Periodic Health Exam
or
Screening in a Nutshell

Mark Karanofsky MDCM CCFP FCFP
Common Core #1
July 27th 2016
Disclosure

• Nothing Commercial
• Vested interest in you all learning this now in your residency
Plan for today

• Introduction
• Jeopardy!
• Break
• The Periodic Health Exam
• Guidelines
• Break
• Professionalism Challenge
• Bonus Game
• Conclusion
PERIODIC HEALTH EXAM
Quebec's Health Minister Gaetan Barrette describes annual physical checkups, as "basically useless."

IS HE CORRECT?
Training Issues

- Residents and students are still in training
- May not have strong evidence for benefit in practice
- Is there a benefit for residents to practice examining normal so that in the future when they see or feel abnormal they have something to compare to?
Periodic Health Exam Resources

- Fiche de prevention clinique
- Preventive care checklist summary (2015)
- Adult male checklist
- Adult female checklist
Preventive Care Checklist Form

For average-risk, routine, female health assessments

Developed by: Dr. Y. Dubey, Dr. R. Mathews, Dr. K. Iqbal
Revised by: Dr. A. Socas, Dr. J. Philby

Please note:
- [Grade A] is strong evidence (from the Canadian Task Force on Preventive Health Care)
- [Grade B] is weak evidence (from the Canadian Task Force on Preventive Health Care)
- [Grade C] is expert opinion (from other Canadian sources)
- [Grade D] is weak evidence (from other sources)

See sources for references, brief for explanations

Current Concerns

<table>
<thead>
<tr>
<th>Lifestyle/Habits</th>
<th>Date:</th>
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<tbody>
<tr>
<td>Family History</td>
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</tr>
<tr>
<td>Education</td>
<td></td>
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<td>Work/Education</td>
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<td>Family Planning</td>
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<td>Contraception</td>
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<td>Sleep</td>
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Update Cumulative Patient Profile

<table>
<thead>
<tr>
<th>Meds</th>
<th>Hospitalizations/Surgeries</th>
<th>Allergies</th>
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Functional Inquiry

<table>
<thead>
<tr>
<th>HEENT</th>
<th>Normal</th>
<th>Remarks</th>
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<tr>
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<td>Resp</td>
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<tr>
<td>Breasts</td>
<td></td>
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<tr>
<td>GL</td>
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<table>
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<table>
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<th>Normal</th>
<th>Remarks</th>
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<td>MSK</td>
<td></td>
<td></td>
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<tr>
<td>Derm</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mental Health</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Constitutional X</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Age</th>
<th>≤ 64 years</th>
<th>≥ 65 years</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mammography 50-74 yrs, q3-2 yrs</td>
<td>Mammography 50-74 yrs, q3-2 yrs up to 74 yrs</td>
<td></td>
</tr>
<tr>
<td>Colonoscopy</td>
<td>Colonoscopy</td>
<td></td>
</tr>
<tr>
<td>Cervical Cytology q3 yrs (if ever sexually active and 25-69 yrs)</td>
<td>Cervical Cytology q3 yrs (if ever sexually active and up to 69 yrs)</td>
<td></td>
</tr>
<tr>
<td>Gonorrhea/Chlamydia/STi/PHP/HIV/HCV screen (high res)</td>
<td>Gonorrhea/Chlamydia/STi/PHP/HIV/HCV screen (high res)</td>
<td></td>
</tr>
<tr>
<td>Fasting Lipid Profile q1-5 yrs (≤50 yrs, postmenopausal or smoker if at risk)</td>
<td>Fasting Lipid Profile q1-5 yrs (≤70 yrs)</td>
<td></td>
</tr>
<tr>
<td>A1C or FPG if at risk</td>
<td>A1C or FPG if at risk</td>
<td></td>
</tr>
<tr>
<td>Bone Mineral Density if at risk</td>
<td>Bone Mineral Density</td>
<td></td>
</tr>
</tbody>
</table>

Immunizations

<table>
<thead>
<tr>
<th>Vaccine</th>
<th>Remarks</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tetanus vaccine q10 yrs</td>
<td>Meningococcal vaccine</td>
</tr>
<tr>
<td>Influenza vaccine q1 yr</td>
<td>Hepatitis A/B vaccine</td>
</tr>
<tr>
<td>Acute pertussis vaccine</td>
<td>Human papillomavirus vaccine (≤45 yrs)</td>
</tr>
<tr>
<td>Measles/Mumps/Rubella vaccine</td>
<td>Varicella vaccine (≥12 yrs)</td>
</tr>
</tbody>
</table>

Assessment and Plans

<table>
<thead>
<tr>
<th>Date:</th>
<th>Signature:</th>
</tr>
</thead>
</table>

References: See explanation sheet for references and recommendations

The term is a guide to the adult female health examination. Last updated February 2019.
The recommendations are for average-risk adults.
GUIDELINES
Disclaimer

Guidelines are just Guidelines
Always need updating
Guidelines

- Out of date after 5 years
- Somewhat out of date on day published
- Need to make sure that guideline applicable and appropriate for patient/population
- Not 100% perfect but a starting point for discussion
To Whom and When Should we do Screening?
How well do you know your Screening Guidelines?
Cancer

- Breast Cancer
- Cervical Cancer
- Prostate Cancer
- Colon Cancer
- Lung Cancer
Breast Cancer Screening

- Recommendations on screening for breast cancer in average-risk women aged 40–74 years
- The Canadian Task Force on Preventive Health Care
Mammogram

Population:
- Women aged 40-74 without personal or family history of breast cancer, known BRCA1 or 2 mutation, or prior chest wall radiation

Burden of illness
- 22,700 new cases of breast cancer
- 5,400 deaths from breast cancer in Canada during 2009.
Mammogram

For women aged 40-49
  • we recommend not routinely screening.
    ▢ Weak recommendation; moderate quality evidence

For women aged 50-69
  • we recommend routinely screening.
    ▢ Weak recommendation; moderate quality evidence

