TOP 10 Most Impactful Articles from 2018 Canadian Family Physician

CFP • MFC

CANADIAN FAMILY PHYSICIAN • LE MÉDECIN DE FAMILLE CANADIEN

The official journal of the College of Family Physicians of Canada

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College of Family Physicians of Canada

Faculty/Presenter Disclosures

- **Faculty: Mike Allan**
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  - **Consulting Fees:** N/A
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  - **Other:** Bedmed, INR range (publicly funded research studies)

PEER PATIENTS EXPERIENCE EVIDENCE RESEARCH

THE COLLEGE OF FAMILY PHYSICIANS OF CANADA

LE COLLÈGE DES MÉDECINS DE FAMILLE DU CANADA

Faculty/Presenter Disclosures

- **Faculty: Nick Pimlott**
- **Salary: College of Family Physicians of Canada**
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  - **Consulting Fees:** None
  - **Patents:** None
  - **Other:** None

Learning Objectives

By the end of this activity, participants will be able to:

- Identify the 10 articles most impactful articles from Canadian Family Physician (CFP) in 2018
- Describe the key recommendations from CFP's top guidelines from 2018
- Describe and interpret key finding in each article to identify practical key take away messages

NP

Top 10 Canadian Family Physician Articles of 2018

Simplified guideline for prescribing medical cannabinoids in primary care	72665
Deprescribing benzodiazepine receptor agonists	59720
Deprescribing antipsychotics for behavioural and psychological symptoms of dementia and insomnia	24158
Systematic review of systematic reviews for medical cannabinoids	16127
Stubborn heel pain. Treatment of plantar fasciitis using high-load strength training	16062
Teach your parents and providers well. Call for refocus on the health of trans and gender-diverse children	15117
Primary care of adults with intellectual and developmental disabilities	15101
Approach to tinnitus management	12316
Ketogenic diet for weight loss	12063
Approach to the detection and management of chronic kidney disease	7963
Infant sleep training: rest easy?	7807

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LE COLLÈGE DES
MÉDECINS DE FAMILLE
DU CANADA

A patient asks you whether medical cannabinoids will help to improve their neuropathic pain. How confident do you feel that medical cannabinoids can meaningfully improve neuropathic pain?

Very confident

Somewhat confident

Neutral

Not confident

MA

Simplified guideline for prescribing medical cannabinoids in primary care

G. Michael Allan, Jamil Ramji, Danielle Perry, Joey Ton, Nathan P. Beahm, Nicole Crisp, Beverly Dockrill, Ruth E. Dubin, Ted Findlay, Jessica Kirkwood, Michael Fleming, Ken Makus, Xiaofu Zhu, Christina Korownyk, Michael R. Kolber, James McCormack, Sharon Nickel, Guillermina Noël and Adrienne J. Lindblad

Systematic review of systematic reviews for medical cannabinoids

Pain, nausea and vomiting, spasticity, and harms

G. Michael Allan, Caitlin R. Finley, Joey Ton, Danielle Perry, Jamil Ramji, Karyn Crawford, Adrienne J. Lindblad, Christina Korownyk and Michael R. Kolber

Can Fam Physician 2018 (Feb): 64: 111-20.
Can Fam Physician 2018 (Feb): 64: e78-e94.

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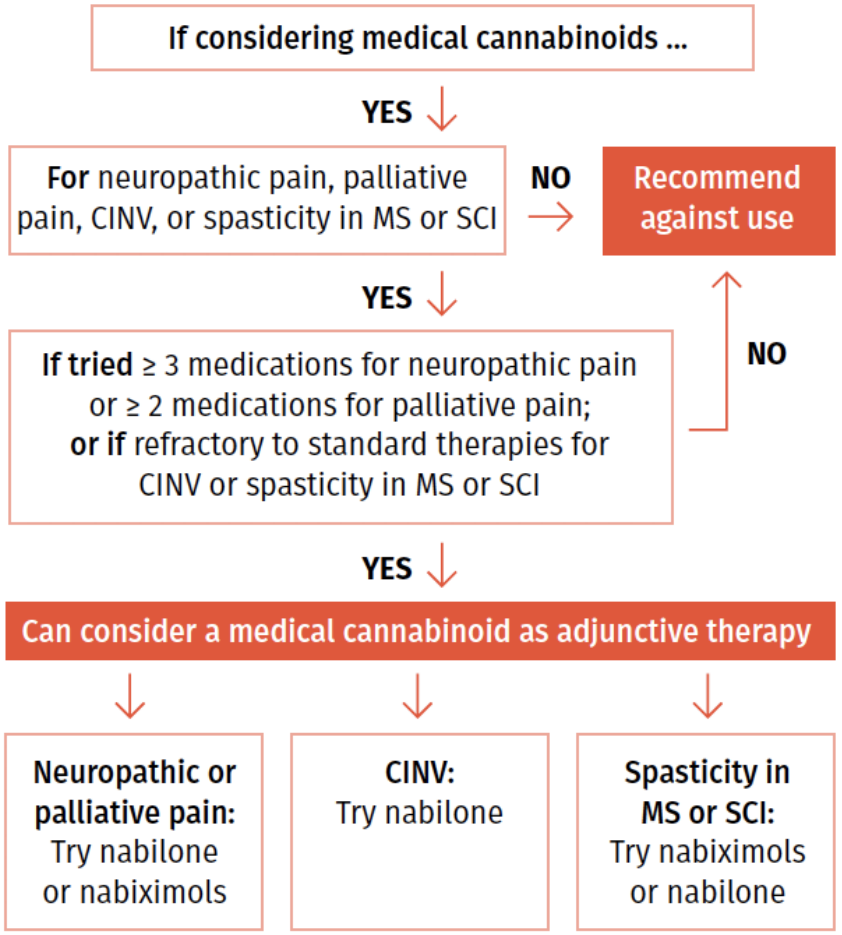
LE COLLÈGE DES MÉDECINS DE FAMILLE DU CANADA

Simplified guideline for prescribing medical cannabinoids in primary care



We **recommend against prescribing medical marijuana (particularly smoked) as a first-line cannabinoid** owing to a high risk of bias in available studies and unknown long-term consequences

In all cases, **potential harms and benefits should be discussed with the patient**

CINV—chemotherapy-induced nausea and vomiting, MS—multiple sclerosis, SCI—spinal cord injury.

