Italy’s Slow Medicine campaign

“Doing more does not mean doing better”

Tests, treatments and procedures at risk of inappropriateness in Italy that physicians, other health professionals and patients should talk about

May 2015
The top 5 recommendations released in 2014
1. Don’t use the so-called "food intolerance tests" as a tool for the dietary treatment of obesity or for diagnosing suspected food intolerances.

2. Avoid treating obesity and eating disorders with pre-printed diets and in the absence of a multidimensional approach.

3. Don’t encourage an extensive and indiscriminate use of dietary supplements as preventive measures in cancer and cardiovascular disease.

4. Avoid restrictive approaches not proven to be effective and not involving the family in overweight problems and obesity in children.

5. Avoid Artificial Nutrition (AN) in clinical situations in which an evidence-based approach has not proven its efficacy, i.e. in patients with advanced dementia or cancer at the terminal stage.
1. Don’t define a treatment program that includes radiation therapy without the involvement of the radiation oncologist from the beginning (that is, immediately after diagnosis of the disease) in the definition of the program.

2. Don’t recommend the use of technical or "special" radiotherapy equipment without a motivated reason of the radiation oncologist.

3. Don’t use, to the extent possible, prolonged radiation therapy treatments when the purpose of radiation therapy is symptomatic and palliative in people with reduced life expectancy.

4. Don’t perform radiation therapy treatment for degenerative joint disease (benign), especially under the age of 60.

5. Don’t perform PET, CT, and radionuclide bone scans in the staging of prostate cancer at low risk for metastasis in patients undergoing radical radiation therapy, except in a clinical research setting.
1. Don’t perform routine echocardiography as part of routine follow-up in patients with mild to moderate valvular heart disease or with left ventricular dysfunction, in the absence of new symptoms, signs or clinical events.

2. Don’t perform exercise stress test as part of routine follow-up in asymptomatic patients after surgical or percutaneous revascularization.

3. Don’t perform 24 hour Holter monitoring in patients with effort chest pain who can perform exercise stress test, unless arrhythmias should be investigated.

4. Don’t perform stress cardiac imaging test during the initial evaluation of suspected ischemic heart disease.

5. Don’t perform exercise stress test as screening of ischemic heart disease in asymptomatic patients at low cardiovascular risk.
1. Don’t prescribe antibiotics to prevent infectious complications from neutropenia in cancer patients treated with standard dose chemotherapy.

2. Don’t routinely prescribe serum cancer markers during the diagnostic or staging process of cancers.

3. Don’t routinely use cancer-directed therapy for solid cancer patients with low performance status (3 or 4) or progressive after 2-3 therapeutic lines, but prioritize palliative care.

4. Don’t perform laboratory tests (including biochemical profile), imaging (chest x-rays, liver and pelvic ultrasound, PET, CT and radionuclide bone scans) or serum cancer markers for asymptomatic patients after surgery for breast cancer, in the absence of clinical signs.

5. Don’t prescribe chemotherapy in the systemic treatment of ductal carcinoma in situ of the breast.
1. Don’t perform allergy tests for drugs (including anesthetics) and/or foods when there are not clinical history and symptoms suggestive of hypersensitivity reactions.

2. Don’t perform the so-called “food intolerance tests” (apart from those which are validated for suspect celiac disease or lactose enzymatic intolerance)

3. Don’t perform serological allergy tests (i.e.: total IgE, specific IgE, ISAC) as first-line tests or as “screening” assays.

4. Don’t treat patients sensitized to allergens or aptens if there is not a clear correlation between exposure to that specific allergen/aptenuen and symptoms suggestive of allergic reaction. This recommendation is particularly strong for allergen immunotherapy and elimination diets.

5. Don’t diagnose asthma without having performed lung function tests (including bronchodilating test and/or bronchial challenge).
1. Avoid contraindicating routinely vaccination in case of allergies.

2. Avoid performing routine allergy testing in children with acute urticaria.

3. Avoid prescribing mucolytics in children with bronchial asthma.

4. Avoid prescribing routine immunological tests in children with recurrent respiratory infections.

5. Avoid ruling out a food from the diet only for the positivity of skin prick tests and/or specific serum IgE.
1. Don’t recommend routine imaging of the spine in patients with low back pain in the absence of warning signs or symptoms (red flags).

2. Don’t routinely prescribe antibiotics for acute infections of the upper airways. Evaluate their opportunity for patients at risk of lower respiratory tract infections or in the presence of clinical worsening after some days.

3. Don’t routinely prescribe proton pump inhibitors to patients not at risk for peptic ulcer. For pharmacological treatment of patients with gastroesophageal reflux disease (GERD), they should be titrated to the lowest effective dose needed to achieve therapeutic goals, educating the patient to desirable periods of suspension.

4. Don’t prescribe non steroidal anti-inflammatory drugs (NSAIDS) without initially assessing, and periodically reassessing, the true clinical indication and the risk of side effects in that moment and for that patient.