For women aged 70-74
  • we recommend routinely screening.
    ▢ Weak recommendation; low quality evidence
<table>
<thead>
<tr>
<th>Age Group</th>
<th>Number of Women Screened</th>
<th>Unnecessary Breast Biopsy</th>
<th>False Positive Mammogram</th>
</tr>
</thead>
<tbody>
<tr>
<td>40-49</td>
<td>- about 2100 women</td>
<td>- 75 women</td>
<td>- about 690 women</td>
</tr>
<tr>
<td></td>
<td>would need to be</td>
<td>have an unnecessary breast</td>
<td>will have a false positive</td>
</tr>
<tr>
<td></td>
<td>screened every 2 to 3</td>
<td>biopsy</td>
<td>mammogram leading to</td>
</tr>
<tr>
<td></td>
<td>years</td>
<td></td>
<td>unnecessary anxiety and</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>follow-up testing</td>
</tr>
<tr>
<td>50-69</td>
<td>- about 720 women</td>
<td>- 26 women</td>
<td>- about 204 women</td>
</tr>
<tr>
<td></td>
<td>would need to be</td>
<td>have an unnecessary breast</td>
<td>will have a false positive</td>
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<tr>
<td></td>
<td>screened every 2 to 3</td>
<td>biopsy</td>
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<td></td>
<td>unnecessary anxiety and</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>follow-up testing</td>
</tr>
<tr>
<td>70-74</td>
<td>- about 450 women</td>
<td>- 11 women</td>
<td>- about 96 women</td>
</tr>
<tr>
<td></td>
<td>would need to be</td>
<td>have an unnecessary breast</td>
<td>will have a false positive</td>
</tr>
<tr>
<td></td>
<td>screened every 2 to 3</td>
<td>biopsy</td>
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<td></td>
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<td>unnecessary anxiety and</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>follow-up testing</td>
</tr>
</tbody>
</table>
Mammogram

For every 1,000 women screened for about 11 years - about 5 women will unnecessarily undergo surgery for breast cancer
Cervical Cancer

• Canadian Task Force on Preventative Health care
  http://canadiantaskforce.ca/guidelines/screening-for-cervical-cancer/

• Recommendations on optimizing cervical cancer screening in Québec
  Direction des risques biologiques et de la santé au travail
  January 2009

• Guidelines on Cervical Cancer Screening in Québec
  Institut national de santé publique du Québec, 2011, 24 pages + annexes. INSPQ's Number: 1371
<table>
<thead>
<tr>
<th>Age</th>
<th>Recommendation</th>
<th>Explanation</th>
<th>Grading of Recommendation</th>
</tr>
</thead>
<tbody>
<tr>
<td>19 or younger</td>
<td>Do not routinely screen</td>
<td>0.3 per 100,000 per year without screening</td>
<td>Strong recommendation; high quality evidence</td>
</tr>
<tr>
<td>20-24</td>
<td>Do not routinely screen</td>
<td>3 per 100,000 per year without screening</td>
<td>Weak recommendation; moderate quality evidence</td>
</tr>
<tr>
<td>25-29</td>
<td>Routine screening every 3 years</td>
<td>9 per 100,000 per year without screening</td>
<td>Weak recommendation; moderate quality evidence</td>
</tr>
<tr>
<td>30-69</td>
<td>Routine screening every 3 years</td>
<td>35 per 100,000 per year without screening</td>
<td>Strong recommendation; high quality evidence</td>
</tr>
<tr>
<td>70 or older</td>
<td>Cease routine screening only if the last 3 Pap tests in the last 10 years were negative</td>
<td>minimal additional benefit of continuing screening if Pap test results have been consistently negative</td>
<td>Weak recommendation; low quality evidence</td>
</tr>
</tbody>
</table>
INSPQ Guidelines

- Screening should start at the age of 21, unless exceptional circumstances indicate otherwise:
  - first sexual relations at a very early age
  - sexual abuse,
  - Immunosuppression
  - or HIV infection.
- Screening tests are to take place every two years when results have been normal.
- Screening may cease at the age of 65 if the results of the last two tests conducted in the previous 10 years were negative.
Prostate Cancer

• Screening for Prostate Cancer (2014)
• www.canadiantaskforce.ca
Guideline

KEEP CALM AND JUST SAY NO
Benefits and Harms of PSA Screening

The Canadian Task Force on Preventive Health Care recommends against screening for prostate cancer with the PSA test.

- The CTFPHC found that the potential small benefit from PSA screening is outweighed by the potential significant harms of the screening and associated follow-up treatment.
- Men should understand that PSA screening may result in additional testing if the PSA level is raised.
- To save one life we would need to diagnose an additional 27 men with prostate cancer.

RESULTS OF SCREENING 1,000 MEN WITH THE PSA TEST
(age 55-69 years, screened over a 15-year period, and with a PSA screening threshold of 3.0 ng/ml)

What are my risks if I don’t get screened?

- Among men who are screened with the PSA test, the risk of dying from prostate cancer is 5 in 1,000.
- Among men who are not screened with the PSA test, the risk of dying from prostate cancer is 6 in 1,000.

720 men will have a negative PSA test
178 men with a positive PSA in whom follow-up testing does not identify prostate cancer

4 of those 178 will experience biopsy complications such as infection and bleeding severe enough to require hospitalization

102 men will be diagnosed with prostate cancer

5 men will die from prostate cancer despite undergoing PSA screening
1 man will escape death from prostate cancer because he underwent PSA screening

Complications of treatment for prostate cancer

For every 1,000 men who receive treatment for prostate cancer:

- 114-214 will have short-term complications such as infections, additional surgeries, and blood transfusions
- 127-442 will experience long-term erectile dysfunction
- up to 178 will experience urinary incontinence
- 4-5 will die from complications of prostate cancer treatment

*Statistics for benefits and harms were calculated from the European Randomized Study of Screening for Prostate Cancer (ERSPC).*
KEY POINTS

- The prevalence of undiagnosed prostate cancer at autopsy is high and increases with age (over 40% in men aged 40-49 years to over 70% in men aged 70 to 79 years).

- Only a small proportion of prostate cancer causes symptomatic disease or death whereas the majority is slowly progressive and not life threatening.

- Screening with PSA may lead to a small reduction in prostate cancer mortality but does not reduce overall mortality.

- PSA thresholds of 2.5ng/ml to 4.0ng/ml are commonly used for screening, with lower thresholds increasing the probability of false positive results and overdiagnosis, but no value completely excludes prostate cancer.

- Harms (such as bleeding, infection, urinary incontinence, false positives and overdiagnosis) are common following PSA screening.

