Subclinical hyperthyroidism guidelines ata

Background: Tirotoxicosis has several etiology, manifestations and potential treatments. Appropriate treatment requires an accurate diagnosis and depends on coexisting diseases and patient preferences. This paper describes evidence-based clinical guidelines for the management of thyrotoxicosis that would be beneficial to general and subspecial physicians and others caring for patients with this condition. Methods: The American Thyroid Association (ATA) has previously co-authored guidelines for the management of thyrotoxicosis that were published in 2011. Since then, significant new literature has been published and the ATA has found it necessary to update the evidence-based guidelines. The Association has assembled a task force of clinical experts who are the authors of the report. They studied the relevant literature through a systematic search for PubMed, supplemented by additional published materials. An evidence-based approach to medicine, including the knowledge and experience of the group, was used to update the 2011 text and recommendations. The strength of the recommendations and the quality of the evidence to support them were assessed in accordance with the approach recommended by the Recommendation, Evaluation, Development and Evaluation Panel. Results: Clinical topics covered include initial evaluation and management of thyrotoxicosis; control of Graves' hyperthyroidism using radioactive iodine, antithyroid drugs or surgery; management of toxic multi-fatal goiter or toxic adenoma using radioactive iodine or surgery; Graves' disease in children, adolescents or pregnant patients; subclinical hyperthyroidism; hyperthyroidism in patients with Graves' orbitopathy; and managing other causes of thyrotoxicosis. New paradigms following the publication of the 2011 guidelines are presented to evaluate the etiology of thyroid toxicosis, the management of Graves hyperthyroidism with antithyroid drugs, the management of pregnant hyperthyroid patients, and the preparation of patients for thyroid surgery. Sections on the less common causes of thyrotoxicosis have been expanded. Conclusions: One hundred and twenty-four evidence-based recommendations have been developed to assist in the care of patients with thyrotoxicosis and to share what the task force considers to be current, rational and optimal medical practice. 1. Surks MI, Ortiz E, Daniels GH, et al Subclinical Thyroid Disease: Scientific Review and Guidelines for Diagnosis and Management. Jama. 2004;291(2):228–238....2. Donangelo I, Braunstein GD. Update on subclinical hyperthyroidism. Am Pham Doctor. 2011;83(8):933–938.3. Selmer C, Olesen JB, Hansen ML, et al. Subclinical and Clear Thyroid Dysfunction and mortality from all causes and cardiovascular events: a large population study. J Blade Endorinool Metab. 2014;99(7):2372–2382.4. Collette TH, Gussekloo J, Bauer DC, etc. Collaboration in thyroid research. Subclinical hyperthyroidism and risk of coronary heart disease and mortality. Arch Intern Med. 2012;172(10):799-809.5. Gencer B, Collet TH, Virgini V, etc.; Collaboration in thyroid research. Subclinical thyroid dysfunction and risk of heart failure: individual analysis of participant data from 6 prospective cohorts. Circulation. 2012;126(9):1040–1049.6. Nanchen D, Gussekloo J, Westendorp RG, et al; PROSPER Group. Subclinical thyroid dysfunction and risk of heart failure in older adults with a high risk of cardiovascular disease. J Blade Endorinool Metab. 2012;97(3):852–861.7. Blum MR, Bauer DC, Collette TH, et al; Collaboration in thyroid research. Subclinical thyroid dysfunction and fracture risk: meta-analysis. Jama. 2015;313(20):2055–2065.8. Sweeney LB, Stuart C, Gaitonde DY. Tyreorite: a comprehensive approach. Am Pham Doctor. 2014;90(6):389–396.9. Hollowell JG, Staehling NW, Flanders WD, et al. TTH Serum, T/4 and Thyroid Antibodies in the United States Population (1988-1994): National Health and Nutrition Examination Survey (NHANES III). J Blade Endorinool Metab. 