Choosing Wisely recommendations & how they apply to Rheumatologists

Indicates Rheumatologists are routinely involved in this type of activity/making this kind of decision

Indicates Rheumatologists are occassionally involved in this type of activity or making this kind of decision

Specialty	Recommendation
Anesthesiology	Don't order baseline laboratory studies (complete blood count, coagulation testing, or serum biochemistry) for asymptomatic patients undergoing low-risk non-cardiac surgery.
	Don't order a baseline electrocardiogram for asymptomatic patients undergoing low-risk non-cardiac surgery.
	Don't order a baseline chest X-ray in asymptomatic patients, except as part of surgical or oncological evaluation.
	Don't perform resting echocardiography as part of preoperative assessment for asymptomatic patients undergoing low to intermediate-risk non-cardiac surgery.
	Don't perform cardiac stress testing for asymptomatic patients undergoing low to intermediate risk non-cardiac surgery.
Cardiology	Don't perform stress cardiac imaging or advanced non-invasive imaging in the initial evaluation of patients without cardiac symptoms unless high-risk markers are present.
	Don't perform annual stress cardiac imaging or advanced non-invasive imaging as part of routine follow-up in asymptomatic patients.
	Don't perform stress cardiac imaging or advanced non-invasive imaging as a pre-operative assessment in patients scheduled to undergo low-risk non-cardiac surgery.
	Don't perform echocardiography as routine follow-up for mild, asymptomatic native valve disease in adult patients with no change in signs or symptoms.
	Don't order annual electrocardiograms (ECGs) for low-risk patients without symptoms.
Critical care	Don't start or continue life supporting interventions unless they are consistent with the patient's values and realistic goals of care.
	Don't prolong mechanical ventilation by over-use of sedatives and bed rest.
	Don't continue mechanical ventilation without a daily assessment for the patient's ability to breathe spontaneously.
	Don't order routine chest radiographs for critically ill patients, except to answer a specific clinical question.
	Don't routinely transfuse red blood cells in hemodynamically stable ICU patients with a hemoglobin concentration greater than 70 g/l (a threshold of 80 g/L may be considered for patients undergoing cardiac or orthopedic surgery and those with active cardiovascular disease).
Emergency medicine	Don't order CT head scans in adults and children who have suffered minor head injuries (unless positive for a head injury clinical decision rule).
	Don't prescribe antibiotics in adults with bronchitis/asthma and children with bronchiolitis.
	Don't order lumbosacral (low back) spinal imaging in patients with non-traumatic low back pain who have no red flags/pathologic indicators.
	Don't order neck radiographs in patients who have a negative examination using the Canadian C-spine rules.
	Don't prescribe antibiotics after incision and drainage of uncomplicated skin abscesses unless extensive cellulitis exists.
	Don't order CT head scans in adult patients with simple syncope in the absence of high-risk predictors.
	Don't order CT pulmonary angiograms or VQ scans in patients with suspected pulmonary embolism until risk stratification with decision rule has been applied and when indicated, D-dimer biomarker results are obtained.
	Don't use antibiotics in adults and children with uncomplicated sore throats.
	Don't order ankle and/or foot X-rays in patients who have a negative examination using the Ottawa ankle rules.
	Don't use antibiotics in adults and children with uncomplicated acute otitis media.
Endocrinology and metabolism	Don't recommend routine or multiple daily self-glucose monitoring in adults with stable type 2 diabetes on agents that do not cause hypoglycemia.
	Don't routinely order a thyroid ultrasound in patients with abnormal thyroid function test unless there is a palpable abnormality of the thyroid gland.
	Don't use Free T4 or T3 to screen for hypothyroidism or to monitor and adjust levothyroxine (T4) dose in patients with known primary hypothyroidism.
	Don't prescribe testosterone therapy unless there is biochemical evidence of testosterone deficiency.
	Don't routinely test for Anti-Thyroid Peroxidase Antibodies (anti – TPO).

