reduction, like lipid control and exercise and that stuff. It would not be sufficient just to use it solely for cardiovascular risk reduction.

Matt: The other thing they said is you can use the Gail risk score. Once you've gotten through the cardiovascular risk and you've decided, okay, if they're low risk and you want to prescribe or intermediate risk and you have a conversation, you still want to prescribe. Assessing the risk of breast cancer, you can use the Gail score for their five-year risk of breast cancer. If they have a lower risk of breast cancer, then it'd be more favorable to starting, patients with a high risk of breast cancer, you probably shouldn't start, and intermediate, again, it's going to be like a

shared decision-making thing. Basically, you're assessing cardiovascular risk and breast cancer risk. If someone's had a prior VTE or stroke, that would pretty much be a no-go.

Paul: Yeah.

Matt: The last thing I will say is the formulation. It looks like some of the micronized progestin formulations just have a better risk profile. Some of the transdermal preparations have a better risk profile. There's a lot, I mean, some formulations are estrogen and progesterone. They're transdermal, there's oral, there's IUDs, yeah, there's a lot of stuff, but essentially you just have to think, like, okay, start whatever formulation you're going to try, start on the low dose. Estrogen and progesterone should be used if they still have a uterus because you don't want to just build up the lining without that protective effect of the progestin and that's it. If they no longer have a uterus, then they can get estrogen alone. So, it was a really good session. I do think we should do a full episode on this.

Chris: Yeah.

Matt: This is part two of the recap. We have a lot of great people with us. Carolyn Chan, Era Kryzhanovskaya,-

Era: Wow.

Matt: -Paul Williams, Justin Berk. We're going to start with Era because she has to get out of here. She's got important places to be, Paul.

Paul: I mean, we all do.

Matt: As do you. Yes. So, probably by the end of this it's just going to be me and Justin.

[laughter]

Matt: Probably Chiu Man will jump into.

Paul: [crosstalk] just talking to a microphone by himself.

Matt: Yes, Chiu Man is going to jump into, he's waiting in the wings. We have Chiu Man in the basement drinking five cups of coffee right now, Paul.

Matt: All right, Era.

Era: Yes.

Matt: Tell us, which session would you like to start with? It doesn't have a clever name.

Era: It does. It's Friday. We got to be spicy, exciting. I went to a session yesterday called Making Sparks Fly. What's new in the evaluation and treatment of low sexual desire in women? Let me tell you, sparks were flying. This is a team out of Pittsburgh and they shared just incredible tools, incredible stats around low sexual desire with significant distress, also called Hypoactive Sexual Desire Disorder or HSDD and it's super common. It affects many people. Now there are two FDA-approved medications to treat it. Before we get into the treatment, one thing that I found really helpful was that they shared a very easy validated tool to diagnose this, which is the

Decreased Sexual Desire Screener or DSDS because how many acronyms aren't enough? There's never enough.

Matt: Wow.

Era: I know. It's a simple five-question validated screen tool to help you assess sexual problems and diagnose generalized acquired Hypoactive Sexual Desire Disorder. Did I say enough times? HSDD. Once you've made that diagnosis, you have to go through and figure out, is this person premenopausal, postmenopausal? If they are premenopausal, there are now two FDA-approved medications for them. I'm going to butcher these names, but that is flibanserin, it's a 5-HT1A agonist and a 5-HT2A antagonist. And that has been effective. And again, FDA-approved pill that you take daily. The other one, bremelanotide is a melanocortin receptor agonist, which is an injection that you use. And you do it 45 minutes before anticipated sexual activity. Side effect, hyperpigmentation. So interesting to note.

Matt: Ah, melanocortin?

Era: But is available. Makes sense, right?

Matt: Yeah, okay.

Era: Just based on mechanism. But what they were sharing is that while these two are the FDA-approved medications, there's also our tried-and-true bupropion, Buspar, and actually testosterone. So, hormone treatment has been-- [crosstalk]

Matt: Wait buspirone or bupropion?

Era: Sorry, bupropion and buspirone or Buspar, both of them.

Matt: Oh.

Era: Yeah.

Matt: Okay.

Era: Yeah, I know.

Chris: Anything with the B I think, actually are.

Matt: Okay. That's good.

Era: Yeah, exactly. So, far not buprenorphine as far as I know.

Paul: [crosstalk] just a great choice.

Era: Yes. But exciting times because I feel like there's a lot of momentum also and there's FDA-approved medications. One thing that they emphasize is that this is really great and also therapy we know works as well, and there're different types of therapy. They actually offered a site that gets you access to sexual health therapists as well.

Matt: I'm a little skeptical of the flibanserin one, which I know it was a controversial approval process. It was initially not approved and then they appealed it to get it approved because there was nothing else. I think it causes, like, a lot of, is it dizziness the side effect?

Era: I think so. Yeah.

Matt: I have not used it, but did the experts get into which one of these are they using? Do they find them helpful?

Era: It's funny that you say that, Matt, because if I'm remembering correctly and I could be hallucinating because it's been a wild 48 hours and altitude gets to me, but I'm pretty sure that none of them have actually prescribed this recently. The experience with it in the room was low.

Matt: Yes.

Era: But I think the whole point is that you know that these things exist. If you've tried therapy, you've tried bupropion, you've tried Buspar, you've had these conversations and said, "You know maybe it's now time to look at something else."

Matt: Yeah.

