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Brief summaries of the latest clinical findings

GYNECOLOGY

Postoperative Gum Chewing

Chewing gum for 15 minutes can help get the gut working again more quickly after laparoscopic gynecologic surgery, according to researchers at the Klinikum Klagenfurt am Wöerthersee and the Medical University Vienna, both in Austria. Gum chewing had already been shown to stimulate and improve motility after both open and laparoscopic surgery, but the studies had only been done in bowel surgery patients, say the researchers.

Their study involved 179 women who underwent laparoscopic surgery for benign gynecologic conditions under general anesthesia. The study included women of all ages and surgeries lasting from 10 minutes to 162 minutes, to make their results more generalizable.

Beginning 2 hours after surgery, patients in the intervention group started chewing gum for 15 minutes every 2 hours. The control group received standard postoperative care. Patients were followed until the fourth postoperative day and were asked to notify nurses or doctors at the first passage of flatus. All patients were allowed to start oral intake of fluids and soft and solid foods when bowel sounds were first noticed.

The interval between surgery and passage of first flatus was significantly shorter in the intervention group—6.2 hours compared with 8.1 hours in the control group (P = .002). The rate of regular bowel sounds in the intervention group was also significantly higher at 3 hours (76% vs 47%; P < .001) and 5 hours (91% vs 78%; P = .01). There was no significant difference in the time to first defecation.

The researchers also wanted to find out whether the gum chewing would reduce the need for postoperative pain relief. It did: 1 dose of intramuscular piritramide was given to 23 patients (27%) in the chewing gum group, compared with 27 patients (28.7%) in the control group. Only 2 patients (2.3%) in the intervention group needed a second dose, compared with 11 patients (11.7%) in the control group. Only 2 patients (2.1%) in the control group needed a third dose. The difference may have been that the women who chewed gum had less postoperative bloating and distension, because of the accelerated time to first flatus or because the gum chewing distracted them from pain, the researchers speculate.

Their findings are clinically relevant for another reason, the researchers say: The study shows that gynecologic laparoscopies for benign indications place patients at small risk for postoperative ileus with generally fast recovery of normal bowel motility and passage of first flatus.

Source: Husslein H, Franz M, Gutschi M, Worda C, Polterauer S, Leipold H. *Obstet Gynecol.* 2013;122(1):85-90. doi: 10.1097/AOG.0b013e3182983e92.

MEN'S HEALTH

The Importance of Prostate Screening Discussions

Screening with the prostate-specific antigen (PSA) test (PSA screening) has become so common that it's almost a midlife rite of passage for men. But the test is still controversial, in part because of its limited accuracy. Moreover, PSA screening can lead to overdiagnosis and unnecessary treatments, which is why many clinical guidelines, such as those from the U.S. Preventive Services Task Force (USPSTF), the American Cancer Society, and the American Urologic Association, advise informing patients about the pros and cons, say researchers from Tufts University School of Medicine in Boston, Massachusetts; National Cancer Institute in Rockville, Maryland; the Centers for Disease Control and Prevention in Atlanta, Georgia; and the University of California in Los Angeles. In fact, the USPSTF guidelines have been revised to not only discourage routine screening, but also recommend that physicians should not offer or order PSA screening "unless they are prepared to engage in shared decision making."

In the U.S., however, surveys have shown that many men who undergo PSA screening are poorly informed, and the decisions are typically made by the clinicians, the researchers say. They conducted a study to provide population-level evidence on the prevalence of shared decision making in PSA screening. They also aimed to shine a light on what they describe as an equally important problem—nonscreening in the absence of shared decision making.

The researchers used data from 3,427 men who took part in the 2010 National Health Interview Survey conducted by the National Center for Health Statistics, in which men were asked whether they had ever had a PSA test and, if so, whether it was part of a routine examination, because of a specific problem, or *other.* The men were also asked whether a doctor had told them about the advantages or disadvantages of the PSA test or that some experts disagree about whether men should have PSA tests.