Family medicine	Don’t do imaging for lower-back pain unless red flags are present.
	Don’t use antibiotics for upper respiratory infections that are likely viral in origin, such as influenza-like illness, or self-limiting, such as sinus infections of less than seven days of duration.
	Don’t order screening chest X-rays and ECGs for asymptomatic or low risk outpatients.
	Don’t screen women with Pap smears if under 21 years of age or over 69 years of age.
	Don’t do annual screening blood test unless directly indicated by the risk profile of the patient.
	Don’t routinely measure Vitamin D in low risk adults.
	Don't routinely do screening mammography for average risk women aged 40 - 49.
	Don’t do annual physical exams on asymptomatic adults with no significant risk factors.
	Don’t order DEXA (Dual-Energy X-ray Absorptiometry) screening for osteoporosis on low risk patients.
	Don’t advise non-insulin requiring diabetics to routinely self-monitor blood sugars between office visits.
	Don’t order thyroid function test in asymptomatic patients.
Gastroenterology	Don’t maintain long term Proton Pump Inhibitor (PPI) therapy for gastrointestinal symptoms without an attempt to stop/reduce PPI at least once per year in most patients.
	Avoid using an upper GI series to investigate dyspepsia.
	Avoid performing an endoscopy for dyspepsia without alarm symptoms for patients under the age of 55 years.
	Avoid performing a colonoscopy for constipation in those under the age of 50 years without family history of colon cancer or alarm features.
	Don’t routinely use long term steroid therapy in inflammatory bowel disease.
General surgery	Don’t perform axillary lymph node dissection for clinical stages I and II breast cancer with clinically negative lymph nodes without attempting sentinel node biopsy.
	Avoid the routine use of “whole-body” diagnostic computed tomography (CT) scanning in patients with minor or single system trauma.
	Avoid colorectal cancer screening test on asymptomatic patients with a life expectancy of less than 10 years and no family or personal history of colorectal neoplasia.
	Avoid admission or preoperative chest X-rays for ambulatory patients with unremarkable history and physical exam.
	Don’t do computed tomography (CT) for the evaluation of suspected appendicitis in children until after ultrasound has been considered as an option.
	Avoid repair of minimally symptomatic inguinal hernias where appropriate by offering an option of watchful waiting for up to two years.
Geriatrics	Don’t use antimicrobials to treat bacteriuria in older adults unless specific urinary tract symptoms are present.
	Don’t use benzodiazepines or other sedative-hypnotics in older adults as first choice for insomnia, agitation or delirium.
	Don’t recommend percutaneous feeding tubes in patients with advanced dementia; instead offer oral feeding.
	Don't use antipsychotics as first choice to treat behavioural and psychological symptoms of dementia.
	Avoid using medications known to cause hypoglycemia to achieve hemoglobin A1c <7.5% in many adults age 65 and older; moderate control is generally better.
Headache	Don’t order neuroimaging or sinus imaging in patients who have a normal clinical examination, who meet diagnostic criteria for migraine, and have no “red flags” for a secondary headache disorder.
	Don’t prescribe opioid analgesics or combination analgesics containing opioids or barbiturates as first line therapy for the treatment of migraine.
	Don’t prescribe acute medications or recommend an over-the-counter analgesic for patients with frequent migraine attacks without monitoring frequency of acute medication use with a headache diary.
	Don’t forget to consider the behavioural components of migraine treatment, including lifestyle issues like regular and adequate meals and sleep, and management of specific triggers including stress.
Hematology	Don’t give IVIG as first line treatment for patients with asymptomatic immune thrombocytopenia (ITP).
	During interruption of warfarin anticoagulation for procedures, don’t ‘bridge’ with full-dose low molecular weight heparin (LMWH) or unfractionated heparin (UFH) unless the risk of thrombosis is high.
	Don’t order thrombophilia testing in women with early pregnancy loss.
	Don’t request a fine-needle aspirate (FNA) for the evaluation of suspected lymphoma.
	Don’t transfuse patients based solely on an arbitrary hemoglobin threshold.

