Latest Clinical Guidelines

ClinicalEdge provides succinct summaries of "must-read" news and research. Here are several recently published guidelines on telemedicine, teen binge drinking, primary immunodeficiency, atopic dermatitis in children, obesity, and chronic kidney disease.

IN THIS ARTICLE

ACP: TELEMEDICINE IN PRIMARY CARE SETTINGS

Daniel H, Sulmasy, LS. Policy recommendations to guide the use of telemedicine in primary care settings: an American College of Physicians position paper. *Ann Intern Med.* [Epub ahead of print September 8, 2015]. doi:10.7326/M15-0498.

The American College of Physicians (ACP) has issued policy recommendations to guide the use of telemedicine in primary care settings, along with clinician considerations for those who use telemedicine and policy recommendations on the practice and reimbursement of telemedicine. ACP's position is that telemedicine can potentially be a beneficial and important part of the future of health care delivery; however, it also stresses the importance of balancing the benefits of telemedicine against the potential risks for patients. Among the ACP position statements and recommendations are:

- ACP believes that a valid patient-provider relationship must be established for a professionally responsible telemedicine service to take place.
- ACP recommends the telehealth activities address the needs of all patients without disenfranchising financially disadvantaged populations or those with low literacy or low technologic literacy.

ACP believes that clinicians should use their professional judgment about whether the use of telemedicine is appropriate for a patient.

COMMENTARY

The issue of professional judgment about when it is sufficient to see a patient using a digital interface will ultimately determine the safety and effectiveness of telemedicine. It is a mode of health care delivery that was nonexistent just a few years ago and now has an estimated annual growth rate of 20% per year, with an expected 7 million visits per year by 2018. The potential advantages include health savings, convenience, and the potential to deliver specialized services to people who might otherwise not have access to them. In addition, the use of telemedicine as a part of case-management and patient follow-up has shown promise. In this era of ever-changing technologies, we need to embrace new modes of care with skeptical open arms and be honest about the potential benefits as well as the risks. **—NS**

AAP: BINGE DRINKING AMONG ADOLESCENTS

Siqueira L, Smith VC; Committee on Substance Abuse. Binge drinking (clinical report). *Pediatrics.* 2015;136(3):e718-e726. doi: 10.1542/peds.2015-2337.

A clinical report released by the American Academy of Pediatrics (AAP) details alcohol abuse by children and adolescents in the United States and offers guidance and recommendations to combat this high-risk behavior. The report states that among youth who drink, the proportion that drinks heavily is higher than among adult drinkers.

Among those who drink, binge drinking increases from approximately 50% in those ages 12 to 14 to 72%

Commentary provided by **Neil Skolnik, MD**, Associate Director of the Family Medicine Residency Program at Abington Memorial Hospital in Pennsylvania and Professor of Family and Community Medicine at Temple University in Philadelphia. These items were originally published as part of ClinicalEdge (www.clinicianreviews.com/clinicaledge).

among those ages 18 to 20. Alcohol use is also associated with the leading causes of death and serious injury in this age-group, including motor vehicle accidents, homicides, and suicides. Recommendations offered in the report include

- In the office setting, provide programs designed to deliver messages about binge-drinking prevention to parents.
- Ask adolescents about alcohol use during office visits.
- Encourage schools to adopt preventive measures, including school-based health education programs.

COMMENTARY

Binge drinking in adults is defined as consumption of five or more alcoholic drinks in a two-hour period for men and four or more drinks for women. The number of drinks that qualifies as binge drinking in teenagers is slightly less and varies by age.

Using a 30-day time period, 14% of adolescents (1 out of 7) reported binge drinking. When teenagers drink alcohol, they tend to binge drink. Of students who consume alcohol, two-thirds report binge drinking, and 10% report having drunk 10 or more drinks in a row.

It is important to address this problem with parents and youth beginning at about age 9, as the change in attitudes toward drinking appears to begin between ages 9 and 12. It is also important to remind parents, supported by good evidence, that the message they send to their children about alcohol is the most important influence on teenage and young adult decisions about drinking.[1] **—NS**

1. Turrisi R, Mallett KA, Cleveland MJ, et al. Evaluation of timing and dosage of a parent-based intervention to minimize college students' alcohol consumption. *J Stud Alcohol Drugs.* 2013;74(1):30-40.

MANAGEMENT OF PRIMARY IMMUNODEFICIENCY

Bonilla FA, Khan DA, Ballas ZK, et al. Practice parameter for the diagnosis and management of primary immunodeficiency. *J Allergy Clin Immunol.* [Epub ahead of print September 11, 2015]. doi: 10.1016/j.jaci.2015.04.049.