- PSA should not be used for screening without prior informed discussion, ideally using decision aids to facilitate comprehension.
Colon Cancer

- www.canadiantaskforce.ca
Screening for Colorectal Cancer (CRC)

Who do these recommendations apply to?
- These recommendations apply to **asymptomatic adults aged 50 and older who are not at high risk for colorectal cancer (CRC)**. Adults are at high risk if they have at least one of the following:
  - Previous CRC or adenomatous polyps (e.g., tubular or villous)
  - Inflammatory bowel disease (e.g., ulcerative colitis or Crohn’s disease)
  - Signs or symptoms of CRC (e.g., blood in the stool)
  - History of CRC in one or more first-degree relatives
  - Adults with hereditary syndromes predisposing to CRC (e.g., familial adenomatous polyposis or Lynch syndrome)

This tool provides guidance for primary care practitioners on different screening tests, screening intervals, and recommended ages to start and stop screening.

<table>
<thead>
<tr>
<th>Age</th>
<th>Screen?</th>
<th>Recommendation Strength</th>
<th>Test</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt;50</td>
<td></td>
<td>We suggest not screening</td>
<td></td>
</tr>
<tr>
<td>50 - 59</td>
<td>Yes</td>
<td>Weak</td>
<td>FOBT (either gFOBT or FIT) every 2 years OR flexible sigmoidoscopy every 10 years</td>
</tr>
<tr>
<td>60 - 74</td>
<td>Yes</td>
<td>Strong</td>
<td>FOBT (either gFOBT or FIT) every 2 years OR flexible sigmoidoscopy every 10 years</td>
</tr>
<tr>
<td>75 +</td>
<td>No</td>
<td>Weak</td>
<td>If patient is interested in screening, discuss options and help them reach a decision based on their quality of life, values, and preferences.</td>
</tr>
</tbody>
</table>

- **Strong** recommendation means that most individuals will be best served by the recommended course of action.
- **Weak** recommendation means that many people would want the recommended course of action, but many would not. Primary care practitioners should discuss the potential harms and benefits of screening with their patients.
Colonoscopy

- We recommend not using colonoscopy as a primary screening test for CRC. There is a lack of direct, high-quality evidence of the efficacy of colonoscopy in comparison to that of other screening tests.

- Colonoscopy has greater potential for harms (e.g., minor bleeding, major bleeding, perforation, and death) than the other available tests.

- Colonoscopy requires more time and expertise to perform, and using colonoscopy for screening means that this test will not be as readily available for people with symptomatic disease, such as visible blood in the stool.
Lung Cancer

- www.canadiantaskforce.ca
We recommend screening for lung cancer using low-dose computed tomography (low-dose CT) in adults who

- are aged 55–74
- are current smokers or former smokers who quit within the last 15 years
- have smoked one pack a day for at least 30 years (or two packs a day for 15 years or equivalent; i.e., 30 “pack-years”)

If you think you meet all of these criteria, you should talk to your primary care provider about being screened once a year for up to three years in a row.

We do not recommend being screened for lung cancer with a chest x-ray.
Screening 1000 eligible people with low-dose CT (annually for 3 years)

| 609 | will have a negative low-dose CT scan result |
| 40  | will be diagnosed with lung cancer |
| 351 | will have a positive scan result and find out after further testing that they do not have cancer (false positive) |
| 7   | of the 40 diagnosed lung cancers would not have caused illness or death (overdiagnosis) |
| 3   | will have major complications from invasive follow-up tests |
| 1   | will die from invasive follow-up testing |
| 3   | fewer people will die from lung cancer (vs. when screening with chest x-ray) |

Harm !

Benefit ★
Explaining Risk
Exercise

• Turn to the person next to you.

• Take turns: One act as a patient. The other a doctor

• Discuss the pros and cons of why someone should consider screening for XXXX Cancer at an appropriate age.
Video Resources

Cancer Screening Video

Dr. Mike Evans - Choosing Wisely
Hypertension

- 2016 Canadian Hypertension Education Program Recommendations
- Canadian Hypertension Society
- http://www.hypertension.ca/
Criteria for the diagnosis of hypertension and recommendations for follow-up: overview

Measurement using electronic (oscillometric) upper arm devices is preferred over auscultation.

ABPM: Ambulatory Blood Pressure Measurement
AOBP: Automated Office Blood Pressure
HBPM: Home Blood Pressure measurement
OBPM: Office Blood Pressure measurement
Usual Office BP Threshold Values for Initiation of Pharmacological Treatment

<table>
<thead>
<tr>
<th>Population</th>
<th>SBP</th>
<th>DBP</th>
</tr>
</thead>
<tbody>
<tr>
<td>High Risk (SPRINT population)</td>
<td>≥130</td>
<td>NA</td>
</tr>
<tr>
<td>Diabetes</td>
<td>≥130</td>
<td>≥80</td>
</tr>
<tr>
<td>Moderate-to-high risk (TOD or CV risk factors)*</td>
<td>≥140</td>
<td>≥90</td>
</tr>
<tr>
<td>Low risk (no TOD or CV risk factors)</td>
<td>≥160</td>
<td>≥100</td>
</tr>
</tbody>
</table>

TOD = target organ damage

*AOBP threshold ≥135/85
Recommended Office BP Treatment Targets

Treatment consists of health behaviour ± pharmacological management

<table>
<thead>
<tr>
<th>Population</th>
<th>SBP</th>
<th>DBP</th>
</tr>
</thead>
<tbody>
<tr>
<td>High Risk</td>
<td>≤120</td>
<td>NA</td>
</tr>
<tr>
<td>Diabetes</td>
<td>&lt; 130</td>
<td>&lt; 80</td>
</tr>
<tr>
<td>All others*</td>
<td>&lt; 140</td>
<td>&lt; 90</td>
</tr>
</tbody>
</table>

* Target BP with AOBP < 135/85
New thresholds/targets for the high risk patient post-SPRINT: who does this apply to??

- Clinical or sub-clinical cardiovascular disease
  OR
- Chronic kidney disease (non-diabetic nephropathy, proteinuria <1 g/d, *eGFR 20-59 mL/min/1.73m²)
  OR
- Estimated 10-year global cardiovascular risk ≥15% (• Framingham Risk Score)
  OR
  • Age ≥ 75 years

- Patients with one or more clinical indications should consent to intensive management.
New thresholds/targets for the high risk patient post-SPRINT: who does this NOT apply to??