Era: The other things that they did mention was that sometimes look at the med list, like, look at other medications, SSRIs, ACE inhibitors, other things that patients are taking that might have an effect on sexual desire and can we make those changes before we add on another medication?

Matt: Yeah. Okay. Comments from the-- no? Okay.

Justin: I hate to normalize asking that question and I actually doing the screening and making it part of the purview of primary care. I think when there's no treatment it seems like a little bit of an awkward question and be like, "Oh, I'm really sorry to hear that that's going on, but now that it's like, okay, well, there're a couple of things we can at least try. I think it's normalizing bringing it into primary.

Matt: Yeah. We might need to visit this as, like, a full episode, Paul, I think.

Paul: I think so.

Era: Yes.

Paul: Because.

Paul: Yeah, and because if we're doing true screening, then when you do it, who do you choose? I feel like there's lots of unanswered questions because otherwise, you're already in the diagnosis plan. I'd love to hear more about this.

Matt: We talked about the menopause guidelines being updated earlier. I feel like that could warrant a full episode as well.

Paul: We've got some stuff to do.

Era: They shared a stat that nearly half of women in the US report low sexual desire. I feel like there's 50% of the country that we're not having necessarily this conversation with and can offer.

Paul: Off to do some thinking. Like, what's the reference standard? Because it's very interesting topic.

Matt: Okay, Carolyn, let's go back and forth. Why don't we go Carolyn, which session did you want to talk about first?

Carolyn: I wanted to talk about an amazing clinical case that they discussed during the plenary session. The great imitator strikes again a curious case of headache that Dr. Anne Arnason from UPMC presented. The case started off with a typical headache picture and they did an MRI and actually demonstrated a frontal bone lesion. What shocked me was that it was from syphilis. Osseous involvement in syphilis can actually occur at any stage, which was completely mind blowing to me and I'm like, "Oh, no, I hope I have not missed this diagnosis."

Matt: Can I just say that during this presentation, when the first time the person went to the ER, they were like, "Oh, that's just your skull bone. That's just how your skull is shaped." That's 100% what I would said.

Paul: No, I'm sure [crosstalk] backing because I could see that happening. I don't think it was even the wrong decision to make.

Matt: No, I'm saying I would have said, I probably would have been like, "Oh, yeah, that's just the way your skulls were."

Paul: Your head shapes. [laughs] I wonder how much syphilis you've missed.

[laughter]

Justin: I wonder how much syphilis you've missed.

[laughter]

Carolyn: I commend them for working this all the way up, all the way through, patient ended up with an LP and I think this was my takeaway. That bony involvement is rare in syphilis, but maybe more common than we previously thought, even in early syphilis where they quoted as many as 8.7 cases of secondary syphilis that possibly have osseous involvements, which was surprising.

Matt: Yeah, absolutely. We already mentioned that you were the next presenter at this plenary session. We already talked you up. Just to embarrass you while you're actually here to be embarrassed.

Paul: The best one, I'm just going to go ahead and say it was the best part of the plenary session. I mean, the other ones were very good.

Carolyn: They were all excellent as well as the one that we are currently discussing. Anne absolutely crushed it. I think, too, she made a really important point that cases of syphilis are just rising throughout the country and that we really should be familiar, honestly with our own local prevalence of syphilis, and we should probably be screening patients who are a low-risk

for syphilis, but in high-risk areas where we know that we're starting to see an increased number of cases. I'm going to go home and I'm going to google what is the prevalence of syphilis in my county.

Paul: And the new one that you're going to be moving to in the near future? Because you're going to have to recall it again.

Carolyn: I'm probably just going to do one at a time because I'm probably just going to forget and then mix up the numbers and be like-

Justin: Maybe too disorienting.

Carolyn: "I don't know what I'm supposed to do."

Justin: Yeah, one at a time.

Paul: I did just right-click want to want to praise again Dr. Arneson because as a second-year resident, I was just trying not to make eye contact with anyone. To be giving this talk in this forum and being so poised and doing such a tremendous job and for answering questions, I thought it was a tremendous presentation.

Justin: She did so good. I agree.

Matt: Yeah. All right, Era. Now, I heard that you have a podcast that you're on and if you wanted to plug that and then talk about a teaching session that you wanted to highlight.

Era: Yes, I've been known to participate in a podcast that is called The Curbsiders Teach and we are really excited to be in our third season, which is huge and through that working with the amazing Curbsiders team. It's no surprise that we like teaching and medical education. At SGIM this year were trying to combine a few of our mutual shared interests with folks from Yale, Monty, Colorado, and BMC. We did a workshop called Training Up for Addiction Care, Nuts and Bolts of Addiction Medicine Education in internal medicine residents.

The reason this is really important I just want to shout it out is that we all know that ACGME has requirements for us, it turns out, and those sometimes change. In the recent few months for addiction medicine requirements have evolved for especially internal medicine residencies to not only have people be able to recognize the signs of addiction but have residencies provide clinical experiences in addiction medicine.

What was really important is that in this workshop, we offered a framework, a curricular framework that folks can use to develop an addiction medicine curriculum that can fulfill these requirements. Just want to shout out Kendra Van Kirk from University of Miami, who introduced us to backward design and taught us at Curbsiders Teach, Episode number 21, in case anyone's keeping track of, how to use this curricular format and how to apply it whether it's on rounds, during attending teaching time, or when you're planning and building an addiction medicine curriculum. They're really easy to use, three-step approach to satisfy ACGME requirements.

Matt: Okay. And Carolyn, your show would be a good one to supplement any addiction medicine curriculum I believe.

