THE JOURNAL OF FAMILY PRACTICE

GUEST EDITORIAL

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Keeping up with the evidence (and the residents)

I work with medical students nearly every day that I see patients. I recently mentioned to a student that I have a limited working knowledge of the brand names of diabetes medications released in the past 10 years. Just like the M3s, I need the full generic name to know whether a medication is a GLP-1 inhibitor or a DPP-4 inhibitor, because I know that "flozins" are SGLT-2 inhibitors and "glutides" are GLP-1 agonists. The combined efforts of an ambulatory care pharmacist and some flashcards have helped me to better understand how they work and which ones to prescribe when. Meanwhile, the residents are capably counseling on the adverse effects of the latest diabetes agent, while I am googling its generic name.

Not adopting the new lung cancer screening recommendations would exclude patients most at risk of lung cancer and allow disparities to grow.

The premise of science is continuous discovery. In the first 10 months of 2022, the US Food & Drug Administration approved more than 2 dozen new medications, almost 100 new generics, and new indications for dozens more.[1,2] The US Preventive Services Task Force (USPSTF) issued 13 new or reaffirmed recommendations in the first 10 months of 2022, and it is just one of dozens of bodies that issue guidelines relevant to primary care.[3] PubMed indexes more than a million new articles each year. Learning new information and changing practice are crucial to being an effective clinician.

In this edition of *JFP*, Covey and Cagle[4] write about updates to the USPSTF's lung cancer screening guidelines. The authors reference changing evidence that led to the revised recommendations. When the original guideline was released in 2013, it drew on the best available evidence at the time.[5] The National Lung Screening Trial, which looked at CT scanning compared with chest x-rays as screening tests for lung cancer, was groundbreaking in its methods and results.[6] However, it was not without its flaws. It enrolled < 5% Black patients, and so the recommendations for age cutoffs and pack-year cutoffs were made based on the majority White population from the trial.

Black patients experience a higher mortality from lung cancer and are diagnosed at an earlier age and a lower cumulative pack-year exposure than White patients.[7] Other studies have explored the social and political factors that lead to these disparities, which range from access to care to racial segregation of neighborhoods and tobacco marketing practices.[7] When the USPSTF performed its periodic update of the guideline, it had access to additional research. The updates reflect the new information.

Every physician has a responsibility to find a way to adapt to important new

information in medicine. Not using SGLT-2 inhibitors in the management of diabetes would be substandard care, and my patients would suffer for it. Not adopting the new lung cancer screening recommendations would exclude patients most at risk of lung cancer and allow disparities in lung cancer morbidity and mortality to grow.[7,8]

Understanding the evidence behind the recommendations also reminds me that the guidelines will change again. These recommendations are no more static than the first guidelines were. I'll be ready when the next update comes, and I'll have the medical students and residents to keep me sharp. **JFP**

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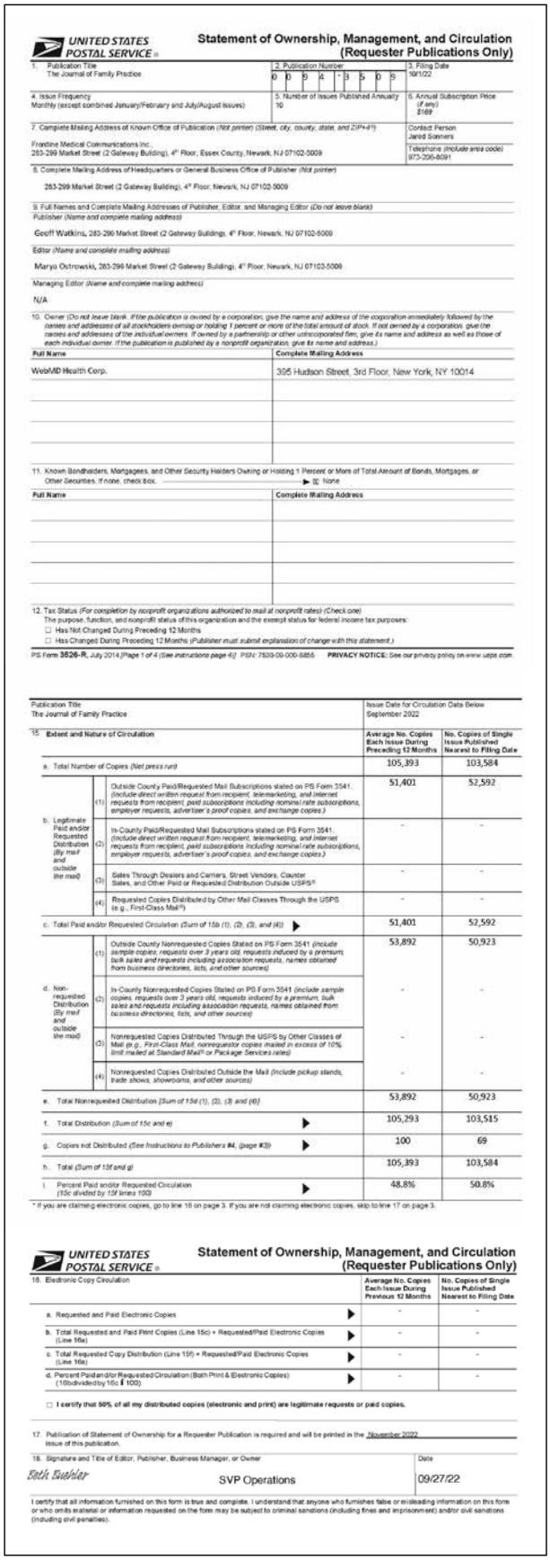

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