☐ POEMs

More Nuanced Guidelines for Lipid Lowering to Prevent CVD

Clinical Question

For the primary and secondary prevention of cardiovascular disease (CVD), how should risk be assessed, and what should be done about elevated lipid levels?

Bottom Line

The authors of this guideline give a more nuanced and less aggressive approach to lipid lowering than other groups. For the primary prevention of CVD, check blood pressure and lipids (nonfasting is fine) to calculate the 10-year CVD risk. If greater than 12%, treat; if 12% or less, discuss treatment with the patient. Pick a moderate-dose statin and do not check lipid levels again. For secondary prevention, use moderate-dose statins and titrate to a higher dose only in a few high-risk patients. Again, do not titrate based on lipid levels. (Level of Evidence = 5)

Synopsis

This guideline was developed by two government agencies tasked with providing health care for active duty military personnel and veterans. The guideline was based on a systematic review of the literature; the authors graded the evidence and the strength of their recommendations using the GRADE system. The panel members had no conflicts of interest.

For primary prevention, calculate 10-year CVD risk using a risk calculator (weak recommendation). The authors suggest three cutoffs: less than 6% risk of CVD:

there is no evidence of benefit with treatment; 6% to 12% risk: there is limited evidence of benefit with treatment; greater than 12%: there is a 20% to 30% decrease in risk with treatment (weak recommendation). Treat most patients at the highest risk, but allow patients at lower risk levels to weigh possible benefit vs. possible risk, such as muscle symptoms and a small risk of diabetes mellitus (weak recommendation). Use a moderate, fixed-dose statin; that is, do not continue to check lipid levels and adjust dosing (strong recommendation).

For secondary prevention, also use a moderate, fixed-dose statin (strong recommendation). In some patients—those with recurrent cardiac events or who have multiple uncontrolled risk factors—consider using higher doses, weighing questionable benefits against a slightly higher risk of developing diabetes (weak recommendation).

Study design: Practice guideline

Funding source: Government

Setting: Various (guideline)

Reference: *Downs JR, O'Malley PG. Management of dyslipidemia for cardiovascular disease risk reduction: synopsis of the 2014 U.S. Department of Veterans Affairs and U.S. Department of Defense clinical practice guideline.* Ann Intern Med. *2015;163(4):291-297.*

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Routine CT Scans for Occult Malignancy Not Useful in Patients with Unprovoked VTE

Clinical Question

Is routine computed tomography (CT) of the abdomen and pelvis helpful in patients with an initial unprovoked episode of venous thromboembolism (VTE)?

Bottom Line

There is no advantage to adding CT of the abdomen and pelvis to a basic screening protocol for occult malignancy in patients with unprovoked VTE. (Level of Evidence = 1b)

Synopsis

Patients with an unprovoked episode of deep venous thrombosis (DVT) or pulmonary embolism (PE) are at increased risk of occult malignancy. However, the best

approach to evaluate patients for cancer is unclear. In this trial, adults with a first diagnosis of an episode of DVT or PE at one of nine Canadian centers were randomized to receive either a basic evaluation for occult malignancy (history and physical, basic blood tests, chest radiography, mammography for women older than 50 years, a Papanicolaou test for sexually active women 18 to 70 years of age, and prostate cancer screening for men older than 40 years) or the same evaluation plus comprehensive CT of the abdomen and pelvis. Patients with impaired renal function or allergy to contrast media, and those who could not easily comply with a CT scan, were excluded. A total of 3,186 patients were evaluated for eligibility, 862 were randomized, and 854 were included in the intention-to-treat analysis. The mean age of the included patients was 53 years; 67% had a DVT, 33% had a PE, and 12% had both. Overall, 33 patients (3.9%) had a new diagnosis of cancer during the first year of follow-up: 14 in the basic screening group, and 19 in the group that also received a CT scan. The mean time to a new cancer diagnosis was 4.2 months for the patients who received basic screening, and four months for those who also received CT.

Study design: Randomized controlled trial (single-blinded)

Funding source: Government

Allocation: Concealed

Setting: Outpatient (specialty)

Reference: *Carrier M, Lazo-Langner A, Shivakumar S, et al.; SOME Investigators. Screening for occult cancer in unprovoked venous thromboembolism.* N Engl J Med. *2015;373(8):697-704.*

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CBT Effective for Chronic Insomnia

Clinical Question

How effective is cognitive behavior therapy (CBT) for patients with chronic insomnia?

Bottom Line

A five-component approach to changing patients' beliefs and behaviors surrounding sleep is effective, at least in the short term, in getting persons to fall asleep and stay asleep, although total sleep time is not increased. The interventions are not difficult, and many are part of typical sleep hygiene practice. (Level of Evidence = 1a−)

Synopsis

Although medication is the primary treatment of chronic insomnia, CBT has been extensively studied as well. To determine its effectiveness, these researchers searched five databases, including the Cochrane Library, and identified 20 studies of 1,162 patients. The CBT used in these studies comprised at least three of five components (see below) and was compared with inactive treatments. Two investigators independently determined the eligibility of studies, extracted the data, and evaluated for risk of bias. There was no evidence of publication bias, although the study qualities were not high (because most studies were not or could not be masked). There was significant heterogeneity among some of the results, especially for outcomes for which there were limited data. Compared with inactive treatments, onset of sleep was 19 minutes earlier, on average, at the end of the treatment period. Minutes spent awake after first falling asleep were significantly fewer (by an average 26 minutes) at the end of treatment. However, overall sleep time did not increase significantly with treatment. Some, but not all, studies found a benefit that persisted after completion of therapy.

Components of CBT for insomnia:

(1) Cognitive therapy: aimed at dysfunctional beliefs and attitudes toward sleep and insomnia

(2) Stimulus control: avoiding nonsleep activities in the bedroom

(3) Sleep restriction: limiting time in bed to match perceived sleep duration to assure that more than 85% of time spent in bed was spent sleeping

(4) Sleep hygiene: typical measures of sleep scheduling and alcohol, caffeine, and nicotine intake

(5) Relaxation techniques: meditation, mindfulness, and so forth

Study design: Meta-analysis (randomized controlled trials)

Funding source: Self-funded or unfunded

Setting: Various (meta-analysis)

Reference: *Trauer JM, Qian MY, Doyle JS, Rajaratnam SM, Cunnington D. Cognitive behavioral therapy for chronic insomnia: a systematic review and meta-analysis.* Ann Intern Med. *2015; 163(3):191-204.*

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