Percentage of people experiencing harms

Type of harm	Cannabinoids	Placebo
Sedation	50%	30%
"Feeling high"	35%	3%
Dizziness	32%	11%
Speech disorders	32%	7%
Ataxia/Muscle twitching	30%	11%
Hypotension	25%	11%
Numbness	21%	4%
Psychiatric	17%	5%
Euphoria	15%	2%
Dysphoria	13%	0.3%
Impaired memory	11%	2%
Withdraw due to harms	11%	~3%
Dissociation/Acute psychosis	5%	0%

Percentage of people experiencing benefits

Benefits	Cannabinoids	Placebo
Chronic Pain (≥30% reduction after 4 weeks)		
Neuropathic pain	38%	30%
Palliative pain	30%	23%
Chemotherapy-induced nausea/vomiting (in 1 day)		
Control of nausea & vomiting	47%	13%
Spasticity (≥30% improvement after 6 weeks)		
Spasticity	35%	25%

Daily doses and costs

Drug	Daily Dose[2]	Approximate cost/month
Nabilone*[1]	2 to 6 mg	$94 to $305
Nabiximols*	4 to 12 sprays	$226 to $903
Medical Marijuana *Dried*	1 to 3 g *typical use*	$250 to $750 Based on $8.37/g

*Manufacturer list price, does not reflect pharmacy dispensing fees.
[1]Only generic nabilone covered by most provincial drug plans.
[2]Studied doses: Nabilone 0.5mg to 8mg/day, nabiximols 4 to 48 sprays/day, smoked marijuana had THC concentrations ranging 1 to 8% up to three time day as tolerated. Daily doses from drug monographs and Health Canada.

Can Fam Physician 2018 (Feb): 64: 111-20.

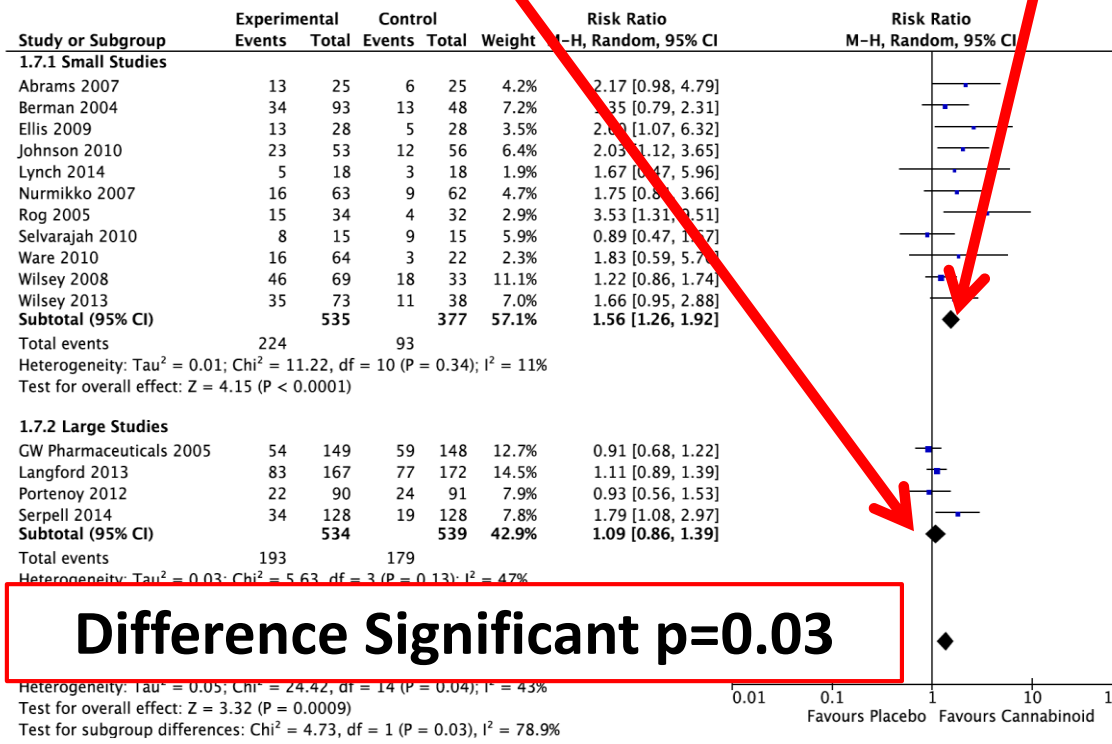
MA

Systematic review of systematic reviews for medical cannabinoids

- 1085 articles: 31 relevant systematic reviews (23 pain, 5 spasticity, 6 nausea and vomiting, and 12 adverse events).
- Lots of Issues:
  - Unblinding (~90%)
  - Enrolment
  - Studies - short (some ≤6 hours) & small
- Moderate reduced pain: ~39% Cannabinoid vs 30% placebo
  - Pain scale: Baseline ~6/10, Placebo down ~0.8 and Cannabinoids 0.2 to 0.8 m ore.

<150 patients: RR 1.56 (1.26-1.92)

>150 patients: RR 1.09 (0.86-1.39)



Can Fam Physician 2018 (Feb): 64: e78-e94.

