



Five Things Physicians and Patients Should Question

1

A routine bone scan is unnecessary in men with low-risk prostate cancer.

Low-risk patients (defined by using commonly accepted categories such as American Urological Association and National Comprehensive Cancer Network guidelines) are unlikely to have disease identified by bone scan. Accordingly, bone scans are generally unnecessary in patients with newly diagnosed prostate cancer who have a PSA <10.0 ng/mL and a Gleason score less than 7 unless the patient's history or clinical examination suggests bony involvement. Progression to the bone is much more common in advanced local disease or in high-grade disease that is characterized by fast and aggressive growth into surrounding areas such as bones or lymph nodes.

2

Don't prescribe testosterone to men with erectile dysfunction who have normal testosterone levels.

While testosterone treatment is shown to increase sexual interest, there appears to be no significant influence on erectile function, at least not in men with normal testosterone levels. The information available in studies to date is insufficient to fully evaluate testosterone's efficacy in the treatment of men with erectile dysfunction who have normal testosterone levels.

3

Don't order creatinine or upper-tract imaging for patients with benign prostatic hyperplasia (BPH).

When an initial evaluation shows only the presence of lower urinary tract symptoms (LUTS), if the symptoms are not significantly bothersome to the patient or if the patient doesn't desire treatment, no further evaluation is recommended. Such patients are unlikely to experience significant health problems in the future due to their condition and can be seen again if necessary. [While the patient can often tell the provider if the symptoms are bothersome enough that he desires additional therapy, another possible option is to use a validated questionnaire to assess symptoms. For example, if the patient completes the International Prostate Symptom Scale (IPSS) and has a symptom score of 8 or greater, this is considered to be "clinically" bothersome.]

4

Don't treat an elevated PSA with antibiotics for patients not experiencing other symptoms.

It had previously been suggested that a course of antibiotics might lead to a decrease in an initially raised PSA and reduce the need for prostate biopsy; however, there is a lack of clinical studies to show that antibiotics actually decrease PSA levels. It should also be noted that a decrease in PSA does not indicate an absence of prostate cancer. There is no information available on the implications of deferring a biopsy following a decrease in PSA.

5

Don't routinely perform ultrasound on boys with cryptorchidism.

Ultrasound has been found to have poor diagnostic performance in the localization of testes that cannot be felt through physical examination. Studies have shown that the probability of locating testes was small when using ultrasound, and there was still a significant chance that testes were present even after a negative ultrasound result. Additionally, ultrasound results are complicated by the presence of surrounding tissue and bowel gas present in the abdomen.



Five More Things Physicians and Patients Should Question

6

Don't prescribe antimicrobials to patients using indwelling or intermittent catheterization of the bladder unless there are signs and symptoms of urinary tract infection.

Antibiotics in the absence of signs and symptoms (which may include fever; altered mental status or malaise with no other cause; flank or pelvic pain; flank or suprapubic tenderness; hematuria; dysuria, urinary urgency or frequency; and, in spinal cord injury patients, increased spasticity, autonomic dysreflexia or sense of unease) is not efficacious and risks inducing resistance to antimicrobials. This applies to both indwelling and intermittent catheterization of the bladder. The major exception is patients needing perioperative antimicrobials. Additionally, initial placement of a suprapubic tube requires a skin puncture or incision and therefore antibiotics should be considered.

7

Don't obtain computed tomography scan of the pelvis for asymptomatic men with low-risk clinically localized prostate cancer.

Computed tomography scan of the pelvis is very unlikely to provide actionable information in men with low-risk prostate cancer (one commonly accepted definition of low-risk prostate cancer is Gleason score less than 7, PSA less than 20.0 ng/mL, and tumor stage of T2 or less). Magnetic resonance imaging of the pelvis may be useful in some men considering active surveillance.

8

Don't remove synthetic vaginal mesh in asymptomatic patients.

There is no clear benefit to mesh removal in the absence of symptoms, and mesh removal in this circumstance exposes the patient to potential complications such as bladder injury, rectal injury and fistula formation.

9

Offer PSA screening for detecting prostate cancer only after engaging in shared decision making.

Shared decision making (between health care provider and patient and, in some cases, family members) is an excellent strategy for making health care decisions when there is more than one medically reasonable option. Since both screening and not screening may be reasonable options, depending on the particular situation, shared decision making is recommended.

10

Don't diagnose microhematuria solely on the results of a urine dipstick (macroscopic urinalysis).

Microhematuria is defined only on urine microscopy: three or more red blood cells per high-powered field on microscopy of a properly collected urinary specimen. Urine dipsticks positive for hemoglobin should be confirmed with urine microscopy, as false positive dipsticks are common. Performing radiographic and cystoscopic evaluation is unnecessary in the absence of microscopically confirmed microhematuria.