2002;87(2):489–499.10. Agini-Lombardi F, Antonangelo L, Martino E. et al. Spectrum of thyroid diseases in the iodine-deficient community: The Pescopagano study. J Blade Endorinool Metab. 1999;84(2):561–566.11. Kanaris GJ, Manowitz NR, Mayor G, Ridgeway EU. Study of the prevalence of thyroid disease in Colorado. Arch Intern Med. 2000;160(4):526-534.12. Rosario PW. Natural history of subclinical hyperthyroidism in elderly patients with TSH between 0.1 and 0.4 MI/L: a prospective study. The Enocrinol wedge (Oxfa). 2010;72(5):685–688.13. Rosario PW. The natural history of subclinical hyperthyroidism in patients under the age of 65. The Enocrinol wedge (Oxfa). 2008;68(3):491–492.14. Vober C.A. Observations concerning the natural history of subclinical hyperthyroidism. Thyroid. 2005;15(7):687–691.15. Biondi B, Palmieri EA, Fazio S, et al. Endogenous subclinical hyperthyroidism affects quality of life and cardiac morphology and function in young and middle-aged patients. J Blade Endorinool Metab. 2000;85(12):4701–4705.16. Petretta M, Bonaduce D, Spinelli L, et al. Cardiovascular hemodynamics and cardiac vegetative control in patients with subclinological and apparent hyperthyroidism. Eur J Endocrinol. 2001;145(6):691–696.17. Sawin CT, Geller A, Wolf PA, et al. Low concentration of tyrotropin in serum as a risk factor for atrial fibrillation in the elderly. N Engl J Med. 1994;331(19):1249-1252.18. Sgarbi JA, Villagna FG, Garberelin B, Villar HE, Romeldini JH. Effects of early antithyroid therapy for endogenous subclinical hyperthyroidism in clinical and cardiac abnormalities. J Blade Endorinool Metab. 1996;81(12):4278–4289.21. Rosario PW. Bone and cardiac abnormalities of subclinical hyperthyroidism in women under 65 years of age. Arc Bras Endocrinol Metabol. 2008;52(9):1448–1451.22. Faber J, Jensen IW, Petersen L, Nygaard B, Heged's L, Siersbaek-Nielsen K. Normalization of thyrophophine serum with radioiodoin treatment for subclinical hyperthyroidism: effect on bone loss in postmenopausal women. The Enocrinol wedge (Oxfa). 1998;48(3):285–290.23. Bushamy S, Verga S, Cotton S, et al. Favorable clinical cardiac and bone effects of antithyroid drug therapy in endogenous subclinical hyperthyroidism. J Endocrinol Invest. 2007;30(3):230–235.24. Abraham-Nordling M, Wallin G, Lundell G, Turling O. Thyroid hormone condition and quality of life in long-term follow-up after randomized treatment of Graves' disease. Eur J Endocrinol. 2007;156(2):173–179.25. Bell RJ, Rivera-Woll L, Davison SL, Topliss DJ, Donat S, Davis SR. Well-being-related quality of life health and cardiovascular disease risk profile in women with subclinical thyroid disease-community study. The Enocrinol wedge (Oxfa). 2007;66(4):548–556.26. Gan EH, Pierce SH. Clinical review: thyroid in mind: cognitive function and low tyrotropin in older adults. J Blade Endorinool Metab. 2012;97(10):3438–3449.27. Tan AP, Beiser A, Wasan RS, et al. Thyroid Function and Alzheimer's Risk: Framingham Research. Arch Intern Med. 2008;168(14):1514-1520.28. Moon JH, Park YJ, Kim TH, et al. Low but normal levels of TSH in serum are associated with the development or progression of cognitive impairment in older adults: The Korean Longitudinal Health and Aging Study (KLoSHA). J Blade Endorinool Metab. 2014;99(2):424–432.29. Vadiveloo T, Donnan PT, Cochrane L, Leese GP. Thyroid Epidemiology, Audit and Research (TEARS): Incidence in patients with endogenous subclinical hyperthyroidism. J Blade Endorinool Metab. 2011;96(5):1344–1351.30. Formiga F, Ferrer A, Padros G, Contra A, Corbella X, Puyol R; OCTABAIX training group. Thyroid condition and functional and cognitive status at a baseline and survival after 3 years of follow-up: study OCTABAIX. Eur J Endocrinol. 