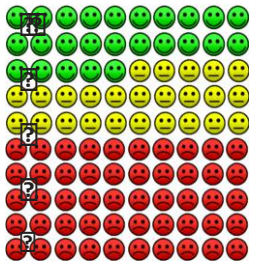
Neuropathic Pain

Benefit Comparison

Outcome: Meaningful (~30%) Pain Improvement

Ordered by decreasing estimated efficacy

Amitriptyline



25 Improve with treatment

25 Improve with placebo or no treatment

50 No improvement

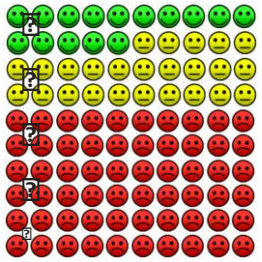
Venlafaxine

17 Improve with treatment

25 Improve with placebo or no treatment

58 No improvement

Gabapentin



15 Improve with treatment

25 Improve with placebo or no treatment

60 No improvement

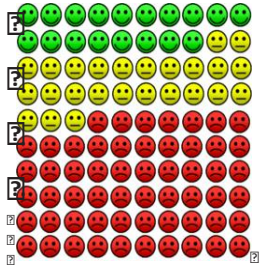
Cannabinoids

9 Improve with treatment

25 Improve with placebo or no treatment

66 No improvement

High Dose Opioids*



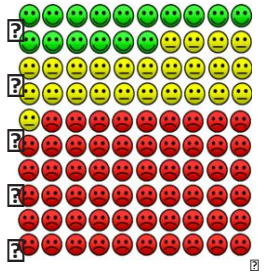
18 Improve with treatment

25 Improve with placebo or no treatment

57 No improvement

*60-110mg oral morphine per day

Pregabalin

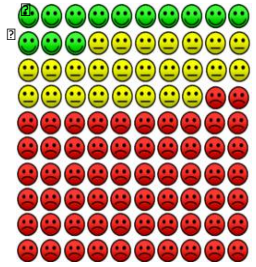


16 Improve with treatment

25 Improve with placebo or no treatment

59 No improvement

Duloxetine



13 Improve with treatment

25 Improve with placebo or no treatment

62 No improvement

Limitations

1. Based on indirect comparisons.
2. Timeframe 4 to 12 weeks.
3. Details on methods available in online supplement.

Improve with treatment

Improve with placebo or no treatment

No improvement

Can Fam Physician 2018 Feb.

http://pain-calculator.com/

Comparing Treatment Options for Pain: The C-TOP Tool

Neuropathic Pain | Osteoarthritis Pain (Coming Soon) | Back Pain (Coming Soon)

Medication Options

- **Amitriptyline** (Elavil®)
- **Cannabinoids** (Nabiximols, nabilone, medical marijuana)
- **Duloxetine** (Cymbalta®)
- **Gabapentin** (Neurontin®)
- **High-Dose Opioids** (morphine, oxycodone)
- **Pregabalin** (Lyrica®)
- **All Treatments** (comparison)

Curious about capsaicin, botox, tramadol, carbamazepine, or venlafaxine for neuropathic pain? Click here to learn more.

Meaningful Pain Relief from Cannabinoids

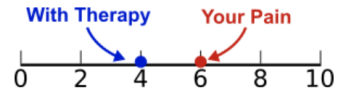
(30% reduction in pain scores)

Cannabinoids Benefit	Placebo Benefit	No Benefit
9% (ranges 3% to 16%)	25%	66%

A typical placebo group response seen in pain studies is **25%** but this can be adjusted in the FAQ section.

Meaningful Pain Relief

An example of a **30% reduction** in pain scores is a decrease from **6** to **4** on a **10** point pain scale



Cannabinoids Harms

Sleepiness	50% (30% placebo)
'Feeling high'	35% (3% placebo)
Speech disorders	32% (7% placebo)
Dizziness	32% (11% placebo)
Stopped due to side effects	11% (3% placebo)

Other Considerations

- Oral capsules can be taken once or twice daily, whereas oral spray can be used multiple times per day
- Side effects are likely more common (many studies included people with proven tolerance to cannabinoids)
- Approximate cost (CAD) for 30-day supply (without dispensing fee): **$94 to $305 (nabilone), $226 to $903 (nabiximols), $250 to $750 based on $8.37/g using 1-3g/day (medical marijuana)**

Screenshot

NP

Deprescribing benzodiazepine receptor agonists

Kevin Pottie, Wade Thompson, Simon Davies, Jean Grenier, Cheryl A. Sadowski, Vivian Welch, Anne Holbrook, Cynthia Boyd, Robert Swenson, Andy Ma, Barbara Farrell

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Box 3. Recommendations

For elderly adults (≥ 65 y) who use BZRAs, we recommend the following:

- Taper the BZRA dose slowly (strong recommendation, low-quality evidence)

For adults (18 to 64 y) who have used BZRAs most days of the week for > 4 wk, we suggest the following:

- Taper the BZRA dose slowly (weak recommendation, low-quality evidence)

Can Fam Physician 2018 (May): 64: 339-51.

Why is patient taking a BZRA?

If unsure, find out if history of anxiety, past psychiatrist consult, whether may have been started in hospital for sleep, or for grief reaction.

- Insomnia on its own OR insomnia where underlying comorbidities m
  For those ≥ 65 years of age: taking BZRA regardless of duration (avo
  For those 18-64 years of age: taking BZRA > 4 weeks

Engage patients (discuss potential risks, benefits, withd

Recommend Depres

- Minimize use of drugs that worsen insomnia (e.g. caffeine, alcohol etc.)
- Treat underlying condition
- Consider consulting psychologist or psychiatrist or sleep specialist

Taper and then stop BZRA

(taper slowly in collaboration with patient, for example ~25% every two weeks, and if possible, 12.5% reductions near end and/or planned drug-free days)

- For those ≥ 65 years of age (strong recommendation from systematic review and GRADE approach)
- For those 18-64 years of age (weak recommendation from systematic review and GRADE approach)
- Offer behavioural sleeping advice; consider CBT if available (see reverse)

Monitor every 1-2 weeks for duration of tapering

Expected benefits:

- May improve alertness, cognition, daytime sedation and reduce falls

Use non-drug approaches to manage insomnia

If symptoms relapse:

Consider

- Maintaining current BZRA dose for 1-2 weeks, then continue to taper at slow rate

Alternate drugs

- Other medications have been used to manage insomnia. Assessment of their safety and effectiveness is beyond the scope of this algorithm. See BZRA deprescribing guideline for details.

Taper

- Collaborate with patient, taper slowly (~25% every two weeks or even 12.5% reductions near end)
- Offer CBT if available

Withdrawal Symptoms

- Insomnia, anxiety, irritability, sweating, gastrointestinal symptoms (all usually mild and last for days to a few weeks)

Contact deprescribing@bruyere.org or visit deprescribing.org for more information.