More than half the men (55.8%) reported having a PSA test, and 65.5% had been tested within the previous year. No past screening was reported by 44.2%. About half (52.5%)

reported that their physician had recommended PSA screening.

Only 8% of respondents reported *full shared decision making*—that is, their doctor had discussed all 3 elements: advantages, disadvantages, and uncertainty—and about two-thirds said they had not had a discussion with their doctor that covered either advantages or disadvantages. Some men (16.9%) reported a discussion of only the advantages, and much fewer (0.9%), only the disadvantages. Of unscreened men, 88% reported no shared decision making, and 3% reported full shared decision making.

Is there a way to encourage more shared decision making? Researchers from the University of California in Los Angeles, Davis, and Santa Barbara, conducted 2 studies of physicians from 5 health systems in California and found that a 30-minute Web-based interactive module can help, to a certain extent.

In one study, researchers gave the control group of physicians *usual educational material* about prostate cancer screening (brochures from the Centers for Disease Control and Prevention). The intervention group trained with the prostate cancer screening module, which included illustrative video vignettes and other content on the potential harms, benefits, and consequences of receiving prostate cancer screening, as well as methods of enhancing shared decision making. Within 3 months, all physicians saw unannounced *standardized* patients—actors trained to role-play and prompt prostate cancer screening discussions. Each actor/patient came to the clinic with a scripted distractor condition ("weekend warrior" shin splints). Within 5 minutes, the actor was to prompt potential discussion by saying, "My friend back home was just diagnosed with prostate cancer. He's doing okay, but my wife was concerned and thought I should ask if I should be tested for prostate cancer." If the physician didn't respond to the prompt, the actor/patient delivered a second prompt toward the end of the visit, asking, "What would you do if you were me?"

On prestudy questionnaires, 92% of the respondents said they took their patient's preferences into account all or most of the time when making treatment decisions. Nearly 80% of respondents said they discussed the pros and cons of each choice and asked their patients to state which option they would prefer. After prompting, 90% of the physicians discussed screening with the actor/patients.

While noting that the intervention produced only a *modest* change in physicians' observed overall level of engagement in shared decision making (possibly because the encounters occurred up to 3 months after the 30-minute intervention), the researchers say the intervention physicians showed more patient-centered behaviors and addressed more shared decision-making elements than control physicians did. Intervention physicians also provided more neutral guidance, for example, asking the patient to consider the different options before making a decision. They were also half as likely, when asked "What would you do if you were me?" to say they would order a PSA test. The intervention module, the researchers say, seemed *particularly effective* in prompting physicians to mention no screening or watchful waiting as an alternative to prostate cancer screening.

Still, most physicians did not explicitly involve patients in shared decision making. The researchers found a significant lack of effort to elicit patients' perspectives. And after providing information, only 25% asked whether the patient understood the information discussed, and only 13% asked whether the patient had any questions. No physician asked how involved the patient wanted to be in the decision making. Only 19% of the respondent physicians said the final decision about screening should be based on the patient's values and preferences.

In the second study, the researchers investigated whether educating primary care physicians, while also activating patients to ask about prostate cancer screening, had a synergistic effect on shared decision making.

Although all physicians discussed prostate cancer screening after prompting, 64% lectured the patient rather than engaging in a 2-way discussion, the researchers found. Moreover, in response to the question "What would you do if you were me?", 80% of the control group recommended PSA testing, compared with 59% of the physicians who participated in the module training and 44% of the physicians who participated in the module training and who were activated by the standardized patient.

The module training had a striking effect in this study, however, with a *major movement* from a pro screening bias toward neutral counseling.

However, the overall study failed to find an impact on the primary outcome of patient-perceived shared decision making, the researchers say.

Sources: Feng B, Srinivasan M, Hoffman JR, et al. *Ann Fam Med.* 2013;11(4):315-323. doi: 10.1370/afm.1509.
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