**Limited or No Evidence:**
- Heart failure (EF <35%) or recent MI (within last 3 months)
- Indication for, but not currently receiving a beta-blocker
- Frail or institutionalized elderly

**Inconclusive Evidence:**
- Diabetes mellitus
- Prior stroke
- eGFR < 20 ml/min/1.73m2

**Contraindications:**
- Patient unwilling or unable to adhere to multiple medications
- Standing SBP <110 mmHg
- Inability to measure SBP accurately
- Known secondary cause(s) of hypertension
Primary Outcome:
Composite of myocardial infarction, acute coronary syndrome not resulting in myocardial infarction, stroke, acute decompensated heart failure, or death from cardiovascular causes.

NNT=61
For high-risk patients, aged ≥ 50 years, with systolic BP levels >\(\geq\)130 mm Hg, intensive management to target a systolic BP \(\leq\)120 mm Hg should be considered.

Intensive management should be guided by automated office BP measurements.

Patient selection for intensive management is recommended and caution should be taken in certain high-risk groups.
New 2016 Recommendation
BP Measurement

- Automated office blood pressure (AOBP) is the preferred method of performing in-office BP measurement.

Automated Office (unattended, AOBP)
Oscillometric (electronic)
### Health Behaviour Management

<table>
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<tr>
<th>Intervention</th>
<th>Target</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reduce foods with added sodium</td>
<td>→ 2000 mg /day</td>
</tr>
<tr>
<td>Weight loss</td>
<td>BMI &lt;25 kg/m²</td>
</tr>
<tr>
<td>Alcohol restriction</td>
<td>≤ 2 drinks/day</td>
</tr>
<tr>
<td>Physical activity</td>
<td>30-60 minutes 4-7 days/week</td>
</tr>
<tr>
<td>Dietary patterns</td>
<td>DASH diet</td>
</tr>
<tr>
<td>Smoking cessation</td>
<td>Smoke-free environment</td>
</tr>
<tr>
<td>Waist circumference</td>
<td>Men &lt; 102 cm  Women &lt; 88 cm</td>
</tr>
<tr>
<td>Potassium supplementation</td>
<td>NEW RECOMMENDATION</td>
</tr>
</tbody>
</table>
III. Assessment of the overall cardiovascular risk

Search for target organ damage

**Cerebrovascular disease**
- transient ischemic attacks
- ischemic or hemorrhagic stroke
- vascular dementia

**Hypertensive retinopathy**

**Left ventricular dysfunction**

**Coronary artery disease**
- myocardial infarction
- angina pectoris
- congestive heart failure

**Chronic kidney disease**
- hypertensive nephropathy (GFR < 60 ml/min/1.73 m²)
- albuminuria

**Peripheral artery disease**
- intermittent claudication
Preliminary Investigations of patients with hypertension

1. Urinalysis
2. Blood chemistry (potassium, sodium and creatinine)
3. Fasting glucose and/or glycated hemoglobin (A1c)
4. Fasting total cholesterol and high density lipoprotein cholesterol (HDL), low density lipoprotein cholesterol (LDL), triglycerides
5. Standard 12-leads ECG

Currently there is insufficient evidence to recommend routine testing of microalbuminuria in people with hypertension who do not have diabetes.
Impact of lifestyle therapies on blood pressure

<table>
<thead>
<tr>
<th>Intervention</th>
<th>Systolic BP (mmHg)</th>
<th>Diastolic BP (mmHg)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diet and weight control</td>
<td>-6.0</td>
<td>-4.8</td>
</tr>
<tr>
<td>Reduced salt/sodium intake</td>
<td>-5.4</td>
<td>-2.8</td>
</tr>
<tr>
<td>Reduced alcohol intake (heavy drinkers)</td>
<td>-3.4</td>
<td>-3.4</td>
</tr>
<tr>
<td>DASH diet</td>
<td>-11.4</td>
<td>-5.5</td>
</tr>
<tr>
<td>Physical activity</td>
<td>-3.1</td>
<td>-1.8</td>
</tr>
<tr>
<td>Relaxation therapies</td>
<td>-3.7</td>
<td>-3.5</td>
</tr>
<tr>
<td>Multiple interventions</td>
<td>-5.5</td>
<td>-4.5</td>
</tr>
</tbody>
</table>

Clinical Guideline: Methods, evidence and recommendations National Institute for Health and Clinical Excellence (NICE) May 2011
Treatment of Adults with Systolic/Diastolic Hypertension without Other Compelling Indications

TARGET <140/90 mmHg

INITIAL TREATMENT AND MONOTHERAPY

Lifestyle modification therapy

- Thiazide
- ACEI
- ARB
- Long-acting CCB
- Beta-blocker*

A combination of 2 first line drugs may be considered as initial therapy if the blood pressure is >20 mmHg systolic or >10 mmHg diastolic above target

• BBs are not indicated as first line therapy for age 60 and above

ACEI, ARB and direct renin inhibitors are contraindicated in pregnancy and caution is required in prescribing to women of child bearing potential
Cholesterol

- Jacques Genest MD1, Ruth McPherson MD PhD, et al.
- Canadian Journal of Cardiology
  - Vol 25 No 10 October 2009
- 2012 Update
Who to Screen

Men ≥ 40 years of age, and women ≥ 50 years of age or postmenopausal
(consider earlier in ethnic groups at increased risk such as South Asians or First Nations individuals)
or
All patients with any of the following conditions, regardless of age:

- Current cigarette smoking
- Diabetes
- Arterial hypertension
- Family history of premature CVD
- Family history of hyperlipidemia
- Erectile dysfunction
- Chronic kidney disease
- Inflammatory disease
- HIV infection
- Chronic obstructive pulmonary disease
- Clinical evidence of atherosclerosis or abdominal aneurysm
- Clinical manifestation of hyperlipidemia
- Obesity (body mass index > 27)

How to Screen

For all: History and examination, LDL, HDL, TG, non-HDL (will be calculated from profile), glucose, eGFR
Optional: apoB (instead of standard lipid panel), urine albumin:creatinine ratio (if eGFR < 60, hypertension, diabetes)