Pottie K, Thompson W, Davies S, Grenier J, Sadowski CA, Welch V, et al. Deprescribing benzodiazepine receptor agonists. Evidence-based clinical practice guideline. *Can Fam Physician* 2018;64:339-51 (Eng), e209-24 (Fr).

deprescribing.org

INSTITUT DE RECHERCHE Bruyère RESEARCH INSTITUTE

open ONTARIO PHARMACY RESEARCH COLLABORATION

COLLÈGE DES DECINS DE FAMILLE CANADA

MA

Teach your parents and providers well

Call for refocus on the health of trans and gender-diverse children

Julia Temple Newhook, Kelley Winters, Jake Pyne, Ally Jamieson, Cindy Holmes, Stephen Feder, Sarah Pickett, Mari-Lynne Sinnott

- Commentary,… Also Approach to
- "~80% of children thought of as transgender will not identify as transgender when adults" leads to incorrect persist or desist
  - Many children/adolescents studied never asserted a transgender identity.
  - Those lost to follow-up assumed cis-gender
  - People often don't identify until later (~40's) but study followed to age 23
  - Up to 35% are non-binary (not male/female) and they were assumed cis-gender
  - Subgroup consistently stating transgender identity continue.
  - No evidence supporting traps cisgender youth as transgender
  - Studies did not examine harms of suppression.

Can Fam Physician 2018 (May): 64: 332-5.

Teach your parents and providers well

Call for refocus on the health of trans and gender-diverse children

Julia Temple Newhook, Kelley Winters, Jake Pyne, Ally Jamieson, Cindy Holr
Sarah Pickett, Mari-Lynne Sinnott

- Support is key:
  - Unsupported home = 14x risk suicide vs supported
  - If good support all round, can have mental health outcomes = cis-gender
- Approach:
  - Listen to and respect the child's own description
  - For children, Focus support on parents.
  - Consult as needed & use resources
  - Advise gender diversity normal & healthy.
  - Provide supportive office and advocate prn to schools

Box 1. Useful tools and resources

Peer support
- Gender Creative Kids Canada website: **www.gendercreativekids.ca**
- Online peer support group, Canadian Parents of Trans and Gender Diverse Kids: **parentsoftranskids@gmail.com**
- Children's Hospital of Eastern Ontario: **www.cheo.on.ca/en/genderidentity**

Providing health care to trans individuals
- Rainbow Health Ontario: **www.rainbowhealthontario.ca/TransHealthGuide**

Respectful and inclusive language in forms
- Center of Excellence for Transgender Health: **www.transhealth.ucsf.edu/trans?page=guidelines-clinic-environment**

Communicating with schools about a child's needs
- Gender Inclusive Schools Toolkit from Gender Spectrum: **https://www.dropbox.com/s/1wpo37oz3wv3nan/Gender%20Inclusive%20Schools%20Toolkit.pdf?dl=0**
- British Columbia's new SOGI 123 (Sexual Orientations and Gender Identities) website, which includes policies, curriculum, and resources: **www.sogieducation.org**
- Government of Manitoba guidelines for supporting and affirming students: **www.edu.gov.mb.ca/k12/docs/support/transgender/guidelines.pdf**

Guides to respectful terminology related to trans and gender-diverse people
- Rainbow Health Ontario and The 519 community centre: **www.the519.org/media/download/2559**
- Government of Canada: **www.canada.ca/en/public-health/services/infectious-diseases/sexual-health-sexually-transmitted-infections/reports-publications/questions-answers-gender-identity-schools/identity-schools.html**

Can Fam Physician 2018 (May): 64: 332-5.

Marjorie is a 75-year-old patient who is taking quetiapine 25mg PO QHS x 1 year for primary insomnia. While she thinks it helps, she is willing to consider stopping. The most appropriate strategy to stop is:

Taper by 25% q1-2 weeks

Taper by 50% q1-2 weeks

Stop antipsychotic today, no tapering necessary

NP

Deprescribing antipsychotics for behavioural and psychological symptoms of dementia and insomnia

Lise M. Bjerre, Barbara Farrelll, Matthew Hogel, Lyla Graham, Geneviève Lemay, Lisa McCarthy, Lalitha Raman-Wilms, Carlos Rojas-Fernandez, Samir Sinha, Wade Thompson, Vivian Welch, Andrew Wiens

- For adults with BPSD treated for ≥3 mo (symptoms stabilized or no response to adequate trial), we recommend the following:
  - Taper and stop antipsychotics slowly in collaboration with the patient and caregivers: eg, 25%-50% dose reduction every 1-2 wk (strong recommendation, moderate-quality evidence)
- For adults with primary insomnia treated for any duration or secondary insomnia in which underlying comorbidities are managed, we recommend the following:
  - Stop antipsychotics; tapering is not needed (good practice recommendation)

Can Fam Physician 2018 (January): 64: 17-27.

