**Tom Nolan’s research reviews—10 November 2022**

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**How not to discuss anticoagulation**

Let’s begin with a toe curling qualitative study that analysed 37 clinical encounters between doctors in the US and patients about starting anticoagulants for atrial fibrillation. The quotes in the paper look more like excerpts from a *Panorama* investigation or a book called *What not to say to patients:* “[Anticoagulants] reduce your stroke rate from 10% a year down to 2%, and there are generally no side effects except that you bruise easier.” None of the encounters included a balanced discussion of benefits versus risks: “I am very uncomfortable not having you on [an anticoagulant] because you’re going to have a stroke.” The authors called this persuasive language, which roughly translates in everyday language to a guilt trip: “The whole idea is to prevent, God forbid, a stroke, okay? Because if a stroke happens we can’t do anything about it, but right now we can prevent it.” And then there’s the language used to bash warfarin, which only a few years ago was a lifesaving drug: “I’ll just tell this to you because somebody else will, and I don’t like saying this, but it’s true, it’s the main ingredient in rat poison.”

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**Apixaban edges it for gastrointestinal bleed risk**

If that study is anything to go by, very few patients are likely to choose anything other than a direct oral anticoagulant (DOAC), but which one? A study in *Annals of Internal Medicine* looked at the medical records of 221 million people, to find those who have been prescribed a DOAC for new onset atrial fibrillation. The researchers followed up half a million patients who had been started on apixiban, dabigatran, rivaroxiban, or edoxaban for up to 10 years. The rates of ischaemic stroke were similar for all four drugs, but apixiban was associated with a slightly lower risk of gastrointestinal bleeding than the others. These findings support the conclusions of various network meta-analyses—but there are still no head-to-head randomised controlled trials in this area.

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**SGLT2 inhibitors for chronic kidney disease**

Drug trials don’t exactly make it easy for clinicians to convey the benefits and risks of treatments to patients. The EMPA-KIDNEY study reports positive findings for the sodium-glucose cotransporter 2 (SGLT2) inhibitor empagliflozin as a treatment to reduce progression of chronic kidney disease, but I’m not sure how I’d translate the findings to help a patient make an informed decision about taking them. In people with chronic kidney disease and an estimated glomerular filtration rate (eGFR) of at least 20 mL/min/1.73 m² but less than 45 mL/min/1.73 m², or an eGFR between 45 and 90 mL/min/1.73 m² with a urinary albumin to creatinine ratio (ACR) of at least 200, 16.9% of those taking a placebo pill daily for two years met the primary outcome of progression of kidney disease (sustained decrease in eGFR to under 10 mL/min/1.73 m² or by at least 40% from baseline, or death from renal causes) or death from cardiovascular causes. One of these outcomes occurred in 13.1% of those taking empagliflozin daily instead of placebo.


**Deprescribing RAS inhibitors**

A sure sign that a drug class has become part of the establishment is when they can only make it into a major journal as part of a deprescribing study. An open-label randomised controlled trial of discontinuing renin-angiotensin system (RAS) inhibitors (angiotensin converting enzyme inhibitors and angiotensin receptor blockers) in people with an eGFR <30 mL/min/1.73 m² set out to explore suggestions from other studies that stopping RAS inhibitors may actually slow decline in renal function. It found no difference in clinically relevant decline in renal function over a three year follow-up period between continuing RAS inhibitors and discontinuing them. Although a small benefit from continuing RAS inhibitors may have been hidden by the small trial size (441 people), it at least suggests that stopping them in this group of patients is unlikely to lead to any sudden, clinically significant deterioration in renal function.


**Reducing surgical site infections**

A “robust benefit” from routinely changing gloves and instruments before abdominal wound closure leads the authors of a cluster randomised control trial published in the *Lancet* to suggest “that it should be widely implemented into surgical practice around the world.” Hospitals where abdominal surgery is performed in seven low and middle income countries were assigned to either current practice or for the whole scrub team to change gloves and instruments before abdominal wound closure. They found a 13% reduction in surgical site infections in the intervention group compared with usual care (P=0.0032), with rates of surgical site infection of 18.9% versus 16.0% respectively. They argue that the cost of this intervention is a fraction of the cost of managing resulting infections, and that the findings should apply to higher resource settings where surgical site infection rates from open abdominal surgery are similar.

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