

# What's New

December 2019

## NEW BOOKS ON CK

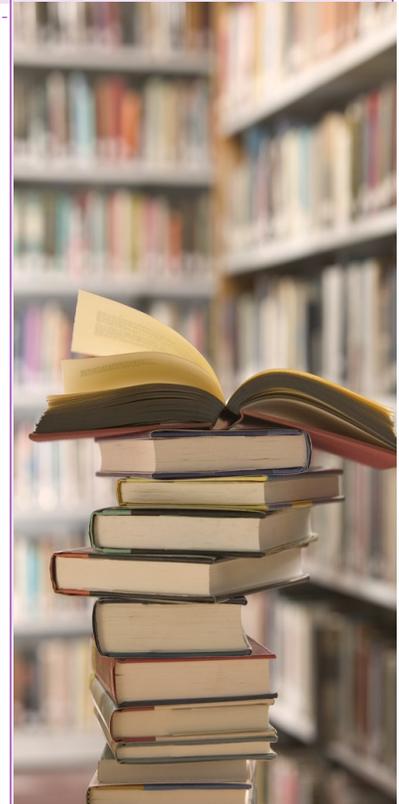
### Coming soon in December

- Acute Rheumatic Fever and Rheumatic Heart Disease*, 1st ed.  
(Dougherty)
- Addiction Medicine: Science and Practice*, 2nd ed. (Johnson)
- Assessment and Treatment of Addiction, The*, 1st ed.  
(Danovitch)
- Atlas of Facial Implants*, 2nd ed. (Yaremchuk)
- Atlas of Uncommon Pain Syndromes*, 4th ed.  
(Waldman)
- Before We Are Born*, 10th ed. (Moore)
- Chimeric Antigen Receptor T-Cell Therapies for Cancer*, 1st ed.  
(Lee)
- Clinical Care of the Runner*, 1st ed. (Harrast)
- Concussion*, 1st ed.  
(Eapen)
- Conn's Current Therapy 2020* (Kellerman)
- Enzinger and Weiss's Soft Tissue Tumors*, 7th ed.  
(Goldblum)
- Essential Surgery: Problems, Diagnosis and Management*, 6th ed.  
(Quick)
- Fundamentals of Emergency Ultrasound*, 1st ed. (McGahan)
- Immunotherapies for Allergic Disease*, 1st ed.  
(Cox)
- Introduction to Vascular Ultrasonography*, 7th ed. (Pellerito)
- Jekel's Epidemiology, Biostatistics, Preventive Medicine, and Public Health*, 5th ed.  
(Elmore)
- Kanski's Clinical Ophthalmology*, 9th ed.  
(Salmon)
- Medical Genetics*, 6th ed.  
(Jorde)
- Middleton's Allergy: Principles and Practice*, 9th ed. (Burks)
- Minimally Invasive Breast Surgery*, 1st ed. (Mok)

[www.clinicalkey.com](http://www.clinicalkey.com)

Clinical Key®

Lead with answers. ☺



## INSIDE THIS ISSUE...

What's new in **ClinicalKey** and **UpToDate** two of our top resources accessible from anywhere with an OpenAthens account...

Register for OpenAthens at :

<https://openathens.nice.org.uk/>

*Munro Kerr's Operative Obstetrics*, 13th ed. (Arulkumaran)

*Oncoplastic Surgery of the Breast*, 2nd ed. (Nahabedian)

*Pediatric Hand Therapy*, 1st ed. (Abzug)

*Surgery of the Hip*, 2nd ed. (Berry)

*Total Knee Arthroplasty*, 3rd ed. (Scott)

*Umphred's Neurological Rehabilitation*, 7th ed. (Lazaro)

*Williams Textbook of Endocrinology*, 14th ed. (Melmed)

### **New and Updated Topics on UpToDate**

#### **Surgical versus medical therapy for heartburn refractory to proton-pump inhibitors**

The optimal approach to heartburn refractory to proton-pump inhibitors (PPI) is debated. In a randomized trial, patients with heartburn refractory to a two-week course of double-dose omeprazole underwent endoscopy, esophageal biopsy, esophageal manometry, and multichannel intraluminal impedance-pH monitoring while on PPI therapy [1]. One-fifth had objective evidence that their symptoms were related to gastroesophageal reflux disease (GERD) and were randomly assigned to receive laparoscopic Nissen fundoplication, active medical management (omeprazole+baclofen±desipramine), or control medical management (omeprazole+placebo). At one year, the proportion of patients in the surgery, active medical, and control medical management groups that achieved ≥50 percent improvement in a GERD quality of life score was 67, 28, and 12 percent, respectively. These results support the efficacy of antireflux surgery, but also underscore the importance of careful patient selection, as 79 percent of patients referred for PPI-refractory heartburn lacked objective evidence of GERD.

