This What This List Was Created (1-5)

The American Society of Hematology (ASH) Choosing Wisely Task Force utilized a modified Delphi technique to collect suggestions from committee members and experts in the specialty focused on the hematology field. The suggested core values of harm, cost, strength of evidence, frequency and control. Fifty-one of 105 core values met were then identified by the Task Force and each core value was then reviewed by experts in the field. The core values were then validated by external experts and the Task Force then determined what was appropriate to recommend for the list.

This What This List Was Created (6-10)

Suggestions for the second ASH Choosing Wisely list were solicited through a draft Committee Members on Practice, a draft for Quality, the ASH Choosing Wisely Task Force, the ASH Clinical Colleague committee members and members of the ASH Practice Parameters. Suggestions were prioritized for review by ASH members, patients, producing evidence-based recommendations, considering both the cost and frequency of tests and treatments, making recommendations in the clinical areas of hematology, and considering the current evidence on the management of patients with these conditions. Six experts rated the items from 1 to 5, with a score of 5 meaning that the item was particularly important. The items were then prioritized based on the median score of the 6 experts. Items were then selected for inclusion in ASH's second Choosing Wisely list of recommendations.

This What This List Was Created (Non-ASH Recommendations)

Asthma, diabetes, obesity, psychotropic medications, and alcohol are also major areas of concern that affect patients, providers, and payers. As a result, the American Academy of Family Physicians (AAFP) has developed guidelines for chronic disease management and surveillance. The American Society of Hematology (ASH) has developed guidelines for management of disease-specific conditions, such as sickle cell disease, thrombosis, and anemia.

Sources


For more information or to see other lists of Five Things Physicians and Patients Should Question, visit www.choosingwisely.org.
Don’t transpose more than the number of red blood cell (RBC) units necessary to relieve symptoms of anemia or to return a patient to a safe hemoglobin range (7 to 8 g/dL). Don’t store RBC units for more than 35 days (56–60 days for young patients and for patients with aplastic anemia) without any likelihood of benefit. Clinicians are urged not to administer two units of RBCs if one unit is sufficient and to use appropriate weight-based dosing of RBCs in children.

Don’t test for thrombophilia in adult patients with venous thromboembolism (VTE) occurring in the setting of major transient risk factors (surgery, trauma or prolonged immobility). Thrombophilia testing is costly and can lead to incorrect results if the patient has a major underlying cause for VTE. Thrombophilia testing is useful in patients with recurrent VTE, those who have a family history of VTE, or those with a strong family history plus a major transient risk factor or a major transient risk factor in combination with a laboratory abnormality that suggests a genetic cause of VTE. Thrombophilia testing is useful in patients with recurrent VTE, those who have a family history of VTE, or those with a strong family history plus a major transient risk factor or a major transient risk factor in combination with a laboratory abnormality that suggests a genetic cause of VTE.

Don’t use inferior vena cava (IVC) filters routed in patients with acute VTE. IVC filters were intentionally designed for non-emergent situations, elevations in the international normalized ratio are best addressed by holding the vitamin K antagonist and/or administering vitamin K. Blood products can cause serious harm to patients, are costly and are rarely indicated in the reversal of vitamin K antagonist. In non-emergent situations, elevations in the international normalized ratio are best addressed by holding the vitamin K antagonist and/or administering vitamin K.

Don’t administer plasma or prothrombin complex concentrates for non-emergent reversal of vitamin K antagonists (i.e., outside of the setting of major transient risk factors and certain specific situations of emergent surgery). Blood products can cause serious harm to patients, are costly and are rarely indicated in the reversal of vitamin K antagonist. In non-emergent situations, elevations in the international normalized ratio are best addressed by holding the vitamin K antagonist and/or administering vitamin K.

Limit surveillance computed tomography (CT) scans in asymptomatic patients following curative-intent treatment for aggressive lymphoma.

