The Atlantic Provinces
Medical Peer Review

It is important to note that these guidelines are meant to be of assistance to assessors in making observations. They should not be taken as standards of any of the Atlantic Provinces Licensing Authorities.

MANAGEMENT OF SPECIFIC DISEASE ENTITIES - Family Medicine/Internal Medicine
1 - CHRONIC OBSTRUCTIVE PULMONARY DISEASE (COPD)

Preventive Measures:

✓ discussion of smoking cessation; annual influenza vaccination; pneumococcal vaccine; exercise program

All Patients with COPD:

✓ documented history of exacerbations with increased sputum production and purulence; increased dyspnea
✓ documented physical findings of increased respiratory rate and wheezing; diffuse crackles without localization
✓ investigations include spirometry with measurement of peak flow and/or FEV1; measurement of oxygen saturation (+/- blood gases) in moderate to severe cases

Therapies:

✓ Bronchodilator Therapy: use of Ipratropium and short-acting beta Agonists for mild cases; long acting bronchodilators for moderate to severe COPD
✓ Corticosteroid Therapy: appropriate use of systemic or inhaled steroids
✓ Oxygen Therapy: optimum oxygenation; use of respiratory specialist referral
✓ Antibiotics: antibiotic use appropriate for exacerbations and level of severity

	N/A	E	S	D
There is evidence that the appropriate preventive measures have been discussed and/or implemented.				
One or more of the appropriate therapies has been undertaken.				
Regular monitoring and documentation of treatment is evident in the event of exacerbation of COPD.				

COMMENTS:

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MANAGEMENT OF SPECIFIC DISEASE ENTITIES - Family Medicine
2 - DYSLIPIDEMIA

Routine screening of:

- ✓ Men over 40 and women over 50 (or postmenopausal), or
- ✓ All patients with other risk factors (smoking, diabetes, hypertension, obesity, COPD, HIV, renal disease, erectile dysfunction, family history of dyslipidemia, inflammatory disease)
- ✓ Use of Framingham Risk Score. If < 5 %, screen every 3-5 years, if > 5 % screen every year.

Health Behaviour Modification

- ✓ Healthy eating habits
- ✓ Smoking cessation
- ✓ Physical exercise (aim for 150 minutes per week)

Awareness of lipid target levels

- ✓ High Risk (Framingham > 20%), consider statins for all patients, target LDL < 2 mmol/L
- ✓ Intermediate risk (Framingham 10 – 19 %), statins if LDL > 3.5, target LDL < 2
- ✓ Low risk (Framingham < 10%), statins if LDL > 5, target is 50 % reduction in LDL

Evidence of long-term follow-up after titration and monitoring of LFT's and CK levels of patients on statins.

	N/A	E	S	D
Appropriate screening has been done; baseline lipid profile has been determined.				
Appropriate medication, diet and lifestyle changes have been prescribed.				
Regular monitoring and long-term follow-up is being done.				

COMMENTS

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MANAGEMENT OF SPECIFIC DISEASE ENTITIES - #3 HYPERTENSION
Cardiology/Family Medicine/Internal Medicine/Nephrology

All patients with hypertension

✓ Blood pressure measured and recorded in all office visits and/or home 24 hr BP monitor

✓ Health Behaviour Management

- Physical exercise 30 -60 minutes 4-7 days per week
- Weight reduction
- Alcohol 2 drinks or less per day, max 14 per week for men, 9 per week for women
- DASH diet
- Sodium restriction to less than 2 g of sodium per day
- Stress management

Therapies

✓ Antihypertensives should be strongly considered for average

- SBP > 160 mmHg or DBP > 100 mmHg in absence of other cardiovascular risk factors
- SBP > 140 mmHg or DBP > 90 mmHg in the presence of macrovascular target organ damage or other independent cardiovascular risk factors

✓ Goals of treatment

- SBP treatment goal < 140 mmHg, DBP treatment goal < 90 mmHg
- In diabetic patients, SBP goal < 130 mmHg, DBP goal < 80 mmHG

✓ Choice of therapies

- Initial therapy should be either
  - Thiazide / thiazide-like diuretic
  - B-blocker (in patients younger than 60, non-diabetic, non-asthmatic)
  - ACE inhibitor (in non-black patients)
  - Long-acting calcium channel blocker (CCB), or
  - ARB's
- If failure of initial therapy, add-on drugs should be chosen from first line choices

Monitoring

✓ Side effects of medications, i.e. B-Blockers (bradycardia), ACE I and ARBs (creatinine and potassium checked 1-2 weeks after drug initiation); diuretics (hypokalemia)

- potassium checked 1-2 weeks after drug initiation); diuretics (hypokalemia)

	N/A	E	S	D
There is evidence of treatment to targets and consistent long-term follow-up (BP monitoring; lifestyle issues)				
The appropriate therapies are being used.				
Regular monitoring and review of therapy and medications is evident.				