Carolyn: Yes, thanks. Thank you for asking. The Curbsiders Addiction Medicine season 2 out July 6.

Matt: And season 1 is really, like, core topics that really should-- if you want to build a good framework and then we're going to be adding layers to that over time.

Carolyn: Totally. Definitely check it out. You'll have to find us on a separate feed, but it's worthwhile, it's worth the search.

Matt: Okay, we will link both those in the show notes for this. But Carolyn, let's talk about demystifying obesity medicine for primary care. This was a workshop you and I both attended this. The speakers Noor Khan, Mehrshid Kiazand, Lakshmi Niranjan, Mihir Patel, Amy Sheer. Three of the five people were there right at this workshop. I can't remember which, anyway, it was a blur, and I also apologize if I mispronounced anybody's name, but they did a fantastic talk, and I wanted to recap some of their pearls.

Carolyn: They did and they created a ton of great content, and they sort of started us off really with the basics. One thing I took away was really thinking about how do we counsel and almost provide lifestyle modifications for patients, particularly exercise. Because I think oftentimes, I'm yeah, move more. Hit at least 150 minutes a week. But they provided a mnemonic called FITTE. F-I-T-T-E. So, advised frequency, such as five days a week intensity, moderate T-time, such as, like 30 minutes during a lunch hour, T-type walking, and E-enjoyment. I got to make sure that the patient actually enjoys the type of activity they're doing.

Matt: Yes, Otherwise, they won't do it.

Carolyn: Yes.

Matt: Yeah, exactly. And I think for moderate intensity exercise, I usually just tell people it'd be hard to carry on a full conversation while you're doing it. Not just like walking where you're talking constantly. You're probably not going intense enough to get the heart rate up. What else from this session did you want to highlight? I have some stuff here too.

Carolyn: Yeah, I think another big thing that really just resonated because of my practice is I have a lot of patients who may be on antipsychotic medications that really-

Matt: Yes. I love this point.

Carolyn: -struggle with waking. And also their mental health is so important. It's not so easy to just stop these medications, but they really can have some negative cardiometabolic effects. But I think it's really important to remember that we can add medications for individuals who are on antipsychotics, such as metformin, which can be really quite effective, a GLP-1 or a phentermine/topiramate. This has actually been studied and can indeed counteract the effect of weight gain. I think for myself I want to start these medications earlier, truly. Once a patient is initiated on one of these, give good old metformin a try and see if we can help counteract it.

Matt: Yes. Yeah. The antipsychotics are some of the obesogenic meds that they mentioned, some of the other ones that are common, like gabapentin, pregabalin, Paul's favorite, he prescribes for everybody, and certain beta blockers like propranolol they mentioned. So, just think about the medications. valproic acid was another one that caused, actually, I think, the most weight gain of the tables they were showing. Think about those and think about

prescribing some medication just to mitigate the risk. Metformin, they said, is not necessarily going to give a ton of weight loss. For some patients, they might get 20 pounds, but it's worth trying for probably two reasons. Number one, to try to mitigate, especially if you're prescribing antipsychotics. The other one is I've had this happen where you can't get a GLP-1 unlocked unless you've tried metformin. If you're using it for diabetes and also sometimes, I've had it even off of diabetes, they want you to try other things before they'll let you prescribe a GLP-1.

Carolyn: I like that terminology you just use unlocked. It sounds like a video game-- [crosstalk] What do I have to do to unlock the next level of medications.

Matt: Carolyn, if you're not thinking of medicine as a video game that you're playing to get to the next level, then I don't think, Paul, she's not doing it right, is she?

Paul: No, you're trying to win medicine, actually, the whole goal.

Carolyn: My mindset, has been changed from here on out. I'll take that out it too.

Matt: Take it from America's PCP. How do you think he's won it?

Paul: Every conversation is a contest. Yeah, that's exactly right.

[laughter]

Matt: Okay, what else? Any other ones from this? I had a couple of other points.

Carolyn: Why don't you share it with us?

Matt: Well, the phentermine/topiramate, this is a bit of a rehash of a point, but everyone worries about phentermine being a controlled substance that's going to shoot someone's blood pressure through the roof. But actually, bupropion is probably the agent that you should be more worried about doing those things. And actually, in trials, phentermine/topiramate, actually, on aggregate had a lowering of blood pressure probably related to weight loss, not necessarily related to the effects of the medication itself. So, I have started to prescribe it. Paul, I think you've prescribed it a couple of times, and are you generally starting at the lowest? Is it the 7.5 dose?

Paul: Yeah, exactly right because I am a coward and it still seems reasonably effective. Yeah.

Matt: The speaker mentioned the pearl that the 37.5 dose is if you prescribe that and then tell them to take half a tab, that may be the cheapest way to get it covered. I haven't tried that in practice yet, but it seemed like maybe something to consider if you're running into cost.

Paul: But point being, you don't have to go in guns blazing, as we talked about in a different episode, titrate to effect.

Matt: Yeah. And, I mean, there was so much in this-- one of the things coming down the pike that I'm excited about, there's these triagonists-- they're still in early trials. I don't even think we have human trials going on yet, but they're basically trying to add in glucagon with the GLP-1, GIP agonists. They're calling these triagonists, where the GLP-1, GIP sort of provides this anorectic effect and insulinotropic effect. The glucagon while it would raise your blood sugar, that's counterbalanced by those agents, but also glucagon increases energy expenditure. They think that the combination of these three really might even lead to even more weight loss, which

I'm curious to see. I'll link to the, I think, it's a mouse study that I found, but I'm very curious to see how soon these things get rolled out.

