409 NO CLEAR BENEFIT FROM ACTIVE CHEST COMPRESSION-DECOMPRESSION COMPARED WITH STANDARD MANUAL CPR

5 April 2014

PEARLS 409, October 2013, written by Brian R McAvoy

Clinical question: How effective is active chest compression-decompression cardiopulmonary resuscitation (ACDR CPR) in adults with cardiac arrest?

Bottom line: There is no clear evidence of a benefit from the use of ACDR CPR compared with standard manual CPR in people with cardiac arrest occurring in different settings and different emergency medical systems. There were no differences between ACDR CPR and standard manual CPR for mortality (immediate or at the time of hospital discharge), severity of neurologic impairment, or complications, such as rib or sternal fractures, pneumothoraces, or hemothoraces. Skin trauma and ecchymoses were more frequent with ACDR CPR.

Caveat: Eight studies were in out-of-hospital settings, one was in an in-hospital setting only, and one had both in-hospital and out-of-hospital components. Assessment of neurologic outcomes was limited, and few participants sustained neurologic damage.

Context: During standard CPR for cardiac arrest the chest is compressed manually and repeatedly by hand. During standard CPR the chest is not manually decompressed. ACDR CPR uses a hand-held suction device that is applied mid-sternum to compress the chest, then actively decompress the chest after each compression.

Cochrane Systematic Review: Lafuente-Lafuente C, Melero-Bascones M. Active chest compression-decompression for cardiopulmonary resuscitation. Cochrane Reviews, 2013, Issue 9. Art. No.: CD002751. DOI: 10.1002/14651858.CD002751.pub3. This review consists of 10 studies involving 4988 participants.

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412 SMALL BENEFIT FROM COGNITIVE BEHAVIORAL THERAPIES FOR FIBROMYALGIA

8 April 2014

PEARLS 412, November 2013, written by Brian R McAvoy

Clinical question: How effective are cognitive behavioral therapies (CBTs) for treating fibromyalgia?

Bottom line: CBTs were superior to controls in reducing pain at the end of treatment by 0.5 points on a scale of 0–10 and by 0.6 points at the time of long-term follow-up (median=6 months). CBTs reduced negative mood at end of treatment by 0.7 points and 1.3 points at long-term follow up. Finally, CBTs reduced disability at end of treatment by 0.7 points and at long-term follow-up by 1.2 points. The dropout rates did not differ between the CBT and control groups. Optimum treatment intensity was between 5 and 25 h. There was no evidence for benefit of self-managed programs as single therapy.

Caveat: Positive effects were only verifiable for face-to-face CBTs, but not for internet- and telephone-based CBTs at end of treatment. Positive effects were only detected in the comparison of CBTs with treatment as usual and waiting list controls, but not with other active treatments (e.g., aerobic exercise) or with attention control (except negative mood) at the end of treatment. Studies that included patients with anxiety and depressive disorders demonstrated a reduction in negative mood, but not pain and disability at the end of treatment.

Context: Fibromyalgia is a clinically well-defined, chronic condition of unknown etiology that is characterized by chronic, widespread pain that often co-exists with sleep disturbances, cognitive dysfunction, and fatigue. Patients often report high disability levels and negative moods. CBTs focus on reducing key symptoms and improving daily functioning, mood, and sense of personal control over pain.

Cochrane Systematic Review: Bernardy K et al. Cognitive behavioural therapies for fibromyalgia. Cochrane Reviews, 2013, Issue 9. Art. No.: CD009796. DOI: 10.1002/14651858. CD009796.pub2. This review consists of 23 studies involving over 2031 participants.

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422 LIMITED BENEFIT FROM TELEPHONE SUPPORT FOR PREGNANT WOMEN

9 May 2014

PEARLS 422, February 2014, written by Brian R McAvoy

Clinical question: Compared with routine care, how effective is telephone support during pregnancy and the first 6 weeks postpartum?

Bottom line: Despite some encouraging findings, there is insufficient evidence to recommend routine telephone support for women accessing maternity services, as the evidence is neither strong nor consistent. Although benefits were found in terms of reduced depression scores, duration of breastfeeding, and increased overall satisfaction, the current trials did not provide sufficiently strong evidence to warrant investment in resources.

Caveat: The overall methodologic quality of the studies was mixed. For any single outcome, there was limited data and most of the results were inconclusive. Many of the trials recruited women from high-risk groups (e.g., high risk for depression or smokers) and the intervention was specifically designed to address the risk factor. All but two of the trials were carried out in high-resource settings.