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MANAGEMENT OF SPECIFIC DISEASE ENTITIES - # 4 - CONGESTIVE HEART FAILURE
Cardiology/Family Medicine/Internal Medicine/

All patients with heart failure:

- ✓ documentation of clinical history and physical exam: symptoms, functional limitations, risk factors, prior cardiac illness, co-morbidities, drugs, alcohol use
- ✓ routine tests including CBC, ECG, chest X-ray, renal function, urinalysis, glucose, lipids, liver enzymes and thyroid function; consider use of natriuretic peptide
- ✓ echocardiography recommended to assess ventricular and valvular function
- ✓ Manage contributing and associated conditions such as hypertension, myocardial ischemia, diabetes, thyroid dysfunction, and Reno vascular disease.

Therapies:

- ✓ lifestyle modification: smoking cessation, restriction of alcohol consumption, regular physical activity; no added salt diet; encourage daily morning weights
- ✓ referral to a heart function program
- ✓ flu shot and pneumococcal vaccine

Drug Therapies:

- ✓ cardiovascular risk factors should be aggressively managed with appropriate drugs
- ✓ all patients with heart failure and ejection fractions less than 40% should be on an ACE inhibitor with a beta blocker or carvedilol unless contraindications exist
- ✓ ARB's should be used if ACE I is not tolerated. Combining ACE inhibitors and ARBs should only be done with caution
- ✓ long-term monitoring of renal function and electrolytes needed with ACE I and ARB's
- ✓ loop diuretics recommended in patients with congestive symptoms
- ✓ electrolytes should be carefully monitored in patients on diuretics
- ✓ use of mineralocorticoid receptor antagonists in patients with EF < 30% if >55 years old or diabetic
- ✓ avoid use of NSAIDS, COX inhibitors, glitazones, non-dihydropridine CCB's
- ✓ Omega 3 fatty acids 1g daily in patients with severe HF and reduced EF
- ✓ Patients with chronic atrial fibrillation should be on other NOAC

	N/A	E	S	D
Clinical history and physical exam are documented.				
It is evident that routine tests have been ordered and completed.				
Appropriate therapies are used and regularly reviewed.				

COMMENTS

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MANAGEMENT OF SPECIFIC DISEASE ENTITIES - Endocrinology/Family Medicine/Internal Medicine
5 - TYPE II DIABETES MELLITUS

Screening:

- ✓ all patients over age 40 should be screened via FBG every three years
- ✓ more frequent screening for patients with risk factors: 1st degree relatives with DM; member of high risk population (Aboriginals); history of impaired glucose tolerance; vascular disease; history of gestational DM; hypertension; dyslipidemia; obesity

Therapies:

- ✓ referral to dietician or diabetic education centre
- ✓ treat to accepted target levels of A1C's; A1C monitoring every three months
- ✓ appropriate use of medications (Metformin in contraindicated in renal impairment)
- ✓ patient self-monitoring of blood glucose recommended
- ✓ regular ophthalmology referral
- ✓ annual urine test for micro-albuminuria

Complications monitoring:

- ✓ retinopathy: loss of vision; nephropathy: renal failure
- ✓ neuropathy: any neurologic symptoms or signs
- ✓ lower limb complications: foot sores or amputations

	N/A	E	S	D
Documentation of appropriate screening is evident.				
Appropriate therapies and referrals are being used.				
Patients are actively involved in their own care.				

COMMENTS:

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MANAGEMENT OF SPECIFIC DISEASE ENTITIES - Family Medicine
6 - CHRONIC PAIN

Documentation for all patients to include

- ✓ Proper investigation of disease (history, physical findings, imaging and appropriate consultations)
- ✓ History of addiction, personal or family history of alcohol or drug abuse.
- ✓ A stepwise approach for the administration of pain medication suggests a sequence of medications
  - Nonopioid medication +/- adjuvants first
  - Opioids (e.g. Codeine) for mild to moderate pain +/- adjuvants, +/- non-opioids
  - Stronger opioids (e.g. Morphine) +/- adjuvants, +/- non-opioids
- ✓ Adjuvants include anticonvulsants (Gabapentin and Pregabalin), antidepressants (Tricyclics, SSRI's, Venlafaxine), topical agents (lidocaine, topical NSAIDS), antispasmodics, Botulinum toxin, benzodiazepines.
- ✓ Prescribing information:
  - Use of patient narcotic information sheet and patient contract
  - Use of narcotic flow sheet
  - Details of prescription which include name of drug, dosage and amount of drug prescribed.
- ✓ Follow-up visits:
  - Documentation on response to treatment, progress toward therapy goals, functional status
  - Rationale for any increase in dosage
  - Monitoring of adverse effects
  - Drug screening for patients who are at higher risk for aberrant drug related behaviors

	N/A	E	S	D
The documented investigations and diagnoses are appropriate to the complaint/condition.				
A patient contract, narcotic flow sheets and/or other evidence of narcotic control is present.				
Response to treatment is appropriately recorded and regularly reviewed.				

COMMENTS:

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