This practice parameter is intended to provide practical guidance on the clinical recognition and diagnosis of primary immunodeficiency (PIDD), along with general principles on management of these disorders. Highlights include

- PIDD has a prevalence of 1:2,000 children.
- PIDD is subdivided into humoral or antibody deficiencies and combined immunodeficiency.
- Initial evaluation is guided by the clinical presentation, and screening tests are applied and followed by advanced tests, ensuring efficient and thorough evaluation of mechanisms of immune dysfunction that underlie the clinical presentation.
- Diagnosis and therapy should be guided overall or performed in consultation with persons and centers with knowledge and experience diagnosing and treating a broad range of immunodeficiencies.

COMMENTARY

Clinicians should be aware of PIDD in order to refer appropriate patients on to an allergist/immunologist for further evaluation. While many different types of PIDD exist, they generally present with recurrent or severe infections or infections by unusual organisms. For example, approximately a quarter of patients older than 2 with invasive pneumococcal disease have an identifiable PIDD. This is a group of disorders that, while rare, is helpful to be aware of and to refer on for further evaluation when indicated. **—NS**

ATOPIC DERMATITIS IN CHILDREN

Eichenfield LF, Boguniewicz M, Simpson EL, et al. Translating atopic dermatitis management guidelines into practice for primary care providers. *Pediatrics.* [Epub ahead of print August 3, 2015]. doi: 10.1542/peds.2014-3678.

Treatment guidelines for atopic dermatitis (AD) in children, designed specifically for use by pediatricians and other primary care providers, include basic management such as skin care, antiseptic measures, and trigger avoidance, to be used regardless of AD severity, according to a roundtable discussion to address challenges in AD management. Recommendations for the primary care provider include

- The diagnosis of eczema is a clinical one, based on a chronic or relapsing course of a pruritic dermatitis consisting of erythematous papules or patches of scaling and/or excoriated skin.
- Basic management is important and should include skin hydration with an appropriate moisturizer, use of diluted bleach baths, trigger avoidance, and acute treatment for flares.
- Treatment of acute flares is managed with topical corticosteroids, using a more potent topical steroid initially and then deescalating therapy to a less potent agent after a few days to weeks.

For patients with moderate-to-severe eczema, maintenance therapy for flare-prone areas should be

UNITED STATES POSTAL SERVICE

Statement of Ownership, Management, and Circulation (Requester Publications Only)

1. Publication Title	2. Publication Number	3. Filing Date
Clinician Reviews	1 0 5 2 - 0 6 2 7	10/1/15
4. Issue Frequency	5. Number of Issues Published Annually	6. Annual Subscription Price
Monthly	12	(if any) $79

7. Complete Mailing Address of Known Office of Publication (Not printer) (Street, city, county, state, and ZIP+4®)
Frontline Medical Communications Inc., 7 Century Drive, Suite 302, Parsippany, Morris County, NJ 07054-4609
Contact Person: Donna Sickles
Telephone (Include area code): 973-206-8005

8. Complete Mailing Address of Headquarters or General Business Office of Publisher (Not printer)
7 Century Drive, Suite 302, Parsippany, NJ 07054-4609

9. Full Names and Complete Mailing Addresses of Publisher, Editor, and Managing Editor (Do not leave blank)
Publisher (Name and complete mailing address)
Joshua Prizer, 7 Century Drive, Suite 302, Parsippany, NJ 07054-4609
Editor (Name and complete mailing address)
Karen Clemments, 7 Century Drive, Suite 302, Parsippany, NJ 07054-4609
Managing Editor (Name and complete mailing address)
Ann Hoppel, 7 Century Drive, Suite 302, Parsippany, NJ 07054-4609

10. Owner (Do not leave blank. If the publication is owned by a corporation, give the name and address of the corporation immediately followed by the names and addresses of all stockholders owning or holding 1 percent or more of the total amount of stock. If not owned by a corporation, give the names and addresses of the individual owners. If owned by a partnership or other unincorporated firm, give its name and address as well as those of each individual owner. If the publication is published by a nonprofit organization, give its name and address.)

