TOP 10 Most Impactful Articles from 2018 Canadian Family Physician

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College of Family Physicians of Canada
Faculty/Presenter Disclosures

- **Faculty**: Mike Allan
- **Salary**: College of Family Physicians of Canada, University of Alberta
- **Relationships with financial sponsors:**
  - **Grants/Research Support**: Alberta College of Family Physicians; Toward Optimized Practice, CIHR, PRIHS, Alberta Health, Ontario LHIN grant,
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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
Top 10 Canadian Family Physician Articles of 2018

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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
Simplified guideline for prescribing medical cannabinoids in primary care


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: e78-e94.
Simplified guideline for prescribing medical cannabinoids in primary care

If considering medical cannabinoids ...

**YES**
- For neuropathic pain, palliative pain, CINV, or spasticity in MS or SCI

**NO**
- Recommend against use

**YES**
- If tried ≥ 3 medications for neuropathic pain or ≥ 2 medications for palliative pain; or if refractory to standard therapies for CINV or spasticity in MS or SCI

**NO**
- Can consider a medical cannabinoid as adjunctive therapy

- Neuropathic or palliative pain: Try nabilone or nabiximols
- CINV: Try nabilone
- Spasticity in MS or SCI: Try nabiximols or nabilone

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.

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### Percentage of people experiencing harms

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

### Percentage of people experiencing benefits

<table>
<thead>
<tr>
<th>Benefits</th>
<th>Cannabinoids</th>
<th>Placebo</th>
</tr>
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<tbody>
<tr>
<td>Chronic Pain (≥30% reduction after 4 weeks)</td>
<td>38%</td>
<td>30%</td>
</tr>
<tr>
<td>Neurotic pain</td>
<td>30%</td>
<td>23%</td>
</tr>
<tr>
<td>Palliative pain</td>
<td>38%</td>
<td>30%</td>
</tr>
<tr>
<td>Chemotherapy-induced nausea/vomiting (in 1 day)</td>
<td>47%</td>
<td>13%</td>
</tr>
<tr>
<td>Control of nausea &amp; vomiting</td>
<td>38%</td>
<td>30%</td>
</tr>
<tr>
<td>Spasticity (≥30% improvement after 6 weeks)</td>
<td>35%</td>
<td>25%</td>
</tr>
</tbody>
</table>

### Daily doses and costs

<table>
<thead>
<tr>
<th>Drug</th>
<th>Daily Dose</th>
<th>Approximate cost/month</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nabilone*¹</td>
<td>2 to 6 mg</td>
<td>$94 to $305</td>
</tr>
<tr>
<td>Nabiximols*</td>
<td>4 to 12 sprays</td>
<td>$226 to $903</td>
</tr>
<tr>
<td>Medical Marijuana Dried*</td>
<td>1 to 3 g</td>
<td>$250 to $750 based on $8.37/g</td>
</tr>
</tbody>
</table>

*Manufacturer list price, does not reflect pharmacy dispensing fees.

¹Only generic nabilone covered by most provincial drug plans.

²Studied 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 times a day as tolerated. Daily doses from drug monographs and Health Canada.
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 more.

<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**

<table>
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<th>Improve with treatment</th>
<th>Improve with placebo or no treatment</th>
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<td>Venlafaxine</td>
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<tr>
<td>Gabapentin</td>
<td>15</td>
<td>60</td>
<td></td>
</tr>
<tr>
<td>Duloxetine</td>
<td>13</td>
<td>62</td>
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*60-110mg oral morphine per day

**Neuropathic Pain**

**Outcome:** Meaningful (~30%) Pain Improvement

Ordering by decreasing estimated efficacy

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*60-110mg oral morphine per day

**Comparison of Treatment Options for Pain:**

**The C-TOP Tool**

**Medication Options**

- **Amitriptyline**
- **Venlafaxine**
- **Gabapentin**
- **Duloxetine**
- **Pregabalin**
- **High-Dose Opioids**
- **Cannabinoids** (Nabiximols, nabina, medical cannabis)

