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The Choosing Wisely Campaign in Paediatrics

The 'Choosing Wisely' (CW) campaign was launched by the American Board of Internal Medicine in 2012. It was adopted into paediatric practice the following year 2013. It has spread to more than 25 countries and 80 organisations1.

The premise is that 20-30% of investigations and therapies are unnecessary, add no value, and may on occasions be harmful. An early move was to invite physicians to submit 5 don'ts from their sphere of clinical practice.

The key issues for CW is to avoid overdiagnosis and overtreatment. CW asks 4 key questions before embarking on a test or treatment, what are the benefits, what are the risks, what are the alternatives, and what if we do nothing.

The recommendations are not intended to impose strict restrictions, but rather to stimulate debate about the best care for the individual child. The emphasis is that quality and not quantity lies at the heart of good paediatric care.

Internationally, many paediatric faculties and societies have set down a suite of recommendations. The suggestions from the different groups show considerable overlap. The first group of recommendations were published by the AAP (American Academy of Pediatrics), avoid chest x-rays in bronchiolitis, acid suppression therapy in infants with GOR (gastro-oesophageal reflux), the continuation of pulse oximetry when a child is stable in room air2. More recently3 the AAP has stated that children presenting to the ED with common medical problems have a high rate of unnecessary tests. These investigations lead to avoidable pain, unnecessary radiation, and prolonged length of stay in the department. It is suggested that routine screening tests should not be undertaken in children with a psychiatric admission. CT scans should not be ordered for uncomplicated febrile seizures.

The ADHD diagnosis rates vary by geographic location. More than 5% of US children are receiving medications for ADHD. There is a debate about the overlap between normal childhood behaviour development and ADHD. Probiotics in the treatment of acute gastroenteritis did not confer any benefits and may increase the number of vomiting episodes3.

The American Academy of Nursing states that children should have care supported by evidence, it should be truly necessary, and it should be free from harm.

The RCPCH have issued 4 recommendations, helmet therapy is not effective in the treatment of postural plagiocephaly in children, polyethylene glycol should be used in preference to lactulose for the treatment of constipation, buccal midazolam or lorazepam should be used in the treatment of prolonged seizures in young children in preference to rectal or IV diazepam, bronchodilators should not be used mild bronchiolitis.

The Canadian Paediatric Society have recommended the avoidance of routine throat swabs in children with a viral pharyngitis, IgG testing without taking a detailed allergy history, and the use of cough and cold remedies in children under 6 years old.

Other CW recommendations include the avoidance of x-rays for constipation, skull x-rays in infants with postural plagiocephaly, chest x-rays for mild asthma, sinus x-rays for sinusitis, CT scans for minor head injuries, steroids for bronchiolitis, and EEGs in neurologically normal children following a simple febrile convulsion.

When the impact of CW has been measured, it has been found that it has resulted in a 20-30% reduction in 'low value' investigations and treatments. There was a 31% reduction in chest x-rays for bronchiolitis, 21% reduction in acid suppressant therapy for GOR, 20% reduction in chest x-rays for asthma, and just 2.9% reduction in steroids for LRTIs5. The reasons why CW recommendations are frequently not adopted are multifactorial. There is a tendency for clinicians to hold on to old habits. There is uncertainty about the recommended changes to clinical practice. There are the family expectations about doing something even when it is for no good reason. Anxieties around diagnostic uncertainty is a major driver of excessive investigations. Fear of litigation may also be influencing clinical decision making and therapeutic management. There clearly needs to be more engagement with the public about why CW is important for them. Their understanding can be helped by providing them with a clear description of their condition, the likely prognosis with and without treatment, what's known from the evidence and what's not known, and what are the main side-effects of treatment.

Another challenging problem is that novel and promising medical interventions supported by limited data are quickly adopted. When more complete evidence emerges that the practice has little value, the process of withdrawing the intervention is protracted.
The choosing wisely campaign is a reminder of the importance to carefully consider whether a test or a treatment is necessary for the individual child. It stresses the need to avoid therapeutic creep. The vast array of diagnostic modalities and therapeutic options make over treatment a real possibility.
On the other hand the wealth of evidence based medicine now available makes the delivery of high quality care more feasible. The specialty needs to constantly and systematically review how children are investigated and managed when they present to our EDs, OPDs and as inpatients.

The essence of good paediatric practice is detailed history taking, careful physical examination, and considered investigation and treatment.

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Editor

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