Rapid recommendations

Updates from 2023 guidelines: part 2

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The field of medicine is ever evolving, and keeping abreast of the latest clinical practice guidelines is a continuous pursuit for health care professionals. This article, the second in a 3-part series, consolidates guideline updates from 2023 pertaining to respiratory care, dermatology, gastroenterology, concussion management, and urology. By presenting these revisions in a concise and accessible format, we aim to equip family physicians with the necessary knowledge to integrate the latest evidence-based recommendations into their daily practices seamlessly, ultimately enhancing patient outcomes.

Guideline updates

The Canadian Thoracic Society (CTS) and the Global Initiative for Chronic Obstructive Lung Disease (GOLD) recommend initiating maintenance treatment with either a long-acting muscarinic antagonist (LAMA) or a long-acting β_2-agonist (LABA) for all patients with chronic obstructive pulmonary disease (COPD) (conditional recommendation).[1,2] In addition, for patients with stable COPD and moderate to high symptoms (modified Medical Research Council questionnaire score ≥2 or COPD Assessment Test score ≥10) but low exacerbation risk and forced expiratory volume in 1 second less than 80% (GOLD group B), these guidelines now recommend dual LAMA-LABA bronchodilator therapy as first-line treatment (conditional recommendation, moderate-quality evidence).[1,2] In this patient group the LAMA-LABA combination has greater efficacy than monotherapy with comparable side effects. [2]

The CTS gives a strong recommendation to initiate triple inhaler therapy with a combination of LAMA, LABA, and inhaled corticosteroid (ICS) for patients with COPD who have a higher risk of exacerbations and greater symptom burden (strong recommendation, high-quality evidence).[1] For this population, GOLD takes a more stepwise approach. In the highest-risk group (E), GOLD recommends initiating LAMA plus LABA dual bronchodilation therapy first.[2] Triple therapy with ICS is conditionally recommended if the patient's blood eosinophil count exceeds 0.3×10^9/L, although this is based on limited direct evidence in treatment-naive patients (conditional recommendation, low-quality evidence).[2] The CTS advises against stepping down to dual LAMA-LABA bronchodilation (conditional recommendation, low-quality evidence).[1] The CTS and GOLD guidelines both discourage LABA-ICS inhaler combinations without a LAMA bronchodilator when an ICS is indicated for COPD management.[1,2]

The American Academy of Dermatology recommends considering topical calcineurin inhibitors such as pimecrolimus cream or tacrolimus ointment as alternatives to corticosteroids for sensitive skin areas and for mild-to-moderate atopic dermatitis (AD) in adults (strength of recommendation not stated).[3] Crisaborole 2% ointment, a phosphodiesterase-4 inhibitor, is recommended for patients with similar cases of AD. However, these recommendations do not undermine the crucial role that topical corticosteroids play in AD treatment. For patients with moderate AD not managed well by topical treatments, ruxolitinib cream (a Janus kinase inhibitor) is recommended, with the guideline authors noting its associated risks of serious infections, malignancies, and thrombosis. The authors strongly encourage the use of emollients and moisturizers for AD care, particularly after bathing, with wet-wrap therapy for severe AD flares. These guidelines discourage routine use of topical antimicrobials, antihistamines, and antiseptics but acknowledge that bleach baths might help prevent infections.

The American Gastroenterological Association recommends using a combination of patient-reported symptoms and objective biomarkers to monitor patients with ulcerative colitis (conditional recommendation, moderate certainty of evidence).[4] This guideline recommends using fecal calprotectin, fecal lactoferrin, and C-reactive protein as biomarkers of disease activity every 6 to 12 months. This multimodal approach aligns with the evolving treat-to-target strategy prioritizing symptomatic and endoscopic remission to reduce relapse risk, corticosteroid use, and complications. Elevated biomarker levels in asymptomatic patients suggest active inflammation, prompting endoscopic assessment, while patients with normal levels might avoid routine endoscopies when symptoms are absent. Finally, elevated biomarkers in patients with moderate symptoms might prompt empiric treatment and avoid endoscopy.

An update of Ontario's* Living Concussion Guidelines *recommends patients start light physical and cognitive activity 24 to 48 hours after injury, and gradually increase activity intensity as tolerated, in a manner that does not result in substantial or prolonged symptom exacerbation (no evidence level provided).[5,6] Complete rest beyond 48 hours is discouraged, as evidence shows it might delay recovery. Activities considered low risk for sustaining a concussion should be resumed even in patients with mild residual symptoms. A stepwise

progression in return to activity follows if post-activity symptoms increase by no more than 2 points out of 10 on a basic severity scale and resolve within 1 hour.

***The updated* Living Concussion Guidelines *state that adults with prolonged postconcussive symptoms should be educated about tolerance levels and a graduated exposure approach (level B evidence).*[5]** Instead of prescribing complete rest, which might prolong recovery, the guidelines recommend patients gradually increase physical and cognitive activities until mild symptoms onset (no more than a 2-point increase on a 10-point basic severity scale) and then slightly push beyond that point before resting and resuming. This balanced approach, akin to treating an ankle sprain, aims to extend tolerance over time without causing substantial or prolonged symptom exacerbation that affects daily functioning or lingers into the following day. This graduated exposure strategy can be applied to all symptom triggers, including sensory sensitivities such as noise and light.

***For adult patients experiencing substantial cognitive fatigue more than 3 months postconcussion who have not responded to nonpharmacologic treatments, the* Living Concussion Guidelines *suggest a trial of methylphenidate might be considered (level A evidence).*[5]** Starting at low doses, such as 5 mg once daily, then potentially increasing to 5 mg twice daily, methylphenidate can enhance alertness, processing speed, attention, and working memory. Improvements in focus, concentration, and fatigue are often noticed quickly, but patients should consult their provider before discontinuing use.

***The* Living Concussion Guidelines *recommend blue-light therapy as an option for reducing fatigue and excessive daytime sleepiness in adult patients with prolonged postconcussive symptoms (level A evidence).*[5]** Daily morning exposure to blue wavelengths around 460 nm to 480 nm synchronizes circadian rhythms, suppresses melatonin, and increases alertness. Evidence suggests 30 minutes of morning blue-light therapy over the course of 6 weeks can effectively combat daytime sleepiness, fatigue, and depression following a concussion.

***The Canadian Urological Association recommends active surveillance with serial imaging as the preferred management strategy for Bosniak categories III and IV renal cysts measuring 2 cm or less that are stable and have low risk of malignancy (strong recommendation, moderate-quality evidence).*[7]** Despite their malignant potential, these small multilocular cystic neoplasms are increasingly recognized as having low metastatic risk and excellent prognoses when diminutive in size. However, surgical excision, preferably partial nephrectomy, remains the recommended approach for cysts larger than 4 cm or those exhibiting rapid expansion (≥0.5 cm per year) or for individuals at higher oncologic risk who are not candidates for or decline active surveillance (conditional recommendation, low-quality evidence).

Conclusion

This article is the second in a 3-part series summarizing guideline updates from 2023 relevant to primary care. Health care providers are encouraged to appraise the recommendations further before incorporating them into clinical practice, as some might be based on low-quality evidence or expert opinion.

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Competing interests
None declared

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