5. Don’t routinely prescribe benzodiazepines or Z-drugs in older adults as first choice for insomnia. Recommend to use them intermittently and to periodically reassess the clinical indication as well as any side effects.
1. Don’t perform magnetic resonance imaging (MRI) of the spine within the first six weeks in patients with low back pain in the absence of warning signs or symptoms (red flags).

2. Don’t perform routine magnetic resonance imaging (MRI) of the knee in the event of acute pain from trauma or chronic pain.

3. Don’t perform magnetic resonance imaging (MRI) for non-traumatic headache in the absence of warning clinical signs.

4. Don’t perform preoperative chest x-rays in the absence of clinical signs or symptoms which indicate diseases that could affect the outcome of the surgery.

5. Don’t perform routine radiology of the skull in minor head injury.
1. Don’t perform preoperative hair removal with a razor blade in anticipation of surgery (AICO).

2. Don’t incorrectly use collection devices for ostomy with convex plate. (AIOSS)

3. Don’t incorrectly use chemicals for clearing the stomatal complex. (AIOSS)

4. Don’t use abrasive disinfectants on intact skin in the elderly, who are bedridden and with fragile and/or damaged skin. (AIUC)

5. Don’t use bladder training (repeated closure of the catheter) before urinary catheter removal. (AIURO - ANIMO)
The top 5 recommendations released in 2015
1. Avoid routine use of inhaled corticosteroids in upper respiratory tract illness in children.

2. Avoid formula supplement in the first days of life for healthy, full term, breast-fed newborns without proved medical contraindications.

3. Don’t prescribe antibiotics to treat respiratory infections probably due to viral agents in children (pharyngitis, sinusitis, bronchitis).

4. Don’t prescribe Chest Radiography to confirm diagnosis and to follow up in a not complicated pneumonia in children.

5. Avoid using drugs (anti H2, procyclines, protonic pump inhibitors-PPI) in physiological Gastro Esophageal Reflux (GER) not interfering with growth and not associated with clinical signs or symptoms of GER Disease. Don’t prescribe drugs in “happy spitters”.
1. Don’t use brain SPECT (Single photon emission computed tomography) with DAT (dopamine transporter) radiopharmaceuticals in the differential diagnosis of degenerative Parkinsonisms or to convince a patient with Parkinson’s disease that he/she is really affected with that disease.

2. Don’t use 18F-FDG PET-CT as a “screening” test for cancer in healthy subjects.

3. Don’t perform PET/CT with [18F]FDG (Fluorodeoxyglucose) in suspected peripheral osteomyelitis and in differential diagnosing between acute and chronic infection.

4. Don’t perform lymphoscintigraphy and radioguided biopsy of the sentinel node in patients affected by cutaneous melanoma thinner than 0.75 mm, with no ulceration and mitotic rate <1/mm²

5. Don’t treat with radioiodine low-risk differentiated thyroid carcinomas (namely "microcarcinomas" or carcinomas <1 cm, in the absence of unfavorable prognostic factors), after total thyroidectomy
1. Don’t use the ‘sliding scale insulin therapy’ for the treatment of hyperglycemia in hospitalized patients.

2. Don’t prescribe routine glucose self-monitoring to Type 2 diabetes patients who are being treated with drugs that do not cause hypoglycemia.

3. Don’t prescribe screenings for diabetes complications that are not in accordance with the national guidelines.

4. Don’t treat diabetes patients indiscriminately with antiplatelet drugs.

5. Don’t perform routine measurement of C-peptide in diabetes patients.
1. Thyroid US screening is not recommended in patients without thyroid disease’s signs or symptoms and without thyroid carcinoma family history.

2. Avoid excess bone density testing: intervals less than two years are rarely necessary.

3. Use of free testosterone testing is not recommended for hypogonadism or hyperandrogenism diagnosis.

4. FT3 testing is not necessary in most thyroid diseases patients.

5. Thyroid nodules patients should not be treated with L-thyroxine except in selected cases.
1. Don’t clamp the umbilical cord before 1 minute in neonates that do not need resuscitation manoeuvres.

2. Don’t use continuous cardiotocography (CTG) during labour of women at low risk for hypoxia.

3. Don’t require routinely to all patients general blood tests, general coagulation tests or tests for trombophylia to prescribe oral contraceptive medications.

4. Don’t require a pelvic exam or other physical exam to prescribe oral contraceptive medications.

4. Don’t schedule elective, non-medically indicated inductions of labor or Cesarean deliveries before 39 weeks 0 days gestational age.
1. Don’t recommend Enteral Artificial Nutrition through Percutaneous Endoscopic Gastrostomy (PEG) or nasogastric tube in patients with advanced dementia; instead, offer oral assisted feeding.

2. Don’t use antipsychotics as a first choice to treat behavioral symptoms of dementia. Identifying and addressing causes of behavior change can make treatment unnecessary.

3. Don’t use benzodiazepines or other sedative-hypnotics in older adults as first choice for insomnia.

4. In documented clinical and radiological evidence of dementia, don’t ask for brain SPECT (single-photon emission computed tomography) or 18-FDG PET (fluorodeoxyglucose positron emission tomography) or PET (positron emission tomography) with amyloid markers.

