Choosing Wisely®

An initiative of the ABIM Foundation

American Urogynecologic Society

AUGS

Advancing Female Pelvic Medicine and Reconstructive Surgery

Ten Things Physicians and Patients Should Question

1 Avoid using a fluoroquinolone antibiotic for the first-line treatment of uncomplicated urinary tract infections (UTIs) in women.

For women with uncomplicated UTIs (defined as premenopausal, non-pregnant women with no known urologic abnormalities or comorbidities), fluoroquinolone antibiotics should not be considered first-line treatment. Although fluoroquinolones are efficacious in three-day regimens, they have a higher risk of ecological adverse events, such as increasing multidrug resistant organisms. Thus, fluoroquinolones should only be used for the treatment of acute UTIs for women who should not be prescribed nitrofurantoin, trimethoprim-sulfamethoxazole or fosfomycin.

2 Don't perform cystoscopy, urodynamics or diagnostic renal and bladder ultrasound in the initial work-up of an uncomplicated overactive bladder (OAB) patient.

The initial evaluation of an uncomplicated patient presenting with symptoms should include history, physical examination and urinalysis. In some cases, urine culture, post-void residual urine assessment and bladder diaries may be helpful. More invasive testing should be reserved for complex patients, patients who have failed initial therapies (i.e., behavioral therapies and medications), or patients who have abnormal findings on their initial evaluation.

3 Don't exclude pessaries as a treatment option for pelvic organ prolapse.

Nonsurgical treatment options for pelvic organ prolapse include pessaries, which are removable devices that are placed into the vagina to support the prolapsed organs (i.e., uterus, vagina, bladder and/or rectum). A pessary trial can be offered to almost all women with pelvic organ prolapse. Exceptions include women with an active vaginal infection and those who would be noncompliant with follow-up.

4 Avoid using synthetic or biologic grafts in primary rectocele repairs.

Posterior vaginal repair of rectocele is performed for women with symptoms of a posterior vaginal wall bulge or difficulty with defecation. The repair involves suturing the posterior vaginal wall and perineal tissue. The addition of synthetic or biologic grafts to this repair does not improve patient outcomes.

5 Avoid removing ovaries at hysterectomy in pre-menopausal women with normal cancer risk.

For women with an average risk of ovarian cancer (defined as women who do not have a document germline mutation or who do not have a strong family history suspicious for a germline mutation) who are undergoing a hysterectomy for benign conditions, the decision to perform bilateral salpingo-oophorectomy (BSO) should be individualized after appropriate informed consent, including a careful analysis of personal risk factors. There is evidence from observational studies that surgical menopause may negatively impact cardiovascular health and all-cause mortality. Ovarian conservation before menopause is particularly important in patients with a personal or strong family history of cardiovascular disease or stroke.

These items are provided solely for informational purposes and are not intended as a substitute for consultation with a medical professional. Patients with any specific questions about the items on this list or their individual situation should consult their physician.

Items 1–5 Released May 5, 2015; Items 6–10 Released June 24, 2020

6 Do not perform surgery for asymptomatic vaginal exposure of monofilament mesh.

Vaginal exposure of mesh used in surgery for the treatment of pelvic organ prolapse or urinary incontinence is a known complication of such surgeries. Although symptomatic exposure may require treatment, evidence suggests that asymptomatic mesh exposure can be safely watched without surgery to avoid the risks and complications associated with surgery for mesh exposure. Longitudinal expectant management is a reasonable alternative.

7 Avoid presumptive antibiotic treatment of recurrent UTIs in women without first obtaining a UA C&S.

Supporting statement: Although women with uncomplicated, infrequent UTIs can be treated empirically based on symptoms, women with recurrent UTIs (≥3 UTIs in one year, or ≥2 in 6 months) should have a pretreatment urine specimen to document episodes and guide treatment. The use of vaginal, but not oral, estrogen in postmenopausal women is effective in reducing recurrent cystitis and should be used whenever possible. Infectious Diseases Society of America guidelines regarding cystitis should dictate treatment, accounting for antimicrobial resistance and potential ecological adverse effects.