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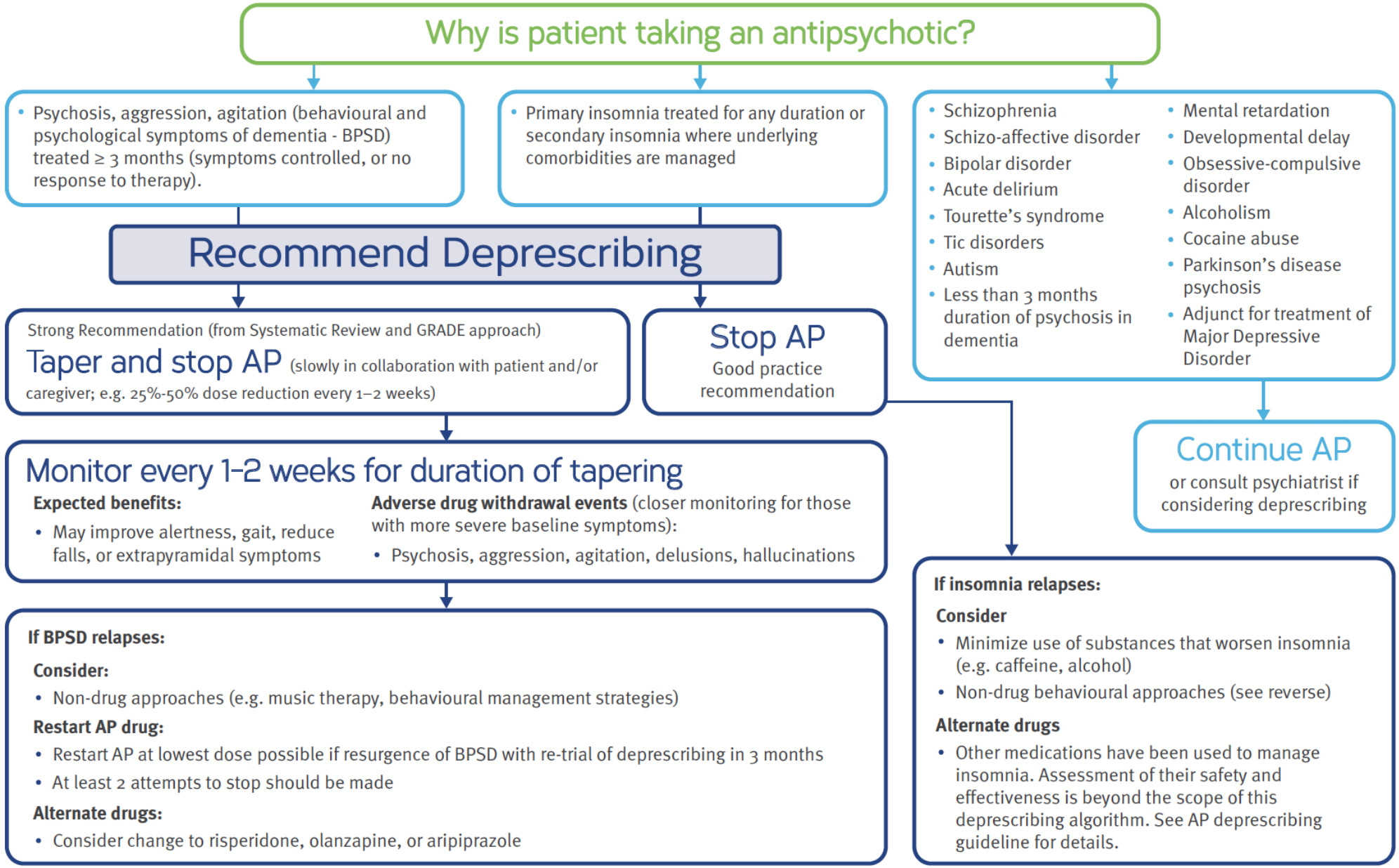
LE COLLÈGE DES MÉDECINS DE FAMILLE DU CANADA

Deprescribing antipsychotics for behavioural and psychological symptoms of dementia and insomnia



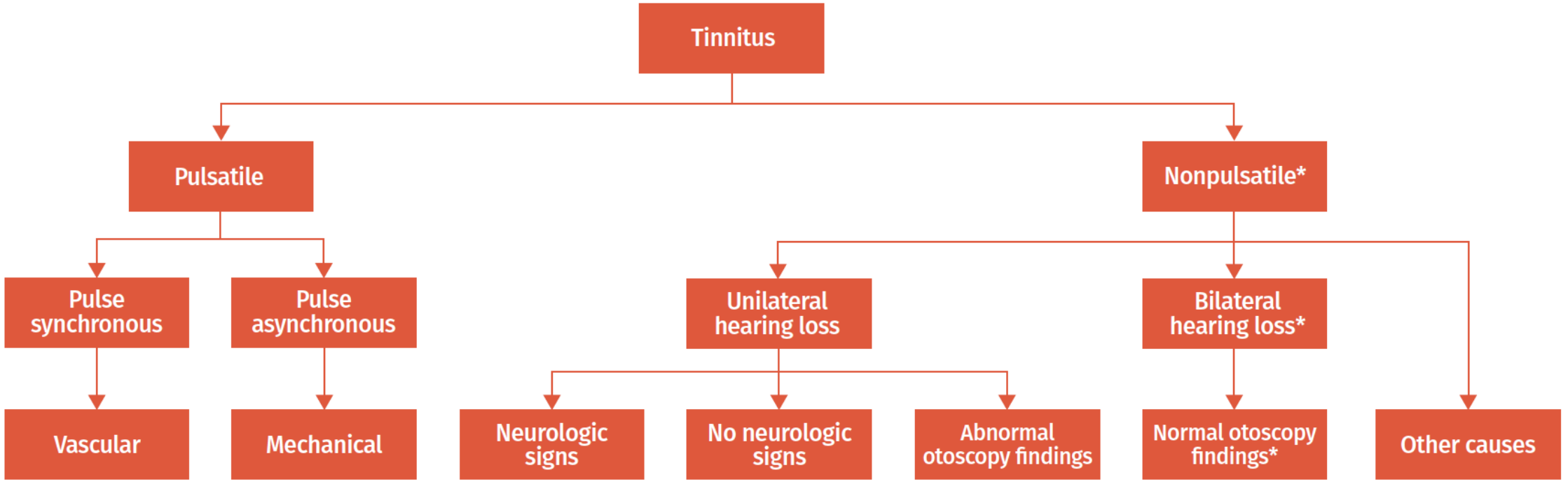
Can Fam Physician 2018 (January): 64: 17-27.

MA

Approach to tinnitus management

Vincent Wu, Bonnie Cooke, Susan Eitutis, Matthew T.W. Simpson, Jason A. Beyea

- ~40% will have tinnitus at least once in a lifetime
  - If present ≥6 months: 14% worsen vs 18% improve (at 5 years)
  - Worsening Tinnitus = worsening Quality of Life (decrease sleep, mood, etc)



Can Fam Physician 2018 (July): 64: 491-5.

Approach to tinnitus management

- Hx: Pulsatile vs non, associated symptoms (hearing loss, vertigo, neuro)
- Px: Objective (pulsatile) tinnitus (e.g. bruit); Otoscopy, neuro, head/neck exam
- Audiology Testing: Mainly for hearing loss (unilateral/bilateral)
- Investigations: imaging.
  - Pulsatile: Magnetic resonance angiogram/venogram of the brain and neck (rule-out vascular)
  - Nonpulsatile unilateral tinnitus and normal otoscopy findings, or asymmetrical SNHL: noncontrast MRI the internal auditory canals recommended.
- Referral: pulsatile, unilateral, or abnormal otoscopy - refer to ENT.
- Treatment: Conservative (improved sleep, reduce stress/caffeine/alcohol, hearing aids (more ambient noise), tinnitus maskers/white noise generators, melatonin, Tinnitus Retraining Therapy or CBT.