Paul: Otherwise, hitting three just feels like a critical threshold that makes me nervous and I don't know why. [Matt laughs] It feels it wasn't like a combination, aspirin, statin, beta blocker. At one point, they were trying to make work. This feels hauntingly-- [crosstalk]

Chris: Polypill.

Matt: Yeah. It's still around? I think it's still around. But yeah, the beta blocker part is probably not the greatest, but we talked about the tripills with Jordy.

Paul: I barely pay attention.

Matt: The calcium channel blocker, ARB, and hydrochlorothiazide, I have started to use those. So far, so good, Paul.

Paul: All right.

Matt: So, Era had to go, but let's talk about sleep, and tell me what was your favorite? We went to the sleep medicine one, OSA.

Carolyn: We have Jessica Camacho, Katherine Green, Mindy Busby, Ann Cartwright, Gruber Curtis. What I loved is it was an interdisciplinary team.

Matt: Now, since you're an improv person, maybe Paul can be your patient. And how would you counsel him? Paul

Paul: He is at the scene.

Matt: Your patient about to be starting CPAP and so why don't you ask Carolyn what that's going to be like?

Paul: All right, Dr. Chan. I understand I need to start CPAP. What will that be like for me?

Carolyn: That's an excellent question Dr. Williams. I expect-

Paul: I'm still a doctor in the scenario?

Carolyn: Yeah, you still are. This is a doctor to doctor.

[crosstalk]

Matt: You're still a lovable curmudgeon.

Paul: Okay.

Matt: And everyone's favorite America's PCP.

Carolyn: All doctors have primary care doctors too.

Chris: True, you normalize having a primary care doctor.

Paul: Sorry for interrupting. Please, carry on.

Carolyn: I expect that you're not going to like it, honestly, probably much at all in the beginning. But what we think is that it just takes a little bit of time to get used to. One thing you can actually try to do is before you use that at night, is to use it while you're awake to just get some practice with how it's going to feel, have the ability to better adjust the mask and the straps to make it as comfortable for you as possible, so you could practice using it while you're watching TV, on your phone, not while you're recording a Curbsiders episode.

Paul: [crosstalk]. No one noticed, it'd be fine.

[laughter]

Carolyn: Something to consider. Yeah.

Paul: And Dr. Chan, what would happen if I don't like the mask? Let's say I'm willing to give this a try, but I don't like the way it fits. I don't like the way it looks. Do I have any kind of options or am I just stuck with this until I'm dead or should I just not use it then?

Carolyn: I have learned today that there are so many options, like, my mind was blown. There are the types where you can do the nasal pillows, which are just prongs in the nose. Of course, there's a classic over-the-nose and mouth, but they even have full face masks. I was really impressed at how many accessories as well you can actually get to help make the fit more comfortable. And a little bit of this is trial and error. If you don't like one, you can just try another mask until we find one that works for you.

Matt: And allow me to interject. Paul, number one, you don't like most things. So, the fact you're not going to like CPAP.

Paul: That's right. I'm really under a bad test case for this. Yeah.

Matt: But yeah, they mentioned that they tell patients, it's going to probably take four to six weeks, maybe even longer for you to acclimate to it. If you don't like it at first, don't give up hope, all hope. The second thing is that for the attachments, they don't tell you this because the companies lose money on this deal, but actually, you have 30 days to return the attachment if you don't like it. One of the therapists was telling us that he used to work for one of the companies. And actually, patients can request a new attachment every three months because they don't last that long. Let's say you had one of the nasal coverings, and after three months, even if you're cleaning it every day, taking proper care of it, you can request a new one so the equipment can be fixed. So, you need to ask about that, but they won't necessarily tell you because they cost them money, which I thought was great, I had no idea.

Carolyn: Another common thing patients tell me is that they don't like the hose that comes down in front of their face, like that elephant trunk hose. They say that when I toss and turn, it just like really gets in the way, gets tangled up. But I didn't know that you can actually get hoses that can be placed on the top of your head. It really falls back posterior to you. So, it really gives you more mobility.

Justin: I think it's called the unicorn hose instead of the elephant hose.

Matt: I like it.

Carolyn: I like it. Yeah

Matt: Yeah, we would all rather be unicorns than elephants, I think.

Justin: Obviously.

Matt: Paul, gosh.

[laughter]

Matt: Paul, when are you leaving again?

Paul: Just whenever you let me go.

Matt: And we talked about this before. One of the breakout sessions was like to read through what the report you get back. Most of these equipment now they have a modem, so they transmit to the patient's phone and there's patient portals. The two big companies are ResMed and Philips, and they both have patient portals and providers can get access to them too. You can look on there and they'll give you a 30-day look back so you can look at what was the median pressure because most machines now are auto-titrating CPAP and you can either set them to a single pressure or you can set them to a range. The starting range they recommended to us was something like 5 to 15 cm water. If you look and you see that the median pressure was 15 and they're still having an AHI that's greater than 5, your goal is to get their AHI, Apnea Hypopnea Index to less than 5. Then you can raise the pressure. You might go up to like 8-18 or something. It sounds like you can make it up.

Carolyn: There was somebody at my group who had a lot of experience with this and we sort of asked like, "Hey, if we're wrong and we raise the pressure, will anything bad happen?" Because I always get worried and stressed about pressing buttons and they were like, no, you could be wrong and nothing bad is going to happen to the patient. The setting is probably more uncomfortable. It's not ideal, but health wise it's not going to.