Hospital medicine	Don’t place or leave in place a urinary catheter without reassessment.
	Don’t prescribe antibiotics for asymptomatic bacteriuria (ASB) in non-pregnant patients.
	Don’t use benzodiazepines and other sedative-hypnotics in older adults as first choice for insomnia, agitation or delirium.
	Don’t routinely obtain neuro-imaging studies (CT, MRI scans, or carotid Doppler ultrasonography) in the evaluation of simple syncope in patients with a normal neurological examination.
	Don’t routinely obtain head computed tomography (CT) scans, in hospitalized patients with delirium in the absence of risk factors.
Infectious disease	Don’t routinely prescribe intravenous forms of highly bioavailable antimicrobial agents for patients who can reliably take and absorb oral medications.
	Don’t prescribe alternate second-line antimicrobials to patients reporting non-severe reactions to penicillin when beta-lactams are the recommended first-line therapy.
	Don’t routinely repeat CD4 measurements in patients with HIV infection with HIV-1 RNA suppression for ≥2 years and CD4 counts ≥500/μL, unless virologic failure occurs or intercurrent opportunistic infection develops.
	Don’t routinely repeat radiologic imaging in patients with osteomyelitis demonstrating clinical improvement following adequate antimicrobial therapy.
	Don’t prescribe aminoglycosides for synergy to patients with bacteremia or native valve infective endocarditis caused by *Staphylococcus aureus* .
Internal medicine	Don’t routinely obtain neuro-imaging studies (CT, MRI, or carotid dopplers) in the evaluation of simple syncope in patients with a normal neurological examination.
	Don’t place, or leave in place, urinary catheters without an acceptable indication (such as critical illness, obstruction, palliative care).
	Don’t transfuse red blood cells for arbitrary hemoglobin or hematocrit thresholds in the absence of symptoms, active coronary disease, heart failure or stroke.
	In the inpatient setting, don’t order repeated CBC and chemistry testing in the face of clinical and lab stability.
	Don’t routinely perform preoperative testing (such as chest X-rays, echocardiograms, or cardiac stress test) for patients undergoing low risk surgeries.
Long term care	Don’t send the frail resident of a nursing home to the hospital, unless their urgent comfort and medical needs cannot be met in their care home.
	Don’t use antipsychotics as first choice to treat behavioural and psychological symptoms of dementia.
	Don’t do a urine dip or urine culture unless there are clear signs and symptoms of a urinary tract infection (UTI).
	Don’t insert a feeding tube in individuals with advanced dementia. Instead, assist the resident to eat.
	Don’t continue or add long-term medications unless there is an appropriate indication and a reasonable expectation of benefit in the individual patient.
	Don’t order screening or routine chronic disease testing just because a blood draw is being done.
Medical microbiology	Don’t collect urine specimens for culture from adults who lack symptoms localizing to the urinary tract or fever unless they are pregnant or undergoing genitourinary
	Don’t routinely collect or process specimens for Clostridium difficile testing when stool is non-liquid (i.e., does not take the shape of the specimen container) or when the
	Don’t obtain swabs from superficial ulcers for culture as they are prone to both false positive and false negative results with respect to the cause of the infection.
	Don’t routinely order nucleic acid amplification testing on cerebrospinal fluid (e.g., herpes simplex virus, varicella zoster virus, enteroviruses) in patients without a
	Don’t routinely obtain swabs during surgical procedures when fluid and/or tissue samples can be collected.
Medical students and trainees	Don’t suggest ordering the most invasive test or treatment before considering other less invasive options.
	Don’t suggest a test, treatment, or procedure that will not change the patient’s clinical course.
	Don’t miss the opportunity to initiate conversations with patients about whether a test, treatment or procedure is necessary.
	Don’t hesitate to ask for clarification on test, treatments, or procedures that you believe are unnecessary.
	Don’t suggest ordering test or performing procedures for the sole purpose of gaining personal clinical experience.
	Don’t suggest ordering test or treatments pre-emptively for the sole purpose of anticipating what your supervisor would want.
Nephrology	Don’t initiate erythropoiesis-stimulating agents (ESAs) in chronic kidney disease (CKD) patients with hemoglobin levels greater than or equal to 100 g/L without symptoms of anemia.
	Don’t prescribe nonsteroidal anti-inflammatory drugs (NSAIDS) in individuals with hypertension or heart failure or CKD of all causes, including diabetes.
	Don’t prescribe angiotensin converting enzyme (ACE) inhibitors in combination with angiotensin II receptor blockers (ARBs) for the treatment of hypertension, diabetic nephropathy and heart failure.
	Don’t initiate chronic dialysis without ensuring a shared decision-making process between patients, their families, and their nephrology health care team.
	Don’t initiate dialysis in outpatients with Stage 5 CKD in the absence of clinical indications.