2014;170(1):69–75.31. Wijsman LW, de Crane AJ, Trompet S, et al. Subclinical Thyroid Dysfunction and Cognitive Decline in Old Age. PLoS one. 2013;8(3):e59199.32. LeFevre ML. Screening for Thyroid Dysfunction: U.S. Preventive Services Task Force Recommendations Statement. Anne Intern Med. 2015;162(9):641-650.33. American Academy of Family Physicians. Recommendation Preventive Service: Screening of thyroid dysfunction, adults. . . February 24, 2016.34 Ross DS, Birch HB, Cooper DS, et al. 2016 American Thyroid Association guidelines for diagnosis and management of hyperthyroidism and other causes of thyrotoxicosis. Thyroid. 2016;26(10):1343–1421.35. Wilson GR, Curry RW Jr. subclinical thyroid disease. Am Pham Doctor. 2005;72(8):1517–1524.36. Srier DC, Boorman KD. Subclinical hyperthyroidism: spores in management. Am Pham Doctor. 2002;65(3):431-438.Page 21. Haye RJ, Jones NE, Williams HC, et al. Global Burden of Skin Diseases in 2010: Analysis of the prevalence and effects of skin diseases. J Invest Dermatol. 2014;134(6):1527–1534....2. Powell RJ, Leech SC, Do S, et al. BSACI Guide to Managing Chronic Urticaria and Angioema. Wedge Exp Allergy. 2015;45(3):547–565.3. Hellgren L. Prevalence of hives in the general population. Acta Allergol. 1972;27(3):236–240.4. Bernstein JA, Lang DM, Khan DA, et al. Diagnosis and Management of Acute and Chronic Urticaria: 2014 Update. J Allergy Wedge Immuno. 2014;133(5):1270–1277.5. Falcon CL, Barton GM, Farr AG, Medjitov R. Mechanism to start allergen-induced T assistant type 2 responses. Nat Immunol. 2008;9(3):310–318.6. Konstantinou GN, Asero R, Ferrer M, et al. EAACI task force paper position: evidence of autoimmune hives and a proposal to determine diagnostic criteria. Allergies. 2013;68(1):27–36.7. UpToDate. New hives. requires a subscription. Access to February 1, 2016.8 Schaefer. Urticaria: evaluation and treatment. Am Pham Doctor. 2011;83(9):1078–1084.9. Souberbier T, Aberer W, Acero R, et al.; European Academy of Allergy and Clinical Immunology; Global Network against Allergy and Asthma; European Dermatology Forum; World Allergy Organization. EAACI/GA(2) LEN/EDF/WAO Guide by Definition, Classification, Diagnosis and Management of Hives: Revision and Update 2013. Allergies. 2014;69(7):868–887.10. Saxe C, Sekerel BE, Orhan F, Cocabas CN, Tunser A. Adalyoglu G. Etiology of various forms of hives in childhood. Pediatrician Dermatol. 2004;21(2):102–108.11. Magerl M, Altrichter S, Borzova E, et al. Definition, diagnostic testing and management of chronic irrefutable hives - Recommendations for consensus EAACI/GA(2) LEN/EDF/UNEV 2016 update and revision. Allergies. 2016;71(6):780–802.12. Confino-Cohen R, Chodick G, Shalev V, Leshno M, Kimhi O, Goldberg A. Chronic hives and autoimmune diseases: associations, found in large population research. J Allergy Wedge Immuno. 2012;129(5):1307–1313.13. Kulthanan K, Jiamton S, Thumpimukvatana N, Pinkau S. Chronic idiopathic urticaria: prevalence and clinical course. J Dermatol. 2007;34(5):294–301.14. Peroni A, Colato C, zononi G, Girolomoni G. Urticarial defeats: if not What else? Differential diagnosis diagnosis Part II. Systemic Diseases. J Am Akade Dermatol. 2010;62(4):557–570.15. Peroni A, Colato C, Schena D, Girolomoni G. Urticarial lesions: if not hives, what else? Differential diagnosis of hives: part of I. Catan diseases. J Am Akade Dermatol. 2010;62(4):541–555.16. Koselle MM, Bossuit PM, Meques JR, Bos JD. Laboratory tests and identified diagnoses in patients with physical and chronic hives and angioedema: a systematic review. J Am Akade Dermatol. 2003;48(3):409–416.17. Trevisonno J, Balram B, Netchiporouk E, Ben-Shoshan M. Physical Hives: A review on classification, triggers and management with a particular focus on prevalence, including meta-analysis. Postgrad honey. 2015;127(6):565-570.18. Fedorovich S., van Kuuren EJ, Hu N. Histamine H2-receptor antagonists for hives. Cochrane Database Syst Rev. 2012; (3):CD008596.19. Pollack CV Jr., Romano TJ. Outpatient treatment of acute hives: the role of prednisone. Ann Emerg Med. 1995;26(5):547-551.20. Sharma M, Bennett C, Carter B, Cohen SN. H1-antihistamines for chronic spontaneous hives: abbreviated Cochrane systematic review. J Am Akade Dermatol. 