Matt: It doesn't go above 20 and probably they just won't tolerate it, is what they told us.

Carolyn: Exactly.

Matt: Yeah. I thought that was all really great stuff. The final part that I just wanted to mention, the leader of this group, because these were all folks from the same sleep medicine center and she was the director, she's an ENT physician who does some of these surgeries. She did disclose that she is a speaker or has been involved with one of these upper airway stimulator companies. However, she went through a couple of surgeries. There's palate surgeries, there's tongue surgeries where they decrease the volume of the tongue. A lot of different options there. She said that what she does is a drug-induced sleep endoscopy to survey the anatomy and inform what surgery she might offer the patient. Most of the surgeries tend to have about a 30% success rate, she said. She said that PAP therapy is much better than that. So, really, you should try that before you even consider a surgery.

For this upper airway stimulator, I think it's very well advertised. Patients will come in and be like, "I'm not going to do CPAP, I want this." No one will pay for that unless they try CPAP first because it is more effective. So, think about that, but that's almost like a pacemaker that gets put into the airway so as they're breathing in, the tongue goes out so that the air can go in. It's timed with their respiration, but I have not seen one of those in the while that many, you guys? Of course, Chiu Man has. Was the patient happy with it? Okay, patient was happy with it. All right, so that's anecdotal evidence N of 1 study.

Paul: Yeah, I think I have an N of 1 too. I think the patient's doing well.

Carolyn: Patient selection is just huge for-

Paul: Yeah.

Carolyn: -that was my take home.

Matt: All right, well, Carolyn, I know we maybe only have you for a couple more seconds and I guess America's PCP the same for him. Would you two like to say goodbye to the audience or [laughs]

Paul: Thanks Chan, always nice to see you.

Carolyn: It's been a pleasure, as always.

Matt: Okay, we're going to stay on for a few minutes. Justin and I, Chiu Man's going to jump in and we're going to finish with some more pearls. Justin, let's go to you. You've been hanging out here. What else do you have from today or from the conference?

Justin: One of the sessions I went to was on Clinical Updates in Dementia Care and Prevention by Halima Amjad, Stephanie Nofel, Mary Thomas, and Mia Yang. This was a nice overview of what the latest updates are in dementia. Talking first about dementia prevention and really focusing that there are at least 12 modifiable risk factors that we do know account for at least 40% of dementias, and that range from everything from smoking to physical activity, social isolation, but even things like structural racism have been shown to be contributing to long-term dementia. That raises the question of are there things we can do to try to prevent dementia in people who are at high risk either because of family risk or because of some of these risk factors. There're really three studies that we reviewed. So, study number one, addressing hearing loss. And this was from Yao et al, a JAMA Neurology article in 2022. That was a meta-analysis that essentially showed a 19% decrease in cognitive decline for individuals who received hearing aids. Hearing aids lead to a 19% decrease in cognitive decline over a two to five-year period.

Chris: That's important now because hearing aids are a lot cheaper right, because they're deprescribed. They're like half the cost they used to be, so good time.

Justin: Major reason.

Matt: They're not in prescription. You can get them over the counter now is what you're saying right?

Chris: Right. Now, because of that, there's a lot more competition, so prices have plummeted, so more access.

Justin: That's great. I don't know that I realized that. So that's excellent too. I think this is one thing that I'm very hyperaware of now. If a patient is having some mild hearing loss, bringing this into the equation of you may not want to deal with this whole hearing aid issue, but let's get it for you because it can help prevent cognitive decline, which I think makes sense. The second similar to hearing loss, vision loss, and so addressing vision loss, this came from a JAMA Internal Medicine 2021 article from Lee et al. That was an observational cohort, but over about 3000 people, that demonstrated a 29% decrease in dementia when cataract surgery was performed. If you had a cataract extracted that was associated with a 29% decrease in dementia diagnosis, and this was more robust in the shorter term after the surgery.

Matt: This is just like observational, looking at patients who had cataract surgery versus didn't, then they fall them out-- [crosstalk]

Justin: That's right. There were issues with this being problematic as an observational study. It was through Kaiser Permanente patients, I think. And so, there were 3000 participants. It was 91% white. But one of the cool things that they did to control for access to eye surgery, meaning, like, maybe just if you have access to eye surgery-

Matt: Oh, yeah,

Justin: -you have less likely. They did compare to individuals who had glaucoma procedures or glaucoma surgeries that would not affect your vision, but would be a proxy for access to ophthalmological surgery. Did show even controlling for that, there was a robust decrease in dementia when cataracts are extracted.

Matt: Yeah, so this is just the thing, the other dementia session that I want to talk about later. One of the things they were saying for patients with mild cognitive impairment, they're just like, "Well, fix their hearing loss." I guess fix their vision would be another thing to fix and remove any medications that might be dulling their cognition and then reevaluate them and see where they're at. I wonder if this is just part of that because patients seem less sharp when they can't hear, can't see.

Justin: Absolutely.

Matt: I wonder if it's also the brain just gets more stimulation, more information.

Justin: I think that's one of the theories is that you're able to focus on what's really going around. You're able to take in the appropriate stimuli and respond to it appropriately because you have more accurate. In the dementia session that you went to, did they talk about blood pressure?