Five More Things Physicians and Patients Should Question

11

Don't treat low-risk clinically localized prostate cancer (e.g., Gleason score is less than 7, PSA less than 10.0 ng/mL, and tumor stage T2 or less) without discussing active surveillance as part of the shared decision-making process.

The ultimate choice of treatment should be based on shared decision making and individualized to the patient's disease characteristics, his overall health, and his personal preferences. The disparity between prostate cancer incidence and mortality implies that many men may not benefit from definitive treatment of localized disease. For men with newly diagnosed low-risk prostate cancer, an active surveillance program represents a valid option that should be discussed. Active surveillance provides a monitored approach that can spare some men the potential risks of definitive treatment while selectively providing effective treatment for more aggressive cancers that warrant intervention.

12

Don't treat uncomplicated cystitis in women with fluoroquinolones if other oral antibiotic treatment options exist.

Due to serious potential side effects associated with the use of fluoroquinolone antibiotics, these drugs should not be prescribed as first line therapy for uncomplicated cystitis in women. Their use should be reserved for situations where recommended first line antibiotic therapies, such as nitrofurantoin or sulfa-trimethoprim, are contraindicated.

13

Don't continue opioid analgesia beyond the immediate postoperative period; prescribe the lowest effective dose and number of doses required to address the expected pain.

The use of opioid analgesia for pain is often appropriate in surgical patient care. However due to the emergence of opioid use disorder as a public health epidemic, the appropriate use of opioid therapy must begin with adherence to minimum prescribing in terms of dose, duration and quantity.

14

Don't obtain urine cytology or urine markers as a part of the routine evaluation of the asymptomatic patient with microhematuria.

Insufficient evidence exists for the use of urine cytology and urine markers in the routine evaluation of the asymptomatic patient with microhematuria, including bladder tumor antigen (BTA) assays, nuclear matrix protein (NMP) assays, and fluorescent in situ hybridization (FISH) assays to detect chromosomal alterations. The psychological stress and unnecessary diagnostic procedures that could result from a false positive test outweigh the potential benefits to these patients.

15

Don't routinely use computed tomography (CT) to screen pediatric patients with suspected nephrolithiasis.

Given the link between radiation exposure from computed tomography (CT) in children and increased cancer risk, imaging test selection should adhere to the principle of ALARA (as low as reasonably achievable) to minimize radiation exposure. Ultrasonography is sufficiently sensitive and specific as an initial imaging test in pediatric patients with suspected urolithiasis. When ultrasound results are negative or indeterminate despite strong clinical suspicion or when proceeding with perioperative planning, CT using a low-dose protocol is an appropriate next step.

How This List Was Created (1–5)

The American Urological Association (AUA) established a committee to review evidence from the association's guidelines and identify potential topics for nomination to the AUA's *Choosing Wisely* list. The committee reviewed a number of recommendations and through a consensus process identified the five tests or procedures that should be questioned. These recommendations were reviewed and approved by the AUA Board of Directors.

How This List Was Created (6–10)

Following its previous successful participation in *Choosing Wisely* in 2013, the American Urological Association (AUA) established a new committee in 2014 to develop a second list of recommendations. The group sought input from the AUA membership in addition to drafting potential suggestions after studying evidence from the association's evidence-based clinical practice guidelines and other clinical documents. The committee reviewed all recommendations and narrowed them to a list of fifteen possibilities. Again, the committee sought AUA member input by asking members to vote for their top five selections from the list of candidate recommendations. After the votes were tallied, the list of five recommendations was determined. These recommendations were reviewed and approved by the AUA Board of Directors in February 2015.

How This List Was Created (11–15)

To continue its successful participation in *Choosing Wisely*, the American Urological Association (AUA) established a new committee in 2016 to develop a third list of recommendations. The group sought input from the AUA membership in addition to drafting potential suggestions after studying evidence from the association's evidence-based clinical practice guidelines and other clinical documents. The committee reviewed all recommendations and narrowed them to a list of twelve possibilities. Again, the committee sought AUA member input by asking members to vote for their top five selections from the list of candidate recommendations. After the votes were tallied, the list of five recommendations was determined. These recommendations were reviewed and approved by the AUA Board of Directors in March 2017.

AUA's disclosure and conflict of interest policy can be found at www.aunet.org.

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Founded in 1902 and headquartered near Baltimore, Maryland, the American Urological Association is a leading advocate for the specialty of urology, and has more than 20,000 members throughout the world. The AUA is a premier urologic association, providing invaluable support to the urologic community as it fosters the highest standards of urologic care through education, research and formulation of health policy.



American Urological Association

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