Framingham Risk Score < 5%
Repeat every 3-5 years

Framingham Risk Score ≥ 5%
Repeat every year
<table>
<thead>
<tr>
<th>Risk level</th>
<th>Initiate therapy if</th>
<th>Primary target LDL C</th>
<th>Alternate target</th>
</tr>
</thead>
<tbody>
<tr>
<td>High FRS ≥ 20%</td>
<td>Consider treatment in all (Strong, High)</td>
<td>≤ 2 mmol/L or ≥ 50% decrease in LDL-C (Strong, High)</td>
<td>Apo B ≤ 0.8 g/L</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Non HDL-C ≤ 2.6 mmol/L (Strong, High)</td>
</tr>
<tr>
<td>Intermediate FRS 10%-19%</td>
<td>➢ LDL-C ≥ 3.5 mmol/L (Strong, Moderate)</td>
<td>≤ 2 mmol/L or ≥ 50% decrease in LDL-C (Strong, Moderate)</td>
<td>Apo B ≤ 0.8 mg/L</td>
</tr>
<tr>
<td></td>
<td>➢ For LDL-C &lt; 3.5 consider if: Apo B ≥ 1.2 g/L or Non-HDL-C ≥ 4.3 mmol/L (Strong, Moderate)</td>
<td></td>
<td>Non HDL-C ≤ 2.6 mmol/L (Strong, Moderate)</td>
</tr>
<tr>
<td>Low FRS &lt; 10%</td>
<td>➢ LDL-C ≥ 5.0 mmol/L</td>
<td>≥ 50% reduction in LDL-C (Strong, Moderate)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>➢ Familial hypercholesterolemia (Strong, Moderate)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Diabetes

- Canadian Diabetes Association Guidelines 2013
- www.diabetes.ca

And

Canadiantaskforce.ca
FPG ≥ 7.0 mmol/L  
Fasting = no caloric intake for at least 8 hours  

*or*  
A1C ≥ 6.5% (in adults)  
Using a standardized, validated assay, in the absence of factors that affect the accuracy of the A1C and not for suspected type 1 diabetes  

*or*  
2hPG in a 75-g OGTT ≥ 11.1 mmol/L  

*or*  
Random PG ≥ 11.1 mmol/L  
Random = any time of the day, without regard to the interval since the last meal.

2hPG = 2-hour plasma glucose; FPG = fasting plasma glucose; OGTT = oral glucose tolerance test; PG = plasma glucose
Recognize pitfalls of A1C: conditions that can affect

<table>
<thead>
<tr>
<th>Factors affecting A1C</th>
<th>Increased A1C</th>
<th>Decreased A1C</th>
<th>Variable Change in A1C</th>
</tr>
</thead>
<tbody>
<tr>
<td>Erythropoiesis</td>
<td>B12/Fe deficiency Decreased erythropoiesis</td>
<td>Use of EPO, Fe, or B12 Reticulocytosis Chronic liver Dx</td>
<td></td>
</tr>
<tr>
<td>Altered hemoglobin</td>
<td></td>
<td></td>
<td>Fetal hemoglobin Hemoglobinopathies Methemoglobin</td>
</tr>
<tr>
<td>Altered glycation</td>
<td>Chronic renal failure ↓↓ erythrocyte pH</td>
<td>ASA, vitamin C/E Hemoglobinopathies ↑ erythrocyte pH</td>
<td></td>
</tr>
<tr>
<td>Erythrocyte destruction</td>
<td>Splenectomy</td>
<td>Hemoglobinopathies Chronic renal failure Splenomegaly Rheumatoid arthritis HAART meds, Ribavirin Dapsone</td>
<td></td>
</tr>
<tr>
<td>Assays</td>
<td>Hyperbilirubinemia Carbamylated Hb ETOH Chronic opiates</td>
<td>Hypertriglyceridemia</td>
<td></td>
</tr>
</tbody>
</table>
3. **Prediabetes**, defined as a state which places individuals at high risk of developing diabetes and its complications, is diagnosed by any of the following criteria:

- **IFG (FPG 6.1 - 6.9 mmol/L)** [Grade A, Level 1].
- **IGT (2hPG in a 75-g OGTT 7.8 to 11.0 mmol/L)** [Grade A, Level 1].
- **A1C 6.0 - 6.4%** [Grade B, Level 2].
Differing Opinions

- CDA vs Task force
Who to screen:

1. All individuals should be **evaluated annually** for type 2 diabetes risk on the basis of **demographic and clinical** criteria [Grade D, Consensus].
When to screen

2. Screening for diabetes using a **FPG and/or A1C** should be performed *every 3 years in individuals ≥ 40 years of age or at high risk using a risk calculator* [Grade D, Consensus]. **More frequent and/or earlier testing** with either a FPG and/or A1c or a 2h PG in a 75 g OGTT should be considered in those at **very high risk** using a risk calculator or in people with **additional risk factors** for diabetes [Grade D, Consensus].
Additional groups to screen

2. **Risk factors** include:
   - First-degree relative with T2DM
   - Member of high-risk population (e.g. Aboriginal, African, Asian, Hispanic, or South Asian)
   - History of prediabetes
   - History of gestational diabetes (GDM)
   - History of delivery of macrosomic infant
Additional groups to screen

Presence of associated problems

- **End organ damage** complications associated with diabetes
  - Microvascular (retinopathy, neuropathy, nephropathy)
  - Macrovascular (coronary, cerebrovascular, peripheral arterial)
- **Vascular risk factors**
  - Low HDL-cholesterol (< 1.0 mmol/L males, 1.3 mmol/L females)
  - Triglycerides ≥ 1.7 mmol/L
  - Hypertension, overweight, abdominal obesity
- **Associated diseases**
  - Polycystic ovarian syndrome, acanthosis nigricans, obstructive sleep apnea, psychiatric disorders (bipolar, depression, schizophrenia), HIV infection
- **Use of drugs** associated with diabetes
  - Glucocorticoids
  - Atypical antipsychotics
  - Highly active antiretroviral therapy (HAART)
  - Others (See Appendix 1 in the full document)
OGTT Indications

3. Testing with a 2hrPG in a **75-g OGTT should be undertaken** in individuals with **FPG of 6.1 to 6.9 mmol/L and/or A1C 6.0 to 6.4%** in order to identify individuals with IGT or diabetes [Grade D, Consensus]