Matt: They didn't, but I know the Lancet, where these twelve modifiable risk factors came from, this was like a 2020 paper. They talked about that and I've been curious about that. That's one of my buy-ins to try to get patients to let us treat their blood pressure is that it can help prevent dementia.

Justin: Yeah, good news, bad news. Based on this update, first I will say that the reviewers went over the SPRINT MIND trial and some of this other data that did show a significant

reduction in mild cognitive impairment. But I won't go into it too much because really, unfortunately, in 2021, there was a new meta-analysis study that looked at all of these studies, including the SPRINT MIND, and ultimately showed no improvement in mild cognitive impairment, no improvement in dementia. Did ultimately say that these are low-quality evidence studies. There's signal that perhaps this is something that can help put off dementia. But the most recent highest quality meta-analysis, which admittedly is not great, showed no improvement with aggressive blood pressure in improving monitor-- [crosstalk]

Matt: That's disappointing.

Justin: It is disappointing.

Chris: It counts as aggressive, but like less than 140/90.

Justin: It was a meta-analysis, so I think it looked at different trials that had different definitions, but-- [crosstalk]

Matt: I imagine the targets were all over the place.

Chris: I'm okay with my octogenarian has like 150/90, right.

Matt: The other issue is it's probably hard to prove because we're so generally, as we talked about on the previous recaps from ACP, we're not great at controlling blood pressure.

Justin: No, we are not.

Matt: it's probably hard to get someone that if you actually control their blood pressure for 30 or 40 years, I'm sure there're other benefits too. So, still try to control blood pressure [crosstalk].

Justin: Sure.

Matt: That's disappointing. What else? Anything else from this one?

Justin: In focusing on what we do have evidence for, we talked about treating depression in dementia specifically, which is very common. There's a great article Watt et al. from BMJ 2021 looked at a comparative efficacy meta-analysis. Long story short, there are mixed results in treating depression with SSRIs, SNRIs, and mirtazapine, which is disappointing. They referenced the SYMBAD trial showing mirtazapine really had no significant effect. But there is some good news in that there are nonpharmacological approaches that may actually be more helpful in treating depression in older adults with dementia. Those are things like cognitive stimulation which can be anything from crossword puzzles to doing things that are actively engaging in the mind, exercise and social interaction, massage and touch therapy actually, and the fourth reminiscence therapy of talking about older times, showing photos, playing music that the person might have listened to in their youth. These are four evidence-based, statistically and clinically significant treatments for depression in older adults with dementia. The stimulation, exercise, social interaction, massage, and touch reminiscence therapy that can really all be done at, like, adult day programs.

Chris: So, tell me, massage touch? Like, they get a massage touch or they're giving other people a massage?

Justin: No, they are receiving the massage. You can train a care partner to really do, I think, just physical touch therapy and massage.

Matt: Did they touch on the monoclonal antibodies, which seem to be so controversial? Is that something you wanted to bring up?

Justin: They did. We can quickly go over the Clarity AD trail from New England Journal of Medicine 2023 evaluated the new monoclonal antibody lecanemab. Good news, bad news again, lecanemab binds to soluble amyloid beta protofibrils. Long story short, it is great at reducing soluble amyloid. It's great. It gets it out of your system. We thought this was something that was a major component in Alzheimer's, but unfortunately the bad news is that clinically the reduction in function does not mitigate that much. Both the placebo group and the monoclonal antibody group declined in cognitive function. The lecanemab decreased a little bit more and it was statistically significant, though it's unclear if it's clinically significant. But there were some pretty significant adverse events including death. These are among people who were- [crosstalk]

Matt: These are brain bleed, right?

Justin: Brain bleeds, yeah. There are some hemorrhages including some asymptomatic hemorrhages that they said don't worry about. But this is all in a population that has pretty mild cognitive impairment. We're not even talking about people with more severe disease. In people with very mild cognitive impairment, those adverse events are pretty significant.

Chris: One question I have in the study is how do they identify the patients to treat? Because there are lots of different type of dementia. Most of the time we're diagnosing Alzheimer's dementia clinically, right. So, do they all have amyloid issues? I don't know. How do they specify those patients?

Matt: I know to get it approved, you have to have a CSF test or a PET scan-

Chris: Got you.

Matt: -in order to get it approved, like if you were trying to prescribe it for somebody. So, I imagine the studies included that too.

Justin: Exactly. That's exactly right.

Matt: Yeah.

Chris: I bet you they went with those mild cognitive impairments because they're trying to make the case for starting these medicines earlier too right.

Matt: We shouldn't gloss over the fact that it was very controversial that the first aducanumab got approved. I think this one is similarly controversial and that there's this what's come out in the past year about some data in some of the early amyloid studies was not on the up and up. Now people are questioning the whole amyloid hypothesis. I've read some experts who argue amyloid is still something we should be looking into other experts are like, were we chasing the wrong thing for the past couple of decades? So, I don't know what to believe. I just know that right now, at least in patients with established amyloid, it's not like what we hoped it would be.

Chris: Right. And again, like the amyloid, there's a wonderful draft like the amyloid gets out of your system, and that's just not clinically.

Matt: Right, because it's the damage already done. If you could prevent the amyloid from ever being there, would that work? They don't know, but apparently, there're a lot of drugs in the pipeline.

Justin: And one specifically, donanemab Is clinical trial data should be out any moment now. There's some signal that it had an improvement in independent activities of daily living, which would be clinically significant. That might be something in the near future.

Chris: That's a similar mechanism, though.