5. In subjects asymptomatic for cognitive impairment, even in familial recurrence, or in patients with memory complaints without any neuropsychological evidence, don’t ask for brain PET (positron emission tomography) with amyloid markers.
1. In gathering information on the history of a transient loss of consciousness, a clear description of a blackout and a list of all drugs in use cannot be omitted.

2. In the clinical evaluation of a patient with a previous transient loss of consciousness, measurement of laying down and standing blood pressure cannot be omitted in order to exclude orthostatic hypotension.

3. In the evaluation of transient loss of consciousness and a normal neurological examination, don’t perform an EEG.

4. Don’t perform vertebral-carotid color-coded duplex ultrasound studies for transient loss of consciousness without other neurological symptoms.

5. In the evaluation of transient loss of consciousness and a normal neurological examination, don’t perform brain imaging studies (CT or MRI).
1. Don’t prescribe acid suppressant therapy in order to prevent stress ulcers in hospitalized patients, unless there is a high risk of bleeding.

2. Don’t treat a bacteriuria with antibiotics in elderly patients without urinary symptoms.

3. Don’t recommend percutaneous feeding tubes in advanced dementia; prefer oral assisted feeding instead.

4. Don’t repeat chemistry testing in the face of clinical and laboratory stability.

5. Don’t transfuse red blood cells for arbitrary Hb levels, without symptoms of active coronary artery disease, heart failure, stroke.
1. Don’t use benzodiazepines in elderly patients as a first choice for insomnia, agitation, delirium.

2. Don’t delay palliative cares in the dying patients.

3. Don’t routinely prescribe lipid lowering drugs in patients with a limited life expectancy.

4. Don’t use non-steroid anti-inflammatory drugs (NSAID) in subjects with arterial hypertension, heart failure, renal insufficiency from any cause, including diabetes.

5. Don’t perform PET/CT for cancer screening in healthy subjects.
1. **Air**: don’t consume energy derived from fossil fuels (coal, petrol, gas). When possible, use renewable energy sources (those which can be provided by solar energy, photovoltaic systems, wind power, geothermic sources and buildings constructed using materials which save energy). The use of private cars should be reduced preferring instead the use of bicycles, public transport, car pooling and walking.

2. **Water**: don’t drink bottled water choosing, where possible, water from the tap which often has better organoleptic characteristics and is subject to rigorous quality control.

3. **Biodiversity**: use antibiotics only when absolutely necessary and only under medical supervision.

4. **Ionized Radiation**: X-rays should not be carried out unless there is a specific clinical indication.

5. **Nutrition**: don’t purchase or consume foods which are mass produced by industry or come from a distant geographical location preferring instead fresh foods (fruit, vegetables, whole wheat cereals and milk) from your local area.
1. Don’t exclude nor defer the oral or parenteral administration of opioids for the palliative treatment of dyspnoea in patients affected by chronic incurable illness with a limited life expectancy.

2. Don’t initiate or prolong artificial nutrition (enteral or parenteral) in late stage cancer patients with a life expectancy of less than a few weeks and a Performance Status <50.

3. Don’t combine drugs for which there is no documented evidence of compatibility and chemical and physical stability in devices for the continuous subcutaneous or intravenous infusion of medications (e.g. Elastomers).

4. When organizing a local palliative care network, don’t omit the activation of II° level home care involving medical staff (doctors and nurses) with specialised training palliative care and team management.

5. Don’t implement programs/pathways aimed at improving the quality of end of life care that are neither proven to be effective or included in specific research programs, unless they are supported and monitored by medical staff belonging to a specialised palliative care team.
1. Don’t perform genetic testing for mutations analysis in the 5,10-Methylene TetraHydrofolate Reductase (MTHFR) gene

2. Don’t perform genetic tests directly to consumers, purchased on websites, pharmacies, gyms, beauty institutions, without a doctor's prescription.

3. Don’t perform genetic tests for monogenic diseases without specific indication both in the physiological procreation or by assisted reproduction technology (ART).

4. Don’t perform HLA genotyping in the presence of established diagnosis of celiac disease or for screening purpose.

5. Don’t perform screening tests of polymorphisms of factor V (Leiden) and Factor II (G20210A) in unselected patients, like all patients with only one episodes of venous thrombosis, in healthy subjects or in pregnant women with no specific anamnestic signs or before starting a treatment with oral contraceptives.
1. Don't use non-interactive lectures as the main teaching method. Privilege the use of interactive methods instead.

2. Don't address topics about clinical or organization choices without considering their ethical, social and inter-professional aspects, patient's expectations and values, and the most appropriate teaching setting (hospital, primary care).

3. Avoid non-structured oral exams, and don't use only cognitive tools of technical knowledge in the assessment of practical skills.

4. Don't let learners perform procedures directly on patients, without having practiced them in an appropriate simulated model, and without proper tutorial supervision.

5. Don't use only cognitive tests with a prevalent biological focus in the selection of candidates for the access to undergraduate and postgraduate medical and health sciences schools.