Can Fam Physician 2018 (July): 64: 491-5.

NP

Stubborn heel pain

Treatment of plantar fasciitis using high-load strength training

Robert Caratun, Nicole Anna Rutkowski, Hillel M. Finestone

- Praxis: Presentation of new approach to Plantar Fasciitis
- Prevalence is 3.5-7%, and common in runners (~8%)
- ~40% have symptoms after 2 years.
- Maybe more degenerative – therefore Plantar Fasciosis or Fasciopathy
- Treatment includes: NSAIDs, local steroid injections, orthotics, night splinting, and stretching
- NEW Treatment = high-load strength training (HLST)
  - RCT of 48 patients: Foot Function improved
    - 21% stretching vs 65% HLST at 3 months (p=0.016)
    - Proportion satisfied: Not quite Stat Sign but 56% vs 75% (NNT ~5).

Can Fam Physician 2018 (Jan): 64: 44-6. Scand J Med Sci Sports 2015: 25: e292–e300

Stubborn heel pain

Figure 3. Muscle-strengthening program to treat plantar fasciitis: *Patient instructions.*

Program protocol

Set-up instructions

Step 1. Roll up a T-shirt in order to create a cylinder that measures approximately 2 cm in diameter (the goal is to wrap your toes around this shape; adjust size accordingly to your unique foot size)

Step 2. Place the T-shirt approximately 5 cm away from the edge of a stair or step and place the toes of the injured foot on it so that they wrap around the cylinder (**Figure 4**)

Step 3. Ensure that the edge of the step is at the halfway point of the foot (it is best if there is a rail to hold on to in order to prevent falls)

Exercise instructions*

Step 1. Perform a heel raise lasting at least 5 seconds going up (concentric phase), pausing at the top for 3 seconds (isometric phase), followed by lowering for 5 seconds (eccentric phase)

Step 2. If possible, perform the heel raise with the other leg in the air. If this cannot be done, or if both legs are injured, heel raises can be done with both feet simultaneously

Program instructions†

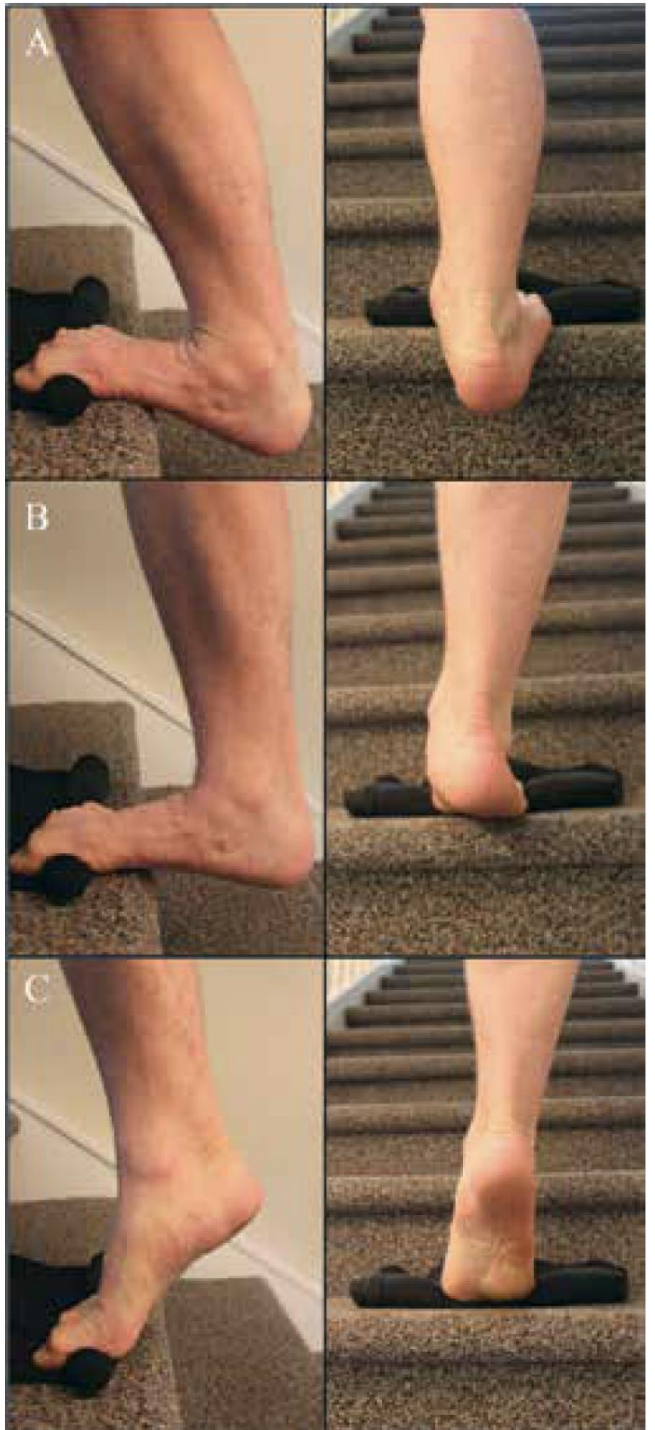
Weeks 1 to 4. Perform 1 set of 10 repetitions using body weight. At the start of the program, you might not be able to achieve 10 repetitions; perform as many as possible

Weeks 5 to 12. Perform 1 set of 10 repetitions using RM. Your RM represents the maximum weight you can lift while maintaining form. In order to achieve the RM weight, fill a backpack with books (the goal is to achieve a weight in the backpack that allows you to complete 10 exercises just before exhaustion

RM—repetition maximum.

*Remember that it will hurt to do the exercises. "Good pain" occurs when it hurts to do the exercise but the next day the pain is not worse. "Bad pain" is pain that increases the day after treatment. If you experience "bad pain," you might have to cut back on the number of repetitions or the amount of weight used.

†Use the progress sheet as a resource to record your heel-raise exercises.



Can Fam Physician 2018 (Jan): 64: 44-6.