2015;73(4):710-716.e4.21. Kavosh er, Khan DA. H1-antihistamines of the second generation in chronic hives: a review based on evidence. Am J Wedge Dermatol. 2011;12(6):361–376.22. Coffin JJ, Auquier P, Dreyfus I, Ortonn JP. How to prescribe antihistamines for chronic idiopathic hives: deslobatadin daily against PRN and quality of life. Allergies. 2009;64(4):605–612.23. Guillaume-Aginaga S, Yauregi Presa I, Aginaga-Ontoso E, Guillon-Grima F, Ferrer M. Updosing non-adising antihistamines in patients with chronic spontaneous hives: systematic review and meta-analysis. Br J Dermatol. 2016;175(6):1153–1165.24. de Silva NL, Damayanthi H, Rajapakse AC, Rodrigo C, Rajapakse S. Leukotriene receptor antagonists for chronic hives: a systematic review. Allergy Asthma Wedge Immuno. 2014;10(1):24.25. Morgan M,Han DA Therapeutic Alternatives for Chronic Urticaria: Evidence-Based Review, Part 2. Anne Allergy Asthma Immuno. 2008;100(6):517–526.26. Mitchell S, Balp MM, Samuel M, McBride D, Maurer M. Systematic review of the treatment of chronic spontaneous hives with inadequate response to licensed first-line treatments. It J Dermatol. 2015;54(9):1088–1104.27. Vena GA, Cassano N, D'Argento V, Milani M. Clobetasol propionate 0.05% in new foam formulation is safe and effective in short-term treatment of patients with delayed hives pressure: a randomized, double-blind, placebo-controlled trial. Br J Dermatol. 2006;154(2):353–356.28. Koselle MM, Meques JR, Bossuyt PM, Bos JD. The natural course of physical and chronic hives and angioedema in 220 patients. J Am Akade Dermatol. Chansakulporn S, Pongpreuksa S, Sangacharoenkit P, et al. Natural history of chronic hives in childhood: childhood: childhood: Study. J Am Akade Dermatol. 2014;71(4):663–668.30. Muller BA. Urticaria and Angiodema: a practical approach. Am Pham Doctor. 2004;69(5):1123-1128.Page 3Imple AHR' Effective Medical Care ReviewsHelping Clinics make the best treatment Of ChoicesDEAN A. SEEHUSEN, MD, MPH, Dwight David Eisenhower Army Medical Center, Fort Gordon, GeorgiaAm Fam Physician. 2017 June 1;95 (11):726-728.This clinical content meets the criteria of AAFP for Continuing Medical Education (CME). See CME quiz questions.Author Disclosure: No relevant financial affiliations. What is the best test for coeliac disease in terms of sensitivity, specificity and safety? Current data on the accuracy of tests used to diagnose coeliac disease supports the excellent sensitivity and specificity of anti-tissue anti-tissue transglutaminase immunoglobulin A (TTG IgA) trials. The available data support the current recommendation of the American College of Gastroenterology (ACG) to use tTG IgA as a first-line test for patients two years and older with suspected celiac disease. (SOR: C based on disease-oriented data.) Testing for deamidated gliadine peptide (DGP) IgA or IgG may be more accurate in children under two years of age. (SOR: C, based on disease-focused data.) The human lymphocyte antigen (HLA), which shows the absence of HLA-D-2 and HLA-D'8 essentially eliminates coeliac disease. (SOR: C, based on disease-focused data.) Video capsule endoscopy and endoscopy with duodenal biopsy are invasive and are associated with a small risk of side effects. (SOR: B, based on inconsistent or limited quality patient-oriented evidence.) eTable describes the tests currently used to diagnose coeliac disease. Coeliac disease is an immune-mediated inflammatory condition that presents in genetically predisposed individuals after consuming gluten-containing foods. Coeliac disease affects about 1% of the population in the United States and Western Europe, most of whom are undiagnosed.1 Prevalence appears to be increasing, although the cause remains unclear. Presentation