Full Name	Complete Mailing Address
Frontline Medical Communications, Inc.	7 Century Drive, Suite 302, Parsippany, NJ 07054-4609
Quadrant Media Corporation	450 Park Avenue, New York, NY 10022

11. Known Bondholders, Mortgagees, and Other Security Holders Owning or Holding 1 Percent or More of Total Amount of Bonds, Mortgages, or Other Securities. If none, check box → ☑ None

Full Name	Complete Mailing Address

12. Tax Status (For completion by nonprofit organizations authorized to mail at nonprofit rates) (Check one)
The purpose, function, and nonprofit status of this organization and the exempt status for federal income tax purposes:
☐ Has Not Changed During Preceding 12 Months
☐ Has Changed During Preceding 12 Months (Publisher must submit explanation of change with this statement.)

Publication Title: Clinician Reviews			Issue Date for Circulation Data Below: September 2015	
15. Extent and Nature of Circulation			Average No. Copies Each Issue During Preceding 12 Months	No. Copies of Single Issue Published Nearest to Filing Date
a. Total Number of Copies (Net press run)			76,295	80,337
b. Legitimate Paid and/or Requested Distribution (By mail and outside the mail)	(1)	Outside County Paid/Requested Mail Subscriptions stated on PS Form 3541. (Include direct written request from recipient, telemarketing, and Internet requests from recipient, paid subscriptions including nominal rate subscriptions, employer requests, advertiser's proof copies, and exchange copies.)	38,846	40,767
	(2)	In-County Paid/Requested Mail Subscriptions stated on PS Form 3541. (Include direct written request from recipient, telemarketing, and Internet requests from recipient, paid subscriptions including nominal rate subscriptions, employer requests, advertiser's proof copies, and exchange copies.)	-	-
	(3)	Sales Through Dealers and Carriers, Street Vendors, Counter Sales, and Other Paid or Requested Distribution Outside USPS®	-	-
	(4)	Requested Copies Distributed by Other Mail Classes Through the USPS (e.g., First-Class Mail®)	-	-
c. Total Paid and/or Requested Circulation (Sum of 15b (1), (2), (3), and (4)) ▶			38,846	40,767
d. Non-requested Distribution (By mail and outside the mail)	(1)	Outside County Nonrequested Copies Stated on PS Form 3541 (include sample copies, requests over 3 years old, requests induced by a premium, bulk sales and requests including association requests, names obtained from business directories, lists, and other sources)	37,141	38,947
	(2)	In-County Nonrequested Copies Stated on PS Form 3541 (include sample copies, requests over 3 years old, requests induced by a premium, bulk sales and requests including association requests, names obtained from business directories, lists, and other sources)	-	-
	(3)	Nonrequested Copies Distributed Through the USPS by Other Classes of Mail (e.g., First-Class Mail, nonrequestor copies mailed in excess of 10% limit mailed at Standard Mail® or Package Services rates)	-	-
	(4)	Nonrequested Copies Distributed Outside the Mail (Include pickup stands, trade shows, showrooms, and other sources)	-	-
e. Total Nonrequested Distribution (Sum of 15d (1), (2), (3) and (4))			37,141	38,947
f. Total Distribution (Sum of 15c and e) ▶			75,987	79,714
g. Copies not Distributed (See Instructions to Publishers #4, (page #3)) ▶			308	623
h. Total (Sum of 15f and g)			76,295	80,337
i. Percent Paid and/or Requested Circulation (15c divided by 15f times 100) ▶			51.1%	51.1%

* If you are claiming electronic copies, go to line 16 on page 3. If you are not claiming electronic copies, skip to line 17 on page 3.

PS Form 3526-R, July 2014 (Page 2 of 4)

UNITED STATES POSTAL SERVICE

Statement of Ownership, Management, and Circulation (Requester Publications Only)

16. Electronic Copy Circulation	Average No. Copies Each Issue During Previous 12 Months	No. Copies of Single Issue Published Nearest to Filing Date
a. Requested and Paid Electronic Copies ▶	-	-
b. Total Requested and Paid Print Copies (Line 15c) + Requested/Paid Electronic Copies (Line 16a) ▶	-	-
c. Total Requested Copy Distribution (Line 15f) + Requested/Paid Electronic Copies (Line 16a) ▶	-	-
d. Percent Paid and/or Requested Circulation (Both Print & Electronic Copies) (16b divided by 16c × 100) ▶	-	-

☐ I certify that 50% of all my distributed copies (electronic and print) are legitimate requests or paid copies.

17. Publication of Statement of Ownership for a Requester Publication is required and will be printed in the November 2015 issue of this publication.