MA

Ketogenic diet for weight loss

Rhonda Ting, Nicolas Dugré, G. Michael Allan and Adrienne J. Lindblad

- Systematic review (13 RCTs, 1577 pts), ketogenic vs low fat. At 12-24 months,
  - Ketogenic diet lost 0.9 kg more than low-fat diet (ss).
- Systematic review (11 RCTs, 1369 pts), at 6-24 months:
  - Ketogenic-type diet lost 2.2 kg vs low-fat (ss)
  - No difference if focus on higher quality studies.
- 6 other systematic reviews (5-24 RCTs) confounded by including low-carbohydrate diets that are likely not ketogenic:
  - no difference in weight to 3.6kg weight loss.
- No systematic reviews or RCTs examine mortality or CVD.
- Best RCT (609 patients):[9] Weight loss at one-year, Low-carb (<20g/day at start) 6.0kg versus low-fat diet 5.3kg; not different.
  - Patient genotypes no impact on weight loss.
  - Individuals weight change varied: -30 to +10 kg in either group.

Canadian Family Physician 2018 (December); 64: 906.

Ketogenic diet for weight loss

Rhonda Ting, Nicolas Dugré, G. Michael Allan and Adrienne J. Lindblad

- Surrogate markers changes seen but likely meaningless (example LDL 0.12 mmol/L higher).
- Typical Canadian diet contains 48% carbohydrates, 32% fat, and 17% protein.
- Most ketogenic diets start carbs <20 to 50 g/d (10% energy intake) for ~2 months, reintroduction.
- Weight loss peaks ~5 months, then slowly regain. Drop-out often high (13-84%) across studies.
- Observational data suggest long-term low carbs associated with increased mortality
- Urine ketone monitoring often advocated but inconsistently reported in RCTs and effect unknown
- **Bottom-Line**: Ketogenic diets can help patients lose about 2 kg more than low-fat diets do at 1 year, but higher-quality studies show no difference. Weight loss peaks at about 5 months but is often not sustained. Individual weight change can vary from losing 30 kg to gaining 10 kg with any diet.

Canadian Family Physician 2018 (December); 64: 906.

NP

Primary care of adults with intellectual & developmental disabilities

2018 Canadian consensus guidelines

William F. Sullivan, Heidi Diepstra, John Heng, Shara Ally, Elspeth Bradley, Ian Casson, Brian Hennen, Maureen Kelly, Marika Korossy, Karen McNeil, Dara Abells, Khush Amaria, Kerry Boyd, Meg Gemmill, Elizabeth Grier, Natalie Kennie-Kaulbach, Mackenzie Ketchell, Jessica Ladouceur, Amanda Lepp, Yona Lunsky, Shirley McMillan, Ullanda Niel, Samantha Sacks, Sarah Shea, Katherine Stringer, Kyle Sue, Sandra Witherbee.

- Challenging for family physicians due to time needed and complexity
- Challenging to write a CPG based on the limited available evidence.
- Many conditions more common in IDD populations
  - E.g. Epilepsy is 1 / 5 with IDD vs 1 / 100 in general population.
  - Others: Diabetes, Thyroid, Osteoporotic fractures, cardiovascular disease, etc
- Others harder to pick-up: Infectious disease, psychiatric disorders, Visual/hearing impairment, etc.
- Lots of Tools: many listed in guideline
  - Other good resource = https://ddprimarycare.surreyplace.ca/tools-2/

Can Fam Physician 2018 (April): 64: 254-79.

Primary care of adults with intellectual & developmental disabilities

2018 Canadian consensus guidelines

1. ID someone known to patient to attend appointments & help with care.
2. Time and supports for patients concerns to be heard & addressed
3. Assess decision-making capacity with tools (eg, the Decision-Making Checklist). When uncertain, refer to those familiar assessing similar.
4. Do PHE using adapted tools (eg, the Preventive Care Checklist Form) including adequacy of financial/community supports
5. Create health action plan with priorities/timelines ok with patients/caregivers. Give them a copy
6. Review medications regularly (q3 mo): start date, indications, dose, effect, and adverse event. Involve a pharmacist if possible
7. Ask patients (and family/caregivers) about patient's relationships, intimacy, and sexuality. Refer as needed for additional services.
8. Consult a PT/OT for adaptations for mobility and activity (wheelchair, walker, modified seating, safety devices, etc)
9. Use adapted clinical tools to promote education/uptake of cancer screening.
10. For Behaviours that challenge: Use formulation assessing causes systematically (HELP, health, envrio, life exp, psych)
11. Screen for antecedents, life events, and other mental distress triggers. Determine importance and obtain collateral history
12. Assess for possible trauma (maybe unknown to care providers); consider PTSD signs like reexperiencing

Can Fam Physician 2018 (April): 64: 254-79.

THE COLLEGE OF FAMILY PHYSICIANS OF CANADA
LE COLLÈGE DES MÉDECINS DE FAMILLE DU CANADA

Julie is a 33yo patient with a 9mo old healthy baby. The baby is waking 3-4 x/night on most nights. Julie is exhausted and wants to know if there is anything that can get her baby to sleep. Which of the following statements is true? Infant sleep training:

A. Reduces the number of infant nighttime awakenings.

B. Improves maternal depression scores.

C. Increases the risk of infant detachment disorder.

D. A and B only

MA

Infant sleep training: rest easy?

Christina Korownyk, Adrienne J. Lindblad

- 6-week RCT (235 infants, mean age 7 months), ≥2 awakenings/night on ≥5 nights/week, Sleep training vs safety education:
  - Reduced parental reports of severe infant sleep problem (4% vs 14%, NNT = 10),
  - Reduced number of infants with ≥2 awakenings/night (31% vs 60%, NNT = 4),
  - improved parent fatigue, sleep quality, and mood scale scores.
- Cluster RCT (328 families with infant sleep problems, mean age 7 months), sleep training vs usual care:
  - At 10 months, decreased infant sleep problems (56% vs 68%, NNT = 9)
  - Non-significant reduced proportion of moms with depression (28% vs 35%).
    - If “depression” at baseline, had ss improvement in depression scores.
  - At 2 years, less moms with “depression” (15% vs 26%, NNT = 9)
  - At 5 years, there was no difference in any outcomes
- Smaller studies and systematic reviews find similar

Canadian Family Physician 2018 (January); 64: 41

Infant sleep training: rest easy?