#### **Makena not effective for reducing spontaneous preterm birth**

Progesterone is administered in the second and third trimesters of pregnancy to women with a history of spontaneous preterm birth (sPTB) to reduce the risk of recurrent sPTB, but emerging data have not confirmed the efficacy reported in earlier trials. In a multicenter international trial (PROLONG) including over 1700 women with a singleton gestation and past history of sPTB, hydroxyprogesterone caproate injections (Makena) did not reduce PTB <35 weeks compared with placebo (11.0 versus 11.5 percent) [2]. After review of these findings, a US Food and Drug Administration advisory committee recommended withdrawing approval for Makena [2,3]. Some UpToDate contributors continue to offer hydroxyprogesterone caproate with shared decision-making, while others use intravaginal natural progesterone in patients with a history of sPTB, pending data from additional trials and revised guidance from major obstetric organizations.



### **Immobilization for stable ankle fractures in adults**

Immobilization in a cast (CI) for approximately six weeks is standard treatment for stable ankle fractures. However, evidence is growing that shorter periods of immobilization may permit comparable healing with a lower risk of complications. In a randomized, noninferiority trial of 247 adults with stable fractures of the lateral malleolus, immobilization for three weeks in a short-leg walking cast or rigid ankle orthosis reduced the short-term loss of ankle mobility and the risk for deep vein thrombosis compared with CI, without compromising fracture healing [4]. While further study is needed to confirm these results, three weeks of immobilization may be a reasonable approach in healthy adults with uncomplicated fractures.

### **Investigational insulin delivery system (artificial pancreas) in type 1 diabetes**

With a hybrid closed-loop insulin delivery system (artificial pancreas), the basal insulin infusion rate is delivered automatically (determined by an algorithm that depends on continuous glucose monitoring [CGM] results), whereas the pre-meal boluses are determined and delivered by the patient. Most hybrid closed-loop systems have been studied for  $\leq 3$  months. In a six-month trial comparing an investigational closed-loop system with a glucose sensor-augmented insulin pump in 168 patients  $\geq 14$  years of age with type 1 diabetes, time spent in target blood glucose range was higher with the closed-loop system (71 versus 59 percent) [3]. In addition, there was an improvement in glycated hemoglobin (A1C) and a reduction in time spent with hypoglycemia. However, there were more hyperglycemic adverse reactions (including one episode of ketoacidosis) in the hybrid closed-loop group (14 versus 2 patients), primarily due to infusion set failures.

### **CSF analysis in well-appearing young febrile infants with UTIs**

The need to perform a lumbar puncture in an otherwise low risk, well-appearing febrile infant with a urinary tract infection (UTI) has been questioned. In a systematic review and meta-analysis of 20 observational studies involving nearly 3900 infants age 29 to 90 days, the pooled prevalence of bacterial meningitis in infants with UTIs was 0.25 percent [4]. Sterile CSF pleocytosis was variably reported (in up to 29 percent of patients with UTIs), leading to unnecessary additional antibiotic coverage for suspected meningitis pending culture results. These findings support avoidance of lumbar puncture in otherwise low risk, well-appearing febrile infants 29 to 90 days of age with UTIs.

**[www.uptodate.com](http://www.uptodate.com)**

**Blackpool Library and Knowledge Service**

**01253 953831/ [bfwh.library.services@nhs.net](mailto:bfwh.library.services@nhs.net)**

**Education Centre : Victoria Hospital : Whinney Heys Rd : Blackpool : FY3 8NR**

**<https://www.bfwh.nhs.uk/our-services/hospital-services/library/>**