

Five Things Physicians and Patients Should Question

1 Don't perform electroencephalography (EEG) for headaches.

EEG has no advantage over clinical evaluation in diagnosing headache, does not improve outcomes and increases cost. Recurrent headache is the most common pain problem, affecting 15% to 20% of people.

2 Don't perform imaging of the carotid arteries for simple syncope without other neurologic symptoms.

Occlusive carotid artery disease does not cause fainting but rather causes focal neurologic deficits such as unilateral weakness. Thus, carotid imaging will not identify the cause of the fainting and increases cost. Fainting is a frequent complaint, affecting 40% of people during their lifetime.

3 Don't use opioid or butalbital treatment for migraine except as a last resort.

Opioid and butalbital treatment for migraine should be avoided because more effective, migraine-specific treatments are available. Frequent use of opioid and butalbital treatment can worsen headaches. Opioids should be reserved for those with medical conditions precluding the use of migraine-specific treatments or for those who fail these treatments.

4 Don't prescribe interferon-beta or glatiramer acetate to patients with disability from progressive, non-relapsing forms of multiple sclerosis.

Interferon-beta and glatiramer acetate do not prevent the development of permanent disability in progressive forms of multiple sclerosis. These medications increase costs and have frequent side effects that may adversely affect quality of life.

5 Don't recommend CEA for asymptomatic carotid stenosis unless the complication rate is low (<3%).

Based on studies reporting an upfront surgical complication rate ranging from 2.3% (ACAS) to 3.1% (ACST) among patients undergoing carotid endarterectomy (CEA) for asymptomatic stenosis of >60%, and an absolute risk reduction for stroke or death of roughly 5-6% in the surgical group at 5 years, several specialty societies (Goldstein et al, 2011; Brott et al, 2011; Chaturvedi et al; Ricotta et al) have recommended that surgery for asymptomatic patients should be reserved for those with a perioperative complication risk of <3% and a life expectancy of greater than 3–5 years. The cited 3% threshold for complication rates may be high because more recent studies have reported lower stroke rates with improvements in both surgical (Brott, 2010) and medical (Marquardt) management. However, there are no recent randomized trials comparing these treatments. Given this, the more recent AHA guidelines (Brott 2011) state that it is “reasonable” to perform CEA for asymptomatic patients with >70% stenosis if the surgical complication rate is “low.”

Reported complication rates vary widely by location (Kresowik), and are dependent on how complications are tracked (self-report vs. neurologist's evaluation vs. administrative data (Wolff T)). Despite calls for rigorous monitoring 15 years ago (Goldstein), most patients will likely need to rely on the surgeon's self-reported rates.

How This List Was Created

The American Academy of Neurology (AAN) established a *Choosing Wisely Working Group* to develop its list of recommendations. Members of this group were selected to broadly represent varying practice settings and neurological subspecialties. Neurologists with methodological expertise in evidence-based medicine and practice guideline development were also included. The working group solicited recommendations from AAN members, which were then rated based upon their judgments of harm and benefit that would result based upon compliance with the recommendation. Based on committee voting and a literature review, candidate recommendations were sent to relevant AAN sections, committees, specialty societies and patient advocacy groups for review and comment. The working group reviewed this feedback and voted on the final Top Five recommendations, which were approved by the AAN Practice Committee and Board of Directors.

AAN's disclosure and conflict of interest policy can be found at www.aan.com.

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