Justin: It's a monoclonal antibody. I'm not sure what it started as.

Matt: Right now, when I'm talking to patients about dementia, it's still all about prevention, especially patients like middle age 40s to 60s that don't yet have dementia. I talk to them about that. Well, let me give some of the pearls from my session. I went to a great workshop on dementia and primary care. The speakers were Dr. Barak Gaster and Dr. Jaqueline Raetz. And they talked about really practical stuff. I did want to plug upfront that there's a website that people can go to, it's called *cognition-primarycare.org* and it has some really practical tools. There're even phrases for everyone's favorite electronic health record, like dot phrases that you can use, and just a lot of practical tips about how to evaluate patients with dementia or suspected dementia.

One of the things they just said is like, "Look for the three worrisome signs." Normal aging is something like you misplace your keys, you have trouble recalling names. But worrisome signs are if people forget something that just happened, if people are suddenly not able to do complex tasks, like making some recipe for a holiday meal that they used to always make, or if they're becoming lost or disoriented in familiar places, those would be concerning signs. You can ask about those and then you definitely want to ask about a friend or family member if there're any other worrisome signs. Those are some of the ways.

They mentioned that mild cognitive impairment, actually about 30% of those patients will not progress to dementia, but 70% will. The main differentiator between the two because both of them can have memory problems. It's really when you start to lose ADLs you would start to call it dementia. But the worrisome symptoms that I just mentioned and some memory trouble, those happen in both mild cognitive impairment and dementia. They recommended as I was mentioning with Justin that, if they have any of those treatable risk factors like vision, like hearing, you treat those.

Other ones they mentioned were like, if they're drinking alcohol, tell them to stop alcohol because even if they were the type of person that could have a bottle of wine and not be affected their whole life, once they're getting up there in age, it might start to affect their cognition. Ask them about if they're taking like, diphenhydramine every night for sleep and if they have sleep apnea or sleep disorder, treat that, treat their depression. All these things can really make mild cognitive impairment. If you think someone has mild cognitive impairment, maybe they just have these things and so you would reevaluate them. They were a fan of the MoCA and MoCA of 24 to 26 is in the mild cognitive impairment range and scores lower than that more consistent with dementia, especially if they have ADLs loss.

Chris: I'm a SLUMS fan, anyone one know SLUMS?

Justin: Mm, I don't know SLUMS.

Matt: We didn't talk about that. They mentioned that there's lots of sleep tests. On their website, they just put one pathway down that they know is pretty practical. One of the practical tips about doing a MoCA or SLUMS because it does take a while, right. What they said is "If a patient brings up memory concerns, you should always take it seriously, especially if you have other staff or family members bringing up memory concerns." You should bring that person back for a-- tell them, "Listen, I'm worried about this. I want to make sure we have enough time. Try to bring them back for a longer visit, like a 40-minute visit, and then you can bill a 99215, use a time-based code for that." The same thing, if you do diagnose dementia or mild cognitive impairment, you can bring them back and to discuss what that means for them. Maybe tell them to bring a family member as well. Just so you're not super running behind in clinic and you can devote the time that you need to for this.

Chris: I've got a good practical tip. I don't know if you guys use the SAGE exam. It's a Self-Administered Gerocognitive Exam.

Matt: No.

Chris: It actually was developed at the Ohio State.

Justin: Mm.

Matt: Oh, oh, surprising.

Chris: If you type in OSU and SAGE, it's in a whole bunch of different languages, too, and you can just print it out. I give them to my patient with a self-addressed envelope and they either mail it back or they can bring them back in their next appointment. And it's pretty comprehensive. Usually in my screening, I do like a Mini-Cog, and then if it's positive, then I give them a SAGE to go home.

Matt: Oh, I love that. That's great.

Justin: That is a [crosstalk] system.

Matt: Yeah.

Justin: And this is in multiple languages, it's very easily accessible online from the Ohio State.

Matt: There you go.

Justin: They have it in Croatian.

Chris: Yes.

Matt: There you go.

Chris: They got some good languages, it's pretty cool.

Matt: I think as far as treatment goes, I think the medications, they said generally they can be safe. They did say that you can give a six-month trial of, like, donepezil, which is one of the most common acetylcholine esterase inhibitors since it's usually started low and then increased, their practice was to also taper it off, but you don't have to continue it. Once people have really advanced dementia, it's not as effective. So, you can taper it off in that case too because then you're also worried about GI side effects anorexia with that. I don't use too much of it in my practice, but I thought that was helpful to hear that they taper it off. I know there's some concern about people just rapidly worsening when you stop them.

Chris: Did they talk about the ever-growing Beers list? I feel like every single medicine is on there now, so it's almost useless to me now.

Matt: Yeah, we didn't talk about the Beers list, but I agree with you. Yeah, everything's on there. My electronic health record pops up a little picture of someone with a cane whenever I order a medication that I shouldn't be.

Justin: Oh, that's hilarious.

[laughter]

Matt: I'm like, yeah, they've been on it for 10 years.

Justin: I don't know if we're talking about it, but they just updated the Beers list this year. The 2023 updated Beers list.

Matt: Absolutely.

Chris: It's getting bigger, I think it just gets bigger and bigger. [crosstalk]

Justin: I can't imagine it getting smaller, yeah.

Chris: Like every blood pressure medicine, small statins are on there. I don't know.

Justin: You know what? Benzos are fine. Go for it. They are [crosstalk].

Matt: Yeah. But I do think that it is important to just run the med list, think about how it's affecting the person's-

Justin: Absolutely.