of coeliac disease varies widely, making clinical suspicion an important key to recognition.2 The Agency for Health Research and quality control included 60 separate studies and 13 systematic reviews of the accuracy of several testing methods. The only studies in which all patients underwent biopsies were included.3 Because endoscopy with a duodenal biopsy is the final test for diagnosing coeliac disease, there is evidence that accuracy is greater in academic centers than in public settings. Endoscopy is associated with a low risk of infection, and bleeding occurs in 1.6 per 1,000 patients. endoscopy capsules is an alternative to duodenal biopsy, and has a very good sensitivity (89.0%) However, this is due to the delay of the capsule capsule 0.9% to 4.6%.3 ACG recommends starting with TTG IgA testing in patients aged two and older.4 tTG IgA testing has excellent sensitivity (over 90%) and specificity (over 95%), giving it a positive predictive value of 89.4% (95% confidence interval ,CI), 88.3 to 90.5) and negative predictive value of 99.0% (95% CI, 98.8 to 99.1). IgA deficiency is more common in patients with coeliac disease and should be excluded if tTG IgA testing is used.2For children under two years of age, ACG recommends using DGP IgA and IgG tests initially.4 Limited data show that DGP IgA and IgG are slightly less sensitive and specific in adults compared to tTG, but more accurate in young children. Endomysis testing igA antibodies has a lower sensitivity than tTG IgA (positive predictive value 79%; 95% CI, 71.0 to 85.5) and equivalent specificity. It is included in several diagnostic algorithms, but is not considered a first-line test in any patient population. HLA input may play a role in the diagnostic assessment of patients suspected of coeliac disease. Among patients with celiac disease, 95% have heterodimer HLA-D'2, while the remaining 5% have heterodimer HLA-D'8. This means that the absence of both of these HLA heterodimers essentially eliminates the disease. Coeliac disease is more common in some populations, and screening has been recommended in patients with type 1.5 diabetes agency Health Research and quality review has not found enough evidence to recommend one testing strategy over another in any particular population, including those with type 1 diabetes. Several diagnostic algorithms were evaluated (one proposed algorithm is available . There was insufficient evidence to compare the relative accuracy of the various algorithms. To see the full article, log in or buy a note access.editor: AFP SOR ratings are different from AHR' Strength of Evidence (SOE) ratings. The views expressed in this article are those of the authors and do not reflect the policies or positions of the U.S. Department of The Army, the Department of the Army, the Department of Defense, or the U.S. Government. Tjon JM, van Bergen J, Coning F. Coeliac Disease: How hard can it get? Immunogenetics. 2010;62(10):641–651....2. Rashid M, Lee J. Serological testing for celiac disease: a practical guide for physicians. Can Fam doctor. 2016;62(1):38–43.3. Agency for Health Research and quality. An effective health program. Diagnosis of coeliac disease: the current state of evidence. Summary of the clinician's research. Rockville, Md.: Health and quality research agency; July 2016. Доступ 8 февраля 2017.4. Рубио-Тапиа А, Хилл ID, Келли CP, Колдервуд AH, AH, Iax American College of Gastroenterology. Clinical recommendations of ACG: diagnosis and management of coeliac disease. Am J Gastroenterol. 2013;108(5):656–676.5. Bakker SF, Tushuizen ME, von Blomberg BM, Bontkes HJ, Mulder CJ, Simsek S. Screening for coeliac disease in adult patients with type 1 diabetes: myths, facts and disputes. Diabetic Metab Sindr. The Agency for Health Research and quality (AHR) is conducting the Effective Health Program as part of its core data mission to improve health care and ensure that the evidence is clear