18. Signature and Title of Editor, Publisher, Business Manager, or Owner: Ann M. Hoppel, Managing Editor — Date: 10/7/2015

I certify that all information furnished on this form is true and complete. I understand that anyone who furnishes false or misleading information on this form or who omits material or information requested on the form may be subject to criminal sanctions (including fines and imprisonment) and/or civil sanctions (including civil penalties).

PS Form 3526-R, July 2014 (Page 3 of 4) PRIVACY NOTICE: See our privacy policy on www.usps.com.

applied regularly or at first sign of a flare-up. Recommended agents include tacrolimus or pimecrolimus (topical calcineurin inhibitors) or medium- or low-potency topical corticosteroids (avoiding medium-potency topical steroids on the face), depending on the severity of eczema.

COMMENTARY

Eczema affects about 12% of US children (ages 0 to 17 years), most of whom have mild disease and are well taken care of by primary care providers. This article provides clear guidance for treatment of a disease that we see quite frequently. Use of diluted bleach baths or washes is an underappreciated approach, and I suspect the clear recommendation for it, based on very good evidence, will lead to a helpful addition to many clinicians' standard approach. **—NS**

OBESITY TREATMENT IN PRIMARY CARE

Fitzpatrick SL, Wischenka D, Appelhans BM, et al. An evidence-based guide for obesity treatment in primary care. *Am J Med.* [Epub ahead of print July 31, 2015]. doi: 10.1016/j.amjmed.2015.07.015.

A new evidence-based guideline from the Society of Behavioral Medicine for obesity management and treatment in primary care is based on the "5As" counseling framework (assess, advise, agree, assist, and arrange). The guide recommends building a multidisciplinary team that helps patients lose weight and maintain their weight loss by

- Addressing patients' psychosocial issues and medical and psychiatric comorbidities associated with obesity treatment failure
- Delivering intensive counseling consisting of goal setting, self-monitoring, and problem solving
- Connecting patients with community resources to assist them in making healthy lifestyle changes.

COMMENTARY

Combating obesity is the critical health issue of the next decade. Currently, two-thirds of the adult population is either overweight or obese, and if the current trend continues, diabetes, one of the most important consequences of obesity, will develop in one out of three Americans born today. Clinicians are generally good at accomplishing the first and second of the three "As": assessing and advising.[1] The challenge for most of us in busy office practices is in assisting patients with the development of specific, concrete goals using specific, concrete behaviors, and then,

when appropriate, arranging for referral to nutritionists, personal trainers, and multicomponent programs to help patients accomplish the agreed-upon goals. **—NS**

1. Spring B, Ockene JK, Gidding SS, et al. Better population health through behavior change in adults. *Circulation.* 2013;128:2169-2176.

MANAGEMENT OF CKD

Vassalotti JA, Centor R, Turner BJ, et al; US Kidney Disease Outcomes Quality Initiative. A practical approach to detection and management of chronic kidney disease for the primary care clinician. *Am J Med.* [Epub ahead of print September 25, 2015]. doi: 10.1016/j.amjmed.2015.08.025.

This guideline was developed for the primary care provider to guide assessment and care of chronic kidney disease (CKD). Recommendations include

- Assessment of estimated glomerular filtration rate (GFR) and albuminuria should be performed for persons with diabetes and/or hypertension but is not recommended for the general population.
- Prevention of CKD progression requires blood pressure < 140/90 mm Hg, use of ACE inhibitors or angiotensin receptor blockers (ARB) for patients with albuminuria and hypertension, A1C < 7% for patients with diabetes, and correction of CKD-associated metabolic acidosis.
- Nephrotoxic drugs (eg, NSAIDs) should be avoided, and providers should be aware to use reduced doses of medications that are renally excreted, such as insulin, many antibiotics, and some statins.

The ultimate goal of CKD management is to prevent disease progression, minimize complications, and promote quality of life.

COMMENTARY

More than 10% of the US population has CKD, defined as a GFR < 60 mL/min/1.73 m^2 and/or albumin-creatinine ratio > 30 mg/g. Both GFR and albuminuria independently predict progression of CKD. Control of blood pressure and A1C and use of an ACE inhibitor or an ARB are well-appreciated methods of slowing CKD progression. What is not as well appreciated is that treatment with ACE inhibitors or ARBs remains renal protective even with GFR < 30. Also important is the use of oral alkali therapy to maintain normal serum bicarbonate levels, which may slow CKD progression. When bicarbonate levels decrease to < 22 mmol/L, sodium bicarbonate (650 mg tid) should be added to raise the bicarbonate level above 22 mmol/L. For patients with severe CKD, referral to a nephrologist is appropriate. **—NS** **CR**