Matt: -in general, in geriatrics, that deprescribing is, like, the best thing in geriatrics.

Justin: Absolutely.

Chris: Absolutely.

Matt: All right, well, we probably could end here, but, Justin, if you really had another thing that you wanted to?

Justin: How about some lightning round clinical updates in primary care? Yes, no?

Matt: Okay, lets do it. Yeah.

Chris: All right.

Justin: Yes/No. Hydrochlorothiazide, does it help prevent recurrent kidney stones?

Matt: I want to say yes.

Justin: New study, hydrochlorothiazide does not help prevent recurrent kidney stones. A lot of people like you thought it would, but the no-stone trial showed hydrochlorothiazide does not help prevent recurrent kidney stones. All right. Mediterranean diet, does it help reduce major adverse cardiovascular events for secondary prevention for people who have already had identified heart disease?

Matt: it's one of those bulletproof things like coffee, always a positive study. I'm going positive study.

Justin: That's always a positive study. That's right. Mediterranean diet associated with a 27% reduction in MACE for secondary prevention from the CORDIOPREV trial Lancet 2022.

Chris: The CORDIOPREV comes up multiple times.

Justin: But they must have a bunch of-- [crosstalk]

Matt: It's big Mediterranean man, a lot of money behind that Mediterranean. It's that olive oil money.

Justin: [crosstalk] all over SGIM. If a patient's eGFR starts going down real low, we need to stop the ACE inhibitor or ARB? Yes or no?

Matt: Well, I hang out with some pretty cool people, so I'm going to say no. I'm going to say no.

Justin: That's exactly right. We do not need to stop the ACE inhibitors when there's a low eGFR per the STOP-ACEi trial-

Chris: How low?

Justin: -New England Journal of Medicine 2022.

Chris: How low, like as low as--

Justin: This is low. Their study was like a very narrow population. They screened a huge amount of people. We're not doing a deep dive in this, but-

Chris: Okay.

Justin: -I don't know that we really be that many people who are too worried.

Chris: They go right into dialysis-- [crosstalk**]**

Matt: But we've talked about on our show before, you can use them in CKD4. You just need to monitor potassium and-

Chris: Exactly.

Matt: - their overall trajectory of renal function.

Justin: All right. And then the final one. I won't do a quiz, but I admit I had not seen this. I was sitting next to America's PCP, Paul Williams, who had heard this one before. New England Journal of Medicine 2022 [unintelligible [01:12:20] et al., albuterol-budesonide combination rescue inhaler was shown to decrease steroid use, ED visits, and hospitalizations when compared to albuterol alone in patients who are already on a controller inhaled corticosteroid. Basically, if you're on fluticasone and albuterol but you're having asthma exacerbations, if you replace the albuterol with this new combination albuterol-budesonide it decreases overall steroid use, EDs, and hospitalizations. So kind of cool. It's not in alignment with GINA recommendations, which would just say switch to the-- [crosstalk]

Matt: ICS, LABA.

Justin: -exactly the formoterol. But this would be another option if the albuterol-budesonide combination medication was available in the United States, which it's not. This is a mute study, but we should all be and know about it because we're academics, and are curious.

Matt: I think the point is that patients need-- if they're having asthma symptoms, they should be taking an inhaled corticosteroid. They can use albuterol as much as they want. We give it continuously when patients are in the hospital and really sick. But if they're using albuterol and having a bad day, a bad week, they should also be taking an inhaled steroid. I think that's the most that I can take away from these. The ICS inhaled corticosteroid/LABA, long-acting beta-agonists, those are good ones if the patient can get them. A lot of patients still are just carrying around albuterol inhalers only.

Justin: That's right.

Matt: And I think that's what we most need to fix first before we argue about like is ICS/LABA better than ICS/albuterol? ICS/SABA versus ICS/LABA.

Justin: LABA.

Matt: Yeah.

Chris: How young was it in the study?

Justin: It did go down to children. I forget how young I went, but the majority were adults.

Chris: Probably 12 or something. That's always like cut-off.

[music]

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

Chris: Yummy.

Justin: Are you still hungry? For more, join our Patreon and get all episodes ad-free, plus twice monthly bonus episodes at *patreon.com/curbsiders*.

Matt: They're just blowing out the levels on the mic.

Justin: I've gotten feedback about this before, no pun intended. You can find show notes at *thecurbsiders.com* and sign up for our mailing list to get our weekly show notes in your inbox, including our Curbsiders Digest recapping the latest practice-changing articles, guidelines, and news and internal medicine.

Matt: And we're committed to high-value practice-changing knowledge. And to do that, we want your feedback. So, you can email us at *askcurbsiders@gmail.com*. You can also find the show on YouTube, Spotify, or Apple Podcasts. This won't be a CME episode because it's a rapid turnaround and I just don't have time. A special thanks to our whole team who helped with this episode. Era, Carolyn, Chris, Justin, Paul. I don't think I'm forgetting anyone else, but if I am, I'm sorry. Our technical production for this episode is done by Pod Paste. Elizabeth Proto runs our social media. Chris “The Chiu Man” Chiu is a moderator on our discord. Stuart Brigham composed our theme music. And with all that, until next time, I've been Dr. Matthew Frank Watto.

Chris: This has been Chris “The Chiu Man” Chiu

Justin: I've been Justin Lee Berk. Thank you and goodnight.

[Transcript provided by SpeechDocs Podcast Transcription]