4. Testing with a 2hPG in a **75-g OGTT may be undertaken** in individuals with a **FPG of 5.6 to 6.0 mmol/L and/or A1C 5.5 to 5.9% and ≥1 risk factor(s)** in order to identify individuals with IGT or diabetes [Grade D, Consensus]
When to screen for Diabetes:

- Screen **every 3 years** in individuals ≥40 years of age
- Screen **every 3 years** in individuals at high risk according to the CANRISK calculator
- Screen **earlier and/or more frequently** in people with additional risk factors for diabetes
- Screen **earlier and/or more frequently** in people at very high risk using the CANRISK calculator
Taskforce
## Results

<table>
<thead>
<tr>
<th>Score</th>
<th>Risk</th>
<th>Recommendation</th>
</tr>
</thead>
<tbody>
<tr>
<td>0–14 points</td>
<td>Low to moderate risk</td>
<td>We recommend <em>not screening</em> for type 2 diabetes.</td>
</tr>
<tr>
<td></td>
<td>1-17% chance of developing diabetes within 10 years.</td>
<td></td>
</tr>
<tr>
<td>15–20 points</td>
<td>High Risk</td>
<td>We recommend <em>screening every 3–5 years</em> with A1c.</td>
</tr>
<tr>
<td></td>
<td>33% chance of developing diabetes within 10 years.</td>
<td></td>
</tr>
<tr>
<td>21–30 points</td>
<td>Very High Risk</td>
<td>We recommend <em>annual screening</em> with A1c.</td>
</tr>
<tr>
<td></td>
<td>50% chance of developing diabetes within 10 years.</td>
<td></td>
</tr>
</tbody>
</table>
Individualizing A1C Targets

A target A1C ≤6.5% may be considered in some patients with type 2 diabetes to further lower the risk of nephropathy and retinopathy which must be balanced against the risk of hypoglycemia.

Most patients with type 1 and type 2 diabetes

Consider if:
- Limited life expectancy
- High level of functional dependency
- Extensive vascular disease
- Multiple co-morbidities
- Recurrent severe hypoglycemia
- Hypoglycemia unawareness
- Long standing diabetes for whom it is difficult to achieve A1C ≤ 7.0% despite effective doses of multiple antihyperglycemic agents including intensified basal-bolus insulin therapy.
To Achieve A1C < 7% - Targets

<table>
<thead>
<tr>
<th>A1C (%)</th>
<th>FPG/preprandial PG (mmol/L)</th>
<th>2-hour postprandial PG (mmol/L)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Target for most patients</td>
<td>≤7.0</td>
<td>4.0–7.0</td>
</tr>
</tbody>
</table>
GET TO TARGET WITHIN 3-6 MONTHS OF DIAGNOSIS
Initial Choice of Therapy Depends on Glycemia

- **Initial A1C < 8.5%**
  - Start metformin
  - OR
  - Reassess in 2-3 months then decide on starting metformin

- **Initial A1C ≥ 8.5%**
  - Start metformin
  - AND
  - Consider combo therapy to achieve ≥1.5% A1C reduction
Start metformin immediately.
Consider initial combination with another antihyperglycemic agent.

A1C <8.5%
Start lifestyle intervention (nutrition therapy and physical activity) +/− Metformin.
If not at glycemic target (2-3 mos)
Start / Increase metformin.

A1C ≥8.5%
Start metformin immediately.
Consider initial combination with another antihyperglycemic agent.
If not at glycemic targets
Add an agent best suited to the individual:

Patient Characteristics
Degree of hyperglycemia
Risk of hypoglycemia
Overweight or obesity
Comorbidities (renal, cardiac, hepatic)
Preferences & access to treatment
Other

Agent Characteristics
BG lowering efficacy and durability
Risk of inducing hypoglycemia
Effect on weight
Contraindications & side-effects
Cost and coverage
Other

Symptomatic hyperglycemia with metabolic decompensation
Initiate insulin +/− metformin

See next page…
### Add an agent best suited to the individual (agents listed in alphabetical order):

<table>
<thead>
<tr>
<th>Class</th>
<th>Relative A1C lowering</th>
<th>Hypoglycemia</th>
<th>Weight</th>
<th>Other therapeutic considerations</th>
<th>Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alpha-glucosidase inhibitor (acarbose)</td>
<td>↓</td>
<td>Rare</td>
<td>neutral to ↓</td>
<td>Improved postprandial control, GI side-effects</td>
<td>$$</td>
</tr>
<tr>
<td>Incretin agents: DPP-4 Inhibitors GLP-1 receptor agonists</td>
<td>↓↓</td>
<td>Rare</td>
<td>neutral to ↓</td>
<td>GI side-effects</td>
<td>$$$</td>
</tr>
<tr>
<td>Insulin</td>
<td>↓↓↓↓</td>
<td>Yes</td>
<td>↑↑</td>
<td>No dose ceiling, flexible regimens</td>
<td>$-$$$$</td>
</tr>
<tr>
<td>Insulin secretagogue: Meglitinide</td>
<td>↓↓</td>
<td>Yes</td>
<td>↑</td>
<td>Less hypoglycemia in context of missed meals but usually requires TID to QID dosing</td>
<td>$$</td>
</tr>
<tr>
<td>Sulfonylurea</td>
<td>↓↓</td>
<td>Yes</td>
<td>↑</td>
<td>Gliclazide and glimepiride associated with less hypoglycemia than glyburide</td>
<td>$</td>
</tr>
<tr>
<td>TZD</td>
<td>↓↓</td>
<td>Rare</td>
<td>↑↑</td>
<td>CHF, edema, fractures, rare bladder cancer (pioglitazone), cardiovascular controversy (rosiglitazone), 6-12 weeks required for maximal effect</td>
<td>$$</td>
</tr>
<tr>
<td>Weight loss agent (orlistat)</td>
<td>↓</td>
<td>None</td>
<td>↓</td>
<td>GI side effects</td>
<td>$$$</td>
</tr>
</tbody>
</table>
Antihyperglycemic Agents and Renal Function