Christina Korownyk, Adrienne J. Lindblad

- Poor Infant sleep: parental depression, psychological distress, & poor health.
- Better infant sleep: good temperament, adaptability, & low distractibility.
- Allowing infants to “cry it out” similarly effective, but parents find more stressful.
- Sleep training is simple and can begin at 6 months.
- No exact formula: Put baby to bed when drowsy and leave the room.
  - If baby cries, do not respond for 2-5 minutes. Then, brief reassurance without picking up.
  - Return if crying continues with gradually extension by 2 to 5 minutes until baby asleep.
  - Infant sleep generally improves within 1 week.
- **Bottom-Line:** Sleep training improves infant sleep problems, with about 1 in 4 to 1 in 10 benefiting compared with no sleep training, with no adverse effects reported after 5 years. Maternal mood scales also statistically significantly improved; patients with the lowest baseline depression scores benefited the most.

Canadian Family Physician 2018 (January); 64: 41

NP

Approach to the detection and management of chronic kidney disease

Allan K. Grill, Scott Brimble

- 3.7-8.3% have CKD. Dialysis ~$100,000/yr
- Who to GFR/ACR: Hypertension, Diabetes, age 60-75 + CVD, indigenous ≥18 yrs.
- Categorizing Chronic Kidney Disease (needs 2 for GFR and 3 for ACR)
  - eGFR of ≥60 and ACR of ≤3 mg/mmol = No CKD
  - eGFR of 30-59 or ACR of 3-60 = CKD, managed by us.
  - eGFR <30 or ACR >60 = CKD, consult nephrologist
- Kidney guidance: www.kidneywise.ca
- Risk of Kidney Failure Risk Equation: https://qxmd.com/calculate/calculator_308/kidneyfailure-risk-equation-4-variable

Canadian Family Physician 2018 (October); 64: 728-35

Approach to the detection and management of chronic kidney disease

Who to screen

Classification of CKD & Who should manage

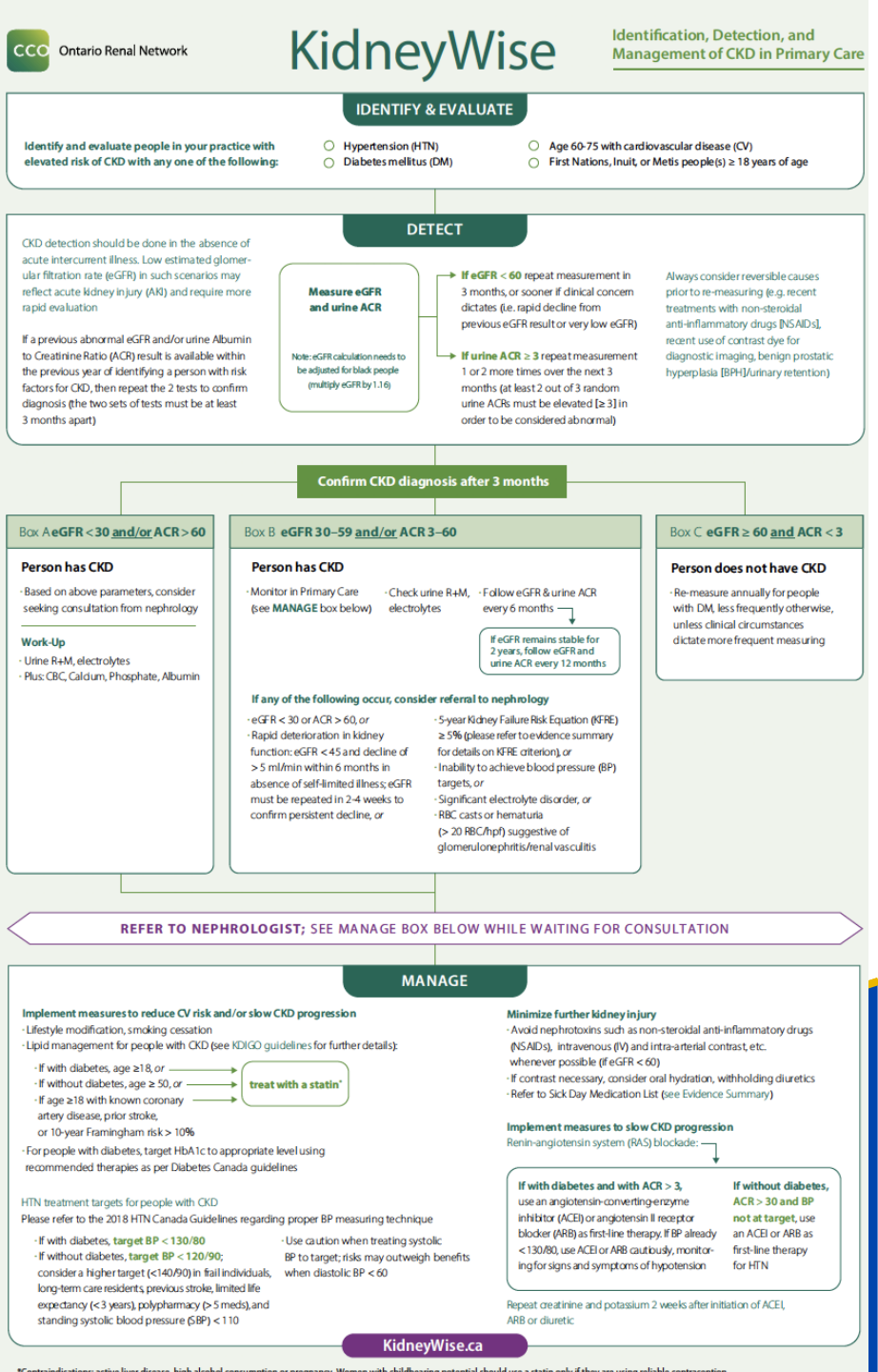
Adjust for African Americans (1.16 for eGFR)

Who gets Statins – DM≥18 yrs, no DM ≥50yrs, 18yrs + CVD or risk estimate >10%

BP targets – with DM 130/80, without 120/90, if complications then 140/90

Classics: Smoking, weight, activity, avoid nephrotoxic meds (SADMANS: sulfonylureas, angiotension converting enzyme inhibitors [ACEIs], diuretics, metformin, ARBs, NSAIDs, & SGLT2)

Canadian Family Physician 2018 (October); 64: 728-35



The END

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