and used. A key clinical question based on a systematic literature review by the AHR Effective Health Programme is presented, followed by an evidence-based response based on a review. The AHRA summary is accompanied by an AFP author's interpretation that will assist physicians in making treatment decisions. See the full review, doctor's resume and consumer summary. This series is coordinated by Kenny Lin, MD, MPH, Deputy Editor of AFP Online.A collection implementing AHR's Effective Health Reviews published by AFP is available in . Page 4JOSEPH AZIZ, MD, Community Health, Inc., and Genesis Health, East Molin, IllinoisAm Fam Physician. 2017 June 1;95 (11):729-730.A 40-year-old woman is presented with a four-day history of sore throat, dry cough, malaise and myalgia. She had no red or water eyes. The day before these symptoms began, she noticed a rash on the inside of her mouth. She had no constitutional symptoms such as fever, chills or weight change. She was not exposed to sick contact or unimmunized children. On inspection she looked good and was not in acute distress. There was mild mild mazzophy of tonsillary with mild erythema and without discharge. A gray-white vesicular eruption with an erythmatic background was observed on the buctic mucous membrane (Figure 1). Based on the patient's history and the results of the physical examination, which one of the following is the most likely diagnosis?A. Fordyce spots.B. Herpetik gingivostomatitis.C. Koplik spots.D. Oral candidiasis. Answer C: Koplik spots. Koplik spots are considered a pathological sign of measles, or rubeol. the measles period is between six and 21 days. The prodrome lasts from two to four days, but can persist as long as Days of the week. Symptoms usually include fever, malaise and anorexia, followed by conjunctivitis, coriander and cough. About 48 hours before the onset of measles, patients may develop enanthema or a mucous rash characterized by Coplica spots. The lesions are whitish, grayish or bluish, 1 to 3 mm high with an erythema base, and are usually visible on the beech mucous membrane opposite the mollum teeth. Measles exantham occurs two to four days after the onset of fever and consists of erythemamatous, maculopular, blanched rash, which classically begins on the face and spreads to the neck, upper trunk, lower trunk and limbs. Clinical improvement usually begins within 48 hours of the onset of the rash.1,2Depreceding the diagnosis of measles requires serological testing with virus-specific immunoglobulin G titers and viral culture. All measles cases must be reported to state health departments. Measles was eradicated in the United States in 2000, but an estimated 3 to 4 million cases are reported worldwide each year. In 2014, 667 cases of measles were reported in the United States, most of which were purchased outside the country.3 Treatments are supportive, including monitoring complications. Isolation is important because the virus is highly contagious.3Fordyce spots benign sebaceous growths. They present as isolated or scattered papules that are discrete, white to yellow, and 1 to 2 mm in size. They are particularly noticeable at the border of vermilion or buccal mucosa.1Gerpetic gingivostomitis presents both several intraoral vesicular lesions and erosion bordering on an inflammatory, erythematosis base. Defeats are usually seen on the lips, gingiva, oral palate, or tongue.1Oral candidiasis, or thrush, can present in several ways. Pseudomembrane form is most common and appears as white plaques on the buccale of the mucosa, palate, tongue, or oropharynx.1 To see the full article, log in or purchase access.1. Gan H, Maldonado YA. Measles: clinical manifestations, diagnosis and treatment (subscription required). Last Updated February 2, 2017 Access April 28, 2017.2. Richardson M, Elliman D, Maguire H, Simpson J, Nicholl A. Evidence base of incubation periods, infectious disease periods and