8 Do not routinely perform cystoscopy or imaging in asymptomatic, never-smoking women younger than 50 years with microscopic hematuria who have less than 25 RBC/HPF.

Asymptomatic hematuria in women is common but less likely to be associated with a urinary tract malignancy compared to men. Data support changing the evaluation requirements for microscopic hematuria in this low-risk group of women. Organizations which do not risk-stratify based on gender may continue to recommend more aggressive diagnostic evaluation in low-risk women.

9 Avoid using anticholinergic medication to treat overactive bladder in women older than 70.

Anticholinergic medications block acetylcholine at muscarinic receptors, which are present throughout the body. These medications have many side effects, including impaired cognition, drowsiness and constipation.” Several cohort studies have raised concern regarding an association between higher exposure to anticholinergics and increased risk of dementia. Given this, beta-3 agonists or 3rd line therapies should be preferentially utilized when possible. When anticholinergics cannot be avoided, the lowest effective dose of anticholinergic should be used, and consideration should be given to decreasing the dose of other concurrent anticholinergic medications

10 Do not perform multichannel urodynamics in women with uncomplicated stress urinary incontinence.

Women with uncomplicated stress urinary incontinence should undergo a thorough evaluation and screening that includes the following: a comprehensive history and physical, demonstration of stress incontinence, urinalysis, assessment of urethral mobility, and measurement of post void residual. If results of that screening are normal, and conventional non-surgical treatment fails, then mid-urethral sling surgery can be performed without further testing. Multichannel urodynamics have not been shown to affect surgical treatment outcomes in women with uncomplicated stress urinary incontinence.

How This List Was Created (1–5)

The Clinical Practice Committee of the American Urogynecologic Society (AUGS) reviewed clinical evidence to identify possible topics along with suggestions for possible topics from the AUGS Board of Directors. By consensus, the Clinical Practice Committee selected the top five most overused tests within specified parameters. Additional input was sought from the AUGS Board of Directors and incorporated. The final list was reviewed and approved by the AUGS Board of Directors.

AUGS' listing of board and committee members and conflict of interest policy can be found at www.augs.org/about.

How This List Was Created (6–10)

The Quality Committee of the American Urogynecologic Society (AUGS) reviewed clinical evidence to identify possible topics along with suggestions for topics from the AUGS Board of Directors. By consensus, the Quality Committee selected the top five, which were based on areas of perceived need and recent published consensus statements as well as reviews of the literature. Additional input was sought from the AUGS Board of Directors and incorporated. The final list was reviewed and approved by the AUGS Board of Directors. AUGS' listing of board and committee members and conflict of interest policy can be found at www.augs.org/about.

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About the ABIM Foundation

The mission of the ABIM Foundation is to advance medical professionalism to improve the health care system. We achieve this by collaborating with physicians and physician leaders, medical trainees, health care delivery systems, payers, policymakers, consumer organizations and patients to foster a shared understanding of professionalism and how they can adopt the tenets of professionalism in practice.

To learn more about the ABIM Foundation, visit www.abimfoundation.org.

About the American Urogynecologic Society

The American Urogynecologic Society (AUGS) is proud to partner with the *Choosing Wisely*® campaign. Founded in 1979, AUGS is the premier non-profit organization representing more than 1,800 members including practicing physicians, nurse practitioners, physical therapists, nurses and health care professionals, as well as researchers from many disciplines, all dedicated to treating female pelvic floor disorders. As the leader in female pelvic medicine and reconstructive surgery, AUGS promotes the highest quality patient care through excellence in education, research and advocacy. Participation in *Choosing Wisely*® complements AUGS' commitment to quality improvement, and improving patient care practices and outcomes.

For more information or questions, please visit www.augs.org.

For more information or to see other lists of Five Things Clinicians and Patients Should Question, visit www.choosingwisely.org.