Context: Telephone communication is increasingly being accepted as a useful form of support within health care. There is some evidence that telephone support may be of benefit in specific areas of maternity care, such as breastfeeding support and women at risk for depression. There is a plethora of telephone-based interventions currently being used in maternity care. It is therefore timely to determine which interventions may be of benefit, which interventions are ineffective, and which interventions may be harmful.

Cochrane Systematic Review: Lavender T et al. Telephone support for women during pregnancy and the first six weeks postpartum. Cochrane Reviews, 2013, Issue 7. Art. No.: CD009338. DOI: 10.1002/14651858. CD009338.pub2. This review consists of 27 studies involving 12,256 participants.

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CONTRACEPTIVE SERVICES WITH A FOCUS ON YOUNG PEOPLE UP TO 25 YEARS OF AGE

NICE guidelines [PH51] Publication date: March 2014

http://www.nice.org.uk/guidance/ph51

This guidance is for NHS and other commissioners, managers, and practitioners who have a direct or indirect role in, and responsibility for, contraceptive services. This includes those working in local authorities, education, and the wider public, private, voluntary, and community sectors. The guidance may also be of interest to young people, their parents and caregivers, and other members of the public.

NICE recommends that young men and women should be given advice and information on all types of contraception to help them choose the best method for their needs and lifestyle. Providing advice and information makes it more likely that contraception will be used effectively.

The recommendations emphasize the need to offer additional tailored support to meet the particular needs and choices of those who are socially disadvantaged or who may find it difficult to use contraceptive services.

The 12 recommendations include advice on the following:

- how to assess local needs and commission comprehensive services;
- offering culturally-appropriate, confidential, non-judgmental, empathic

advice tailored to the needs of the young person;
- ensuring that young people understand their personal information and the reason why they are using the service will be kept confidential;
- providing contraceptive services after pregnancy and abortion;
- encouraging young people to use condoms as well as other forms of contraception; and
- how schools and other education settings can provide contraceptive services.

MANAGING MEDICINES IN CARE HOMES

NICE guidelines [SC1] Publication date: March 2014
http://www.nice.org.uk/guidance/sc1

Managing medicines in care homes is a guideline that applies across both health and social care.

The management of medicines is governed by legislation, regulation, and professional standards, which are monitored and enforced by different regulatory organizations across England, Wales, and Northern Ireland.

Care Quality Commission regulatory changes in England are expected in October 2014 as a result of the Health and Social Care Act (2012). It is expected that the recommendations in the guideline will not change as a result of this because the guideline is based on current evidence. Following publication of the updated regulations, the guideline will be assessed to ensure that any relevant regulations are appropriately referenced.

People living in care homes have the same rights and responsibilities as those who do not live in care homes in relation to NHS care; this is set out in the NHS Constitution for England. Treatment and care should take into account an individual's needs and preferences. Care home residents should have the opportunity to make informed decisions about their care and treatment, in partnership with their health professionals and social care practitioners. Person-centered care is particularly important when considering safeguarding and mental capacity issues; these issues are considered in the guideline in relation to medications.

Helping residents to help look after and self-administer their medications is important in enabling residents to retain their independence. Care home staff should assume residents are able to look after and manage their own medications when they move into a care home, unless indicated otherwise. An individual risk assessment should be undertaken to determine the level of support a resident needs to manage their own medications.

The guideline considers all aspects of managing medications in care homes and recommends that all care home providers have a care home medication policy. The policy should ensure that processes are in place for safe and effective use of medications in the care home. Sections of the guideline provide recommendations for different aspects of managing medications covered by the care home medication policy.

A NICE quality standard is also being developed on managing medications in care homes.

EXERCISE REFERRAL SCHEMES TO PROMOTE PHYSICAL ACTIVITY

NICE guidelines [PH54] Publication date: September 2014
http://www.nice.org.uk/guidance/ph54

This guideline makes recommendations on exercise referral schemes to promote physical activity for people ≥19 years of age. It is an update of recommendation

COCHRANE UPDATES & NICE GUIDELINES

5 in 'Four commonly used methods to increase physical activity' (NICE public health guidance 2).

The guideline focuses on exercise referral schemes that increase physical activity among people who are inactive or sedentary and are otherwise healthy or who have an existing health condition or other risk factors for disease.

The guideline is for primary care practitioners and policy makers, commissioners, and other practitioners with physical activity as part of their responsibility through their work in local authorities and the NHS.

In addition, it may be of relevance to providers of exercise referral schemes, organizations that provide exercise qualifications, and accreditation and members of the public.

This guideline does not cover structured exercise programs designed for managing a specific health condition or for rehabilitation following recovery from a specific condition. This includes cancer, cardiac, or pulmonary rehabilitation programs.