exclusion policies for infectious disease control in schools and preschools published correction appears in Pediatr Infect Dis J. 2001;20 (7):653. Pediatr Infect Dis J. 2001;20(4):380-391.3. Centers for Disease Control and Prevention. Measles (rubeola). . Access 26 2017.This series is coordinated by John E. Delzell Jr., MD, MSPH, Assistant Medical Editor. A collection of photo quizzes published by AFP is available on Published photo quizzes are now posted in the mobile app. Find out more . AFP editors welcome the materials for the photo quiz. Guidelines for the preparation and dispatch of the Photovisation manuscript can be found in the authors' Guide to . In order to be considered for publication, submissions must comply with these guidelines. Emailing afpphoto@aafp.org. 5ERICA BARROWS-NEES, MD, and KATHERINE LANDY, MD, Tacoma Family Medicine Residency, Tacoma, WashingtonAm Fam Physician. 2017 June 1;95(11):732.Does overweight body alter the effectiveness of hormonal contraceptive methods? Hormonal contraceptives (oral contraceptive pills, implants, patches and rings) are very effective in women of all weights. (The power of recommendation: A based on systematic review and cohort studies.) There is no consistently demonstrated increased risk of pregnancy in overweight women using any specific hormonal method of contraception. In 2013, the Cochrane Review looked at 13 hormonal contraceptive trials with more than 49,000 sexually active women between 18 and 49 years of age, comparing pregnancy rates in the body mass index (BMI) range and layer weight.1 The main result was pregnancy. In a secondary analysis of one of the randomized controlled trials included in the Cochrane Review (n No. 6,022), which analyzed two combined oral contraceptives (noretindron/ethinyl estradiol and norgestimat/ethinylestradiol), the only statistically significant finding was an increase in pregnancy risk in women with a BMI of 25 kg per m2 or more, who used noretindron (relative risk 2.49; 95% confidence interval (CI), 1.01 to 6.13). Other secondary analyses evaluating different weight thresholds and BMI for Nordestimat showed no difference in pregnancy risk. A post-special analysis of two randomized controlled trials and one observational study included in the review (N No. 3319) examined pregnancy rates in women using norelgestromomine/ethinylestradiol transdermal patch on deciles of body weight. was rare in any decile, except for a group with women weighing more than 90 kg (198.4 lbs); however, statistical significance is not reported. The quality of the evidence ranged from very low to moderate due to a lack of adjustment to mixed factors. Prospective cohort study (n (n the Cochrane Review examined the effectiveness of peer-to-peer etonogestrel subdermal implant. The only pregnancy in this study occurred in a group of women with a BMI of more than 30 kg per m2. In 2013, a prospective cohort study of 7,486 women between the ages of 14 and 45 compared pregnancy rates in women using oral contraceptives (multiple formulations with a dose of ethynilastradyl from 20 to 35 micrograms), transdermal patch (norelgestromine, 150 micrograms, plus ethinylestradiol, 20 micrograms), or vaginal ring (ethanolestrel, 120 micrograms, plus ethinylestradiol, 15 micrograms).2 The authors conducted a SUBanalysis of BMI, reporting the duration of pregnancy from three months to three years. There was no difference in unintended pregnancies in overweight or obese women (BMI of 25 to 30 kg per m2, or more than 30 kg per m2, respectively) compared to women with normal weight (BMI less than 25 kg per m2) for all methods (overweight: risk factor 1.38; 95% KI, 0.91 to 2.10; obesity: risk factor 0.97; 95% KI, 0.61 to 1.53). To see the full article, log in or buy access.1. Lopez LM, et al. Hormonal contraceptives for contraception in overweight or obese women. Cochrane Database Syst Rev. 2013; (4):CD008452.2. McNicolas C, etc. Contraceptive failures in overweight and obese people are combined with the use of hormonal contraceptives. Obstet Gynecol. 