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EDITORIAL COMMENT

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The authors present a cross-sectional study of guideline adherence for the clinical care of nephrolithiasis patients presenting to the emergency department (ED)¹. Their data source, the National Ambulatory Medical Care Survey, is reflective of national trends in ED encounters. While guideline adherence ranged from a low of 17% for medical expulsion therapy to a high of 63% for imaging, they found that urinary stone patients in the ED most often receive care that does not adhere to clinical guideline recommendations. Unfortunately, this is a trend reflective of many urologic diseases, including prostate cancer, bladder cancer, and urinary tract infections.²⁻⁵

This thoughtful study highlights the fact that there are many performance measures by which care providers are judged to evaluate whether they are providing optimal care for patients outside of clinical outcomes alone.¹ In the current health care climate, these include metrics for quality of care where guideline adherence has been identified as a tangible quality measure. These measures will receive greater emphasis over time, particularly as Centers for Medicare and Medicaid Services have begun to mandate that quality metric achievement is both a reportable outcome and one that may be tied to reimbursement.⁶ Recognizing the importance of this trend, the American Urologic Association (AUA) has initiated the AUA Quality (AQUA) Registry.⁷ This national urologic disease registry's goal is to measure and report on health care quality and patient outcomes. These types of efforts belie the standards to which care providers will continue to be held. Physicians and care organizations would do well to heed the importance of quality metrics in their delivery of patient care.

One barrier to achieving guideline adherence is the separation between specialties of care and their respective guidelines. Neither the American College of Emergency Physicians nor the American Academy of Emergency Medicine endorse specific guidelines for the management of patients presenting with nephrolithiasis. As prostate-specific antigen screening for prostate cancer has demonstrated, different professional societies may take divergent stances regarding patient management guidelines.⁸ Furthermore, in the case of acute renal colic, the vast majority of stone patients who present to the ED do not even seek follow-up in a urologist's office.⁹ Is it therefore right to hold ED physicians accountable to other professional associations' guidelines?

These issues highlight the need for cross-disciplinary communication and education between specialty fields so that guidelines can be a shared resource for all physicians with the unified goal of improving patient care quality. As highlighted in this study, in the case of medical expulsion therapy, its utilization in the ED setting tripled after guideline endorsement occurred in 2006.¹ This practice change was supported by 11 randomized control trials, and

despite this, the overall utilization only increases from 4% to 17% as seen in this current study.¹⁰ As far as facilitating adherence to guidelines both in and outside of urinary stone disease, we still have a long way to go. Open communication between fields coupled with education and studies like this one is likely to continue paving the way.

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