Nuclear medicine	Don’t perform stress cardiac imaging or coronary angiography in patients without cardiac symptoms unless high-risk markers are present.
	Don’t use nuclear medicine thyroid scans to evaluate thyroid nodules in patients with normal thyroid gland function.
	Don’t use a computed tomography angiogram (CTA) to diagnose pulmonary embolism in young patients, particularly women, with a normal chest radiograph; consider a radionuclide lung study (“V\Q study”) instead.
	Don’t do routine bone scans in men with low-risk prostate cancer.
	Don’t repeat DEXA scans more often than every two years in the absence of high risk or new risk factors.
Nursing	Don’t insert an indwelling urinary catheter or leave it in place without daily assessment.
	Don't advise routine self-monitoring of blood glucose between appointments for clients with diabetes who do not require insulin.
	Don’t add extra layers of bedding (sheets, pads) beneath patients on therapeutic surfaces.
	Don’t use oxygen therapy to treat non-hypoxic dyspnea.
	Don’t routinely use incontinence containment products (including briefs or pads) for older adults.
	Don’t recommend tube feeding for clients with advanced dementia without ensuring a shared decision-making process that includes the known wishes of clients regarding future care needs and the perspectives of carers and the health care team.
	Don't recommend antipsychotic medicines as the first choice to treat symptoms of dementia.
	Don’t recommend antimicrobials to treat bacteriuria in older adults unless specific urinary tract symptoms are present.
	Don’t routinely recommend antidepressants as a first-line treatment for mild depressive symptoms in adults.
Occupational medicine	Don’t endorse clinically unnecessary absence from work.
	Don’t prescribe opiates for the treatment of acute or chronic non-cancer pain without first assessing side effects, work status, and capacity to drive a motor vehicle.
	Don’t order X-rays for acute low back pain in the absence of red flags.
	Don’t order blood mercury levels unless: dietary history suggests risk; the patient is pregnant or planning to become pregnant; and/or the patient is occupationally exposed to organomercury compounds.
	Don’t repeat chest X-rays when screening exposed workers for asbestosis unless clinical indications are present.
Oncology	Don’t order test to detect recurrent cancer in asymptomatic patients if there is not a realistic expectation that early detection of recurrence can improve survival or quality of life.
	Don’t perform routine cancer screening, or surveillance for a new primary cancer, in the majority of patients with metastatic disease.
	Avoid chemotherapy and instead focus on symptom relief and palliative care in patients with advanced cancer unlikely to benefit from chemotherapy (e.g., performance status 3 or 4).
	Don’t perform routine colonoscopic surveillance every year in patients following their colon cancer surgery; instead, frequency should be based on the findings of the prior colonoscopy and corresponding guidelines.
	Don’t delay or avoid palliative care for a patient with metastatic cancer because they are pursuing disease-directed treatment.
	Don’t recommend more than a single fraction of palliative radiation for an uncomplicated painful bone metastasis.
	Don’t initiate management in patients with low-risk prostate cancer (T1/T2, PSA < 10 ng/ml, and Gleason score < 7) without first discussing active surveillance.
	Don’t initiate whole breast radiotherapy in 25 fractions as a part of breast conservation therapy in women age ≥50 with early stage invasive breast cancer without considering shorter treatment schedules.
	Don’t deliver care (e.g., follow-up) in a high-cost setting (e.g., inpatient, cancer center) that could be delivered just as effectively in a lower-cost setting (e.g., primary care).
	Don’t routinely use extensive locoregional therapy in most cancer situations where there is metastatic disease and minimal symptoms attributable to the primary tumour (e.g., colorectal cancer).
Orthopaedics	Avoid performing routine post-operative deep vein thrombosis ultrasonography screening in patients who undergo elective hip or knee arthroplasty.
	Don’t use needle lavage to treat patients with symptomatic osteoarthritis of the knee for long-term relief.
	Don’t use glucosamine and chondroitin to treat patients with symptomatic osteoarthritis of the knee.
	Don’t use lateral wedge insoles to treat patients with symptomatic medial compartment osteoarthritis of the knee.
	Don’t use post-operative splinting of the wrist after carpal tunnel release for long-term relief.

Otolaryngology: head & neck surgery	Don’t order specialized audiometric and vestibular neurodiagnostic test in an attempt to screen for peripheral vestibular disease.
	Don’t perform computed tomography or blood work in the evaluation of a patient with sudden sensorineural hearing loss (SSNHL) given its presumed viral etiology.
	Don’t perform auditory brainstem responses (ABR) in patients with asymmetrical hearing loss. Asymmetrical hearing loss is defined as bone conduction threshold difference of: - 20 dB threshold difference at a single frequency - 15 dB threshold difference at 2 frequencies - 10 db threshold difference at 3 frequencies
	Don’t use oral antibiotics as a first line treatment for patients with painless ear drainage associated with a tympanic membrane perforation or tympanostomy tube unless there is evidence of developing cellulitis in the external ear canal skin and pinna.
	Don’t perform particle repositioning maneuvers (Epley or Semont) without a clinical diagnosis of posterior semicircular canal benign paroxysmal positional vertigo in the affected ear.
Paediatric surgery	Don’t order a routine ultrasound for umbilical and/or inguinal hernia.
	Don’t order C-reactive protein (CRP) levels in children with suspected appendicitis.
	Don’t do computed tomography (CT) for the evaluation of suspected appendicitis in children until after ultrasound has been considered as an option.
	