2013;121(3):585-592.Help Desk Answers provides answers to questions submitted by family practitioners in the Family Physicians Network (FPIN). Network members select questions based on their importance to family medicine. The responses are taken from an approved set of evidence-based resources and are peer-reviewed. The strength of the recommendations and the level of evidence for individual studies are assessed using criteria developed by the Evidence-Based Medical Working Group (. The complete database of questions and answers based on evidence is protected by the copyright of FPIN. If you are interested in submitting questions or writing answers for this series, go to or email: questions@fpin.org.This series is coordinated by John E. Delzell Jr., MD, MSPH, Assistant Medical Editor. A collection of FPIN's Support Answers published in the AFP is available on the Family Doctors Requests Network. Used with permission. Page 6Am Fam Doctor. 2017 June 1;95(11):733.What's the best way to measure blood pressure? To get the most accurate measure, let patients sit for a few minutes and then measure their blood pressure on a completely bare hand. Does the difference matter in 4 mm systolic and 6 to 7 mm diastolic matter? This can, especially when deciding whether to add a second or third drug. Also, be sure to confirm office blood pressure with out-of-office measurements (either outpatient blood pressure monitoring or home blood pressure measurements) because many patients are white white Hypertension. (Evidence level 2c) It is important that we measure blood pressure in our offices just as it does in the diagnosis and treatment of hypertension. Otherwise, we run the risk of misclassifying patients and may over-treat or under-treat them. This simple cross-sectional study recruited 186 adults at the Japanese Primary Health Care Clinic and two adult day care facilities. Blood pressure was measured by automatic cuff in three conditions: a fully bare hand, a hand covered with a sleeve no more than 1 mm thick to the wrist (if necessary, a cardigan with a sleeve 1 mm thick), or a hand with a rolled up arm on the elbow. All patients were first asked to sit in a chair five minutes before the measurement, with hand and level support. The researchers systematically changed the order in which blood pressure was measured. For each condition, the final blood pressure was an average of three dimensions. The average age of the participants was 75 years, 62% - women, and 63% - hypertension. The average blood pressure was 129/67 mmHg. art taken on a bare hand, 133/73 mm Hg. art on the arm with full sleeves and 133/74 mm Hg. art on the hand with a rolled up sleeve. The difference persisted after the age and measurement order was adjusted in the variance model analysis. It is also interesting that the average blood pressure decreased from the first measurement (135/74 mmHg) to the second dimension (131/71 mmHg) and to the third dimension (129/70 mmHg). Design Study: Cross-sectionalFunding Source: Self-funded or unfundedSetting: Outpatient (primary care)Help: Ozone S, Shaku F, Sato M, Takayashiki A, Tsutsumi M, Maeno T. Comparison of blood pressure measurements on the bare arm, over the sleeve and over rolled sleeves in the elderly. Pham Pract. 2016;33(5):517-522.To see the full article, log in or gain access. POEMs (patient-centered evidence that matters) are provided by EssentialEvidence Plus, a point of care clinical decision support system published by Wiley-Blackwell. For more information, please . To determine the levels of evidence used in POEMs, see subscribe to a free podcast of these and other POEMs that appear in AFP, search iTunes for POEM week or go to a series of coordinated by Sumi Sexton, MD, Deputy Editor. A collection of POEMs published in AFP is available on . .