CT surveillance in asymptomatic patients in response to aggressive non-Hodgkin lymphoma may be fraught with the small but substantial risk of radiation-induced second malignancies. The risk-benefit assessment of CT surveillance compared to strict use of symptoms or other factors should be individualized. CT surveillance is an option for patients with a high-risk burden, a small risk of radiation-induced malignancies, and patients who lack a history of abdominal resections. CT surveillance is an option for patients with a high-risk burden, a small risk of radiation-induced malignancies, and patients who lack a history of abdominal resections.

Don’t treat with an anticoagulant for more than three months in a patient with a first venous thromboembolism (VTE) occurring in the setting of a major transient risk factor. Anticoagulant therapy is indicated for more than three months in patients with a first venous thromboembolism (VTE) occurring in the setting of a major transient risk factor. Anticoagulant therapy is indicated for more than three months in patients with a first venous thromboembolism (VTE) occurring in the setting of a major transient risk factor. Anticoagulant therapy is indicated for more than three months in patients with a first venous thromboembolism (VTE) occurring in the setting of a major transient risk factor. Anticoagulant therapy is indicated for more than three months in patients with a first venous thromboembolism (VTE) occurring in the setting of a major transient risk factor.

Don’t routinely perform baseline or routine surveillance CT scans in patients with asymptomatic, early-stage chronic lymphocytic leukemia (CLL). In asymptomatic patients, early-stage chronic lymphocytic leukemia (CLL), CT scans are rarely indicated in patients with asymptomatic early-stage chronic lymphocytic leukemia (CLL). In asymptomatic patients, early-stage chronic lymphocytic leukemia (CLL), CT scans are rarely indicated in patients with asymptomatic early-stage chronic lymphocytic leukemia (CLL).

Don’t perform or treat for suspected heparin-induced thrombocytopenia (HIT) in patients with a low pre-test probability of HIT. Don’t perform or treat for suspected heparin-induced thrombocytopenia (HIT) in patients with a low pre-test probability of HIT. Don’t perform or treat for suspected heparin-induced thrombocytopenia (HIT) in patients with a low pre-test probability of HIT. Don’t perform or treat for suspected heparin-induced thrombocytopenia (HIT) in patients with a low pre-test probability of HIT.

Don’t treat patients with immune thrombocytopenic purpura (ITP) in the absence of bleeding or a very low platelet count. Don’t treat patients with immune thrombocytopenic purpura (ITP) in the absence of bleeding or a very low platelet count. Don’t treat patients with immune thrombocytopenic purpura (ITP) in the absence of bleeding or a very low platelet count. Don’t treat patients with immune thrombocytopenic purpura (ITP) in the absence of bleeding or a very low platelet count.

Don’t use warfarin as the initial anticoagulation in patients with acute ST-elevation myocardial infarction (STEMI). Don’t use warfarin as the initial anticoagulation in patients with acute ST-elevation myocardial infarction (STEMI). Don’t use warfarin as the initial anticoagulation in patients with acute ST-elevation myocardial infarction (STEMI). Don’t use warfarin as the initial anticoagulation in patients with acute ST-elevation myocardial infarction (STEMI).

Don’t perform CBC and chemistry testing in the face of clinical stability. If patients are stable and have no significant change in their clinical status, routine laboratory tests are not indicated. Hospitalized patients frequently have considerable volumes of blood drawn (phlebotomy) for diagnostic testing at short periods of time, which can result in significant blood loss and anemia. Laboratory tests are not indicated. Hospitalized patients frequently have considerable volumes of blood drawn (phlebotomy) for diagnostic testing at short periods of time, which can result in significant blood loss and anemia. Laboratory tests are not indicated. Hospitalized patients frequently have considerable volumes of blood drawn (phlebotomy) for diagnostic testing at short periods of time, which can result in significant blood loss and anemia. Laboratory tests are not indicated. Hospitalized patients frequently have considerable volumes of blood drawn (phlebotomy) for diagnostic testing at short periods of time, which can result in significant blood loss and anemia.