**Meaningful Pain Relief from Cannabinoids**

- 20% reduction in pain scores

**With Therapy**

- Cannabinoids: 9%
- Placebo: 25%
- No Benefit: 66%

**Cannabinoids Harms**

- Sleepiness: 50%
- ‘Feeling high’: 35%
- Speech disorders: 32%
- Dizziness: 32%
- Stopped due to side effects: 11%

**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 fees): $94 to $305 (nabiximols), $226 to $903 (nabina), $250 to $750 based on $6.37/g using 1-3g/day (medical guidance)

**http://pain-calculator.com/**

**Additional Information**

- Click here to learn more.
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

• Guideline: Deprescribing
  - Benzodiazepine receptor agonists used for primary insomnia or comorbid insomnia where underlying comorbidities are effectively managed.
  - NOT for other sleep disorders or untreated anxiety, depression, or other physical / mental health conditions contributing to insomnia

• ~30% Long-term care and 15% community seniors. Why not continue,…

Efficacy dwindles ≤4 weeks

Observational evidence shows association with fractures/falls, MVC, functional impairment, respiratory exacerbations (COPD or pneumonia), and memory disturbance

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

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

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 Holm
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/s1/wpo37oz3wv3nan/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
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
Deprescribing antipsychotics for behavioural and psychological symptoms of dementia and insomnia

Lise M. Bjerre, Barbara Farrellll, 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)

Deprescribing antipsychotics for behavioural and psychological symptoms of dementia and insomnia

**Why is patient taking an antipsychotic?**

- Psychosis, aggression, agitation (behavioural and psychological symptoms of dementia - BPSD) treated ≥ 3 months (symptoms controlled, or no response to therapy).
- Primary insomnia treated for any duration or secondary insomnia where underlying comorbidities are managed.
- Schizophrenia
- Schizo-affective disorder
- Bipolar disorder
- Acute delirium
- Tourette’s syndrome
- Tic disorders
- Autism
- Less than 3 months duration of psychosis in dementia
- Mental retardation
- Developmental delay
- Obsessive-compulsive disorder
- Alcoholism
- Cocaine abuse
- Parkinson’s disease psychosis
- Adjunct for treatment of Major Depressive Disorder

**Recommend Deprescribing**

- Strong Recommendation (from Systematic Review and GRADE approach)
- Taper and stop AP (slowly in collaboration with patient and/or caregiver; e.g. 25%-50% dose reduction every 1-2 weeks)

**Monitor every 1-2 weeks for duration of tapering**

- Expected benefits:
  - May improve alertness, gait, reduce falls, or extrapyramidal symptoms
- Adverse drug withdrawal events (closer monitoring for those with more severe baseline symptoms):
  - Psychosis, aggression, agitation, delusions, hallucinations

**If BPSD relapses:**

- Consider:
  - Non-drug approaches (e.g. music therapy, behavioural management strategies)
- Restart AP drug:
  - Restart AP at lowest dose possible if resurgence of BPSD with re-trial of deprescribing in 3 months
  - At least 2 attempts to stop should be made
- Alternate drugs:
  - Consider change to risperidone, olanzapine, or aripiprazole

**If insomnia relapses:**

- Consider:
  - Minimize use of substances that worsen insomnia (e.g. caffeine, alcohol)
  - Non-drug behavioural approaches (see reverse)
- Alternate drugs:
  - Other medications have been used to manage insomnia. Assessment of their safety and effectiveness is beyond the scope of this deprescribing algorithm. See AP deprescribing guideline for details.

**Stop AP**

- Good practice recommendation

**Continue AP**

- or consult psychiatrist if considering deprescribing

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)

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.
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 Fasciossis 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).

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.
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.
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.
Primary care of adults with intellectual & developmental disabilities
2018 Canadian consensus guidelines


• 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/

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

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
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
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.
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

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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)

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The END