**CKD Stage:**
- 5: < 15
- 4: 15-29
- 3: 30-59
- 2: 60-89
- 1: ≥ 90

**GFR (mL/min):**
- < 15
- 15-29
- 30-59
- 60-89
- ≥ 90

### Not recommended / contraindicated
- Acarbose
- Metformin
- Linagliptin
- Saxagliptin
- Sitagliptin
- Exenatide
- Liraglutide
- Gliclazide/Glimepiride
- Glyburide
- Repaglinide

### Caution and/or dose reduction
- Saxagliptin (2.5 mg)
- Sitagliptin (25 mg)
- Exenatide
- Liraglutide
- Gliclazide/Glimepiride (15 mg)
- Glyburide (30 mg)

### Safe
- Gliclazide/Glimepiride (30 mg)
- Gliclazide/Glimepiride (50 mg)
- Glyburide (25 mg)

Osteoporosis

- 2010 clinical practice guidelines for the diagnosis and management of osteoporosis in Canada: summary
- Alexandra Papaioannou MD MSc, Suzanne Morin MD MSc, Angela M. Cheung MD PhD et al.
- www.cmaj.ca
10 year fracture risk

- Assessment of the absolute risk of fracture should be based on established factors, including age, bone mineral density, prior fragility fractures and glucocorticoid use [grade A].
- The 2010 version of the Canadian Association of Radiologists and Osteoporosis Canada tool and the Canadian version of the WHO Fracture Risk Assessment tool should be used in Canada, because they have been validated in the Canadian population [grade A].
ASSESSMENT OF 10-YEAR FRACTURE RISK – Women and Men

<table>
<thead>
<tr>
<th>Assessment of Basal 10-year Fracture Risk: CAROC System</th>
</tr>
</thead>
<tbody>
<tr>
<td>Women</td>
</tr>
<tr>
<td>Men</td>
</tr>
</tbody>
</table>

**NB:** Fragility fracture after age 40 or recent prolonged systemic glucocorticoid use increase CAROC basal risk by one category (i.e., from low-risk to moderate or moderate risk to high).
Encourage basic bone health for all individuals over age 50, including regular active weight-bearing exercise, calcium (diet and supplements) 1200 mg daily, vitamin D 800–2000 IU (20–50 μg) daily and fall-prevention strategies.

**Age < 50 yr**
- Fragility fractures
- Use of high-risk medications
- Hypogonadism
- Malabsorption syndromes
- Chronic inflammatory conditions
- Primary hyperparathyroidism
- Other disorders strongly associated with rapid bone loss or fractures

**Age 50–64 yr**
- Fragility fracture after age 40
- Prolonged use of glucocorticoids or other high-risk medications
- Parental hip fracture
- Vertebral fracture or osteopenia identified on radiography
- High alcohol intake or current smoking
- Low body weight (< 60 kg) or major weight loss (> 10% of body weight at age 25)
- Other disorders strongly associated with osteoporosis

**Age ≥ 65**
- All men and women

**Initial BMD testing**
Calcium and Vitamin D

- Calcium: 1200mg per day including diet
- Vitamin D 800-2000 units daily

Pop Quiz:
- In a Canadian Supermarket, where would you find Vitamin D?
- Eggs and Salmon in small amounts
- Milk (only milk not milk products) ~125 units per serving size
# Treatment Options

## Table A11: First Line Therapies with Evidence for Fracture Prevention in Postmenopausal Women

<table>
<thead>
<tr>
<th>Type of Fracture</th>
<th>Antiresorptive Therapy</th>
<th>Bone Formation Therapy</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Bisphosphonates</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Aclidronate</td>
<td>Risedronate</td>
</tr>
<tr>
<td></td>
<td>Zoledronic Acid</td>
<td>Denosumab</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Raloxifene</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Hormone Therapy (Estrogen)**</td>
</tr>
<tr>
<td>Vertebral</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Hip</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Non-vertebral†</td>
<td>✓</td>
<td>✓</td>
</tr>
</tbody>
</table>

*In clinical trials, nonvertebral fractures are a composite endpoint including hip, femur, pelvis, tibia, humerus, radius, and clavicle.

* For postmenopausal women, ✓ indicates first line therapies and Grade A recommendation. For men requiring treatment, alendronate, risedronate, and zoledronic acid can be used as first line therapies for prevention of fractures [Grade D].

** Hormone therapy (estrogen) can be used as first line therapy in women with menopausal symptoms.
Obesity

www.canadiantaskforce.ca
2015
Children

• The growth monitoring recommendations apply to all children and youth 0–17 years of age who present to primary care.

• We recommend growth monitoring at all appropriate primary care visits using the 2014 WHO Growth Charts for Canada. (Strong recommendation; very low quality evidence)
Children

• We recommend that primary care practitioners **not** routinely offer structured interventions aimed at preventing overweight and obesity in healthy weight children and youth.

• For children and youth aged 2 to 17 years who are overweight or obese, we recommend that primary care practitioners offer or refer to structured behavioural interventions aimed at healthy weight management. (Weak recommendation; moderate quality evidence)
Adults

- We recommend measuring height, weight and calculating BMI at appropriate primary care visits. (wellness visits, visits for medication renewal and other visits where the primary care practitioner deems it appropriate)

- We recommend that practitioners not offer formal, structured interventions aimed at preventing weight gain in normal weight adults.
Adults

• For adults who are obese (30 ≤ BMI < 40) and are at high risk of diabetes, we recommend that practitioners offer or refer to structured behavioural interventions aimed at weight loss. (Strong recommendation; moderate quality evidence)

• For adults who are overweight or obese, we recommend that practitioners offer or refer to structured behavioural interventions aimed at weight loss. (Weak recommendation; moderate quality evidence)

• For adults who are overweight or obese, we recommend that practitioners not routinely offer pharmacologic interventions (orlistat or metformin) aimed at weight loss. (Weak recommendation; moderate quality evidence)
Choosing Wisely

MORE IS NOT ALWAYS BETTER

The same is true for medical tests and treatments. Talk to your doctor about what you need, and what you don't. To learn more, visit www.choosingwisely.ca
Eleven Things Physicians and Patients Should Question

1. **Don’t do imaging for lower-back pain unless red flags are present.**
   Red flags include, but are not limited to, severe or progressive neurological deficits or when serious underlying conditions such as osteomyelitis are suspected. Imaging of the lower spine before six weeks does not improve outcomes.

2. **Don’t use antibiotics for upper respiratory infections that are likely viral in origin, such as influenza-like illness, or self-limiting, such as sinus infections of less than seven days of duration.**
   Bacterial infections of the respiratory tract, when they do occur, are generally a secondary problem caused by complications from viral infections such as influenza. While it is often difficult to distinguish bacterial from viral sinusitis, nearly all cases are viral. Though cases of bacterial sinusitis can benefit from antibiotics, evidence of such cases does not typically surface until after at least seven days of illness. Not only are antibiotics rarely indicated for upper respiratory illnesses, but some patients experience adverse effects from such medications.

3. **Don’t order screening chest X-rays and ECGs for asymptomatic or low risk outpatients.**
   There is little evidence that detection of coronary artery stenosis in asymptomatic patients at low risk for coronary heart disease improves health outcomes. False positive tests are likely to lead to harm through unnecessary invasive procedures, over-treatment and misdiagnosis. Chest X-rays for asymptomatic patients with no specific indications for the imaging have a trivial diagnostic yield, but a significant number of false positive reports. Potential harms of such routine screening exceed the potential benefit.
4 Don't screen women with Pap smears if under 21 years of age or over 69 years of age.
   • Don't do screening Pap smears annually in women with previously normal results
   • Don't do Pap smears in women who have had a hysterectomy for non-malignant disease

The potential harm from screening women younger than 21 years of age outweighs the benefits and there is little evidence to suggest the necessity of conducting this test annually when previous test results were normal. Women who have had a full hysterectomy for benign disorders no longer require this screening. Screening should stop at age 70 if three previous test results were normal.

5 Don't do annual screening blood tests unless directly indicated by the risk profile of the patient.

There is little evidence to indicate there is value in routine blood tests in asymptomatic patients; instead, this practice is more likely to produce false positive results that may lead to additional unnecessary testing. The decision to perform screening tests, and the selection of which tests to perform, should be done with careful consideration of the patient's age, sex and any possible risk factors.

6 Don't routinely measure Vitamin D in low risk adults.

Because Canada is located above the 35° North latitude, the average Canadian's exposure to sunlight is insufficient to maintain adequate Vitamin D levels, especially during the winter. Therefore, measuring serum 25-hydroxyvitamin D levels is not necessary because routine supplementation with Vitamin D is appropriate for the general population. An exception is made for measuring Vitamin D levels in patients with significant renal or metabolic disease.

7 Don't routinely do screening mammography for average risk women aged 40 - 49.

If, after careful assessment of women less than 50 years of age, their risk profile for breast cancer is low, the benefit of screening mammography is also quite low. Furthermore, for this age group there is a greater risk of a false-positive and consequently undergoing unnecessary or harmful follow-up procedures.
8. **Don’t do annual physical exams on asymptomatic adults with no significant risk factors.**

A periodic physical examination has tremendous benefits; it allows physicians to check on their healthy patients while they remain healthy. However, the benefits of this check-up being done on an annual basis are questionable since many chronic illnesses that benefit from early detection take longer than a year to develop. Preventive health checks should instead be done at time intervals recommended by guidelines, such as those noted by the Canadian Task Force on the Periodic Health Examination.

9. **Don’t order DEXA (Dual-Energy X-ray Absorptiometry) screening for osteoporosis on low risk patients.**

While all patients aged 50 years and older should be evaluated for risk factors for osteoporosis using tools such as the osteoporosis self-assessment screening tool (OST), bone mineral density screening via DEXA is not warranted on women under 65 or men under 70 at low risk.

10. **Don’t advise non-insulin requiring diabetics to routinely self-monitor blood sugars between office visits.**

While self-monitoring of blood glucose (SMBG) for patients with diabetes is recommended by certain groups to help monitor glycemic control, for most adults with type II diabetes who are not using insulin, many studies have shown that routine SMBG does little to control blood sugar over time.

11. **Don’t order thyroid function tests in asymptomatic patients.**

The primary rationale for screening asymptomatic patients is that the resulting treatment results in improved health outcomes when compared with patients who are not screened. There is insufficient evidence available indicating that screening for thyroid diseases will have these results.
Professional is not a label you give yourself - it's a description you hope others will apply to you.

- David Maister
Why does it matter?

Patient comfort

vs

Physician individuality/comfort
A discussion

- Dress code
- Behaviours
- Why?
So what do you think?

- What should the rules be for family medicine?
- What should your “dress code” be?
- What behaviours should be encouraged or avoided?
Dress Code - Undergrad

• The Faculty and its affiliated hospitals have a dress code for courses that include patient contact. Students must be well groomed, clean, and dressed appropriately as they fulfill their responsibilities in clinical settings.

• Students should wear their white coats with their name tags, except where they are asked not to, such as in the operating room. Informal or provocative attire is not appropriate. Males are encouraged to wear shirts with collars. Jeans, sneakers and shorts are not acceptable. Clothing that exposes the umbilicus is also not acceptable. Fingernails should be relatively short (otherwise palpation can be painful for the patient), long hair should be tied back, and perfume should be avoided due to allergies. Scrub suits, also known as “greens,” are not to be worn outside of the hospital as they are the property of the hospital.

• Discretion should be used with particular fashion modes (e.g. pierced lips, nostrils and eyebrows, as well as nail polish and large quantities of jewellery). Closed-toe shoes should be worn in any situation where there is use of needles, or risk of body fluids spilling.

• Although some may consider this a petty issue, it is important to remember that illness is a very stressful event for patients and families, and that a professional image contributes to patient confidence.
## Clothing

**Wear**
- Lab coats are acceptable
- Scrubs – especially on call
- Business Casual
- Dress pants or fancy jeans?

**Not wear**
- Gym clothes
- Lululemon
- Torn Jeans
- Scrubs ?not in clinic
- Piercings?
- Blue jeans
- Eccentric clothing
- Hair cuts out of ordinary?
Behaviours

Do

- Good Manners
- ? Using phone for the patient in front of you

Not Do

- Chew gum while seeing patients
- Not eating/drinking
- Text/use cell phones
Summary

- The check up may no longer be paid for but screening is still indicated
- Review and keep up to date with screening guidelines and programs
- Practice talking about risks and benefits
- There are no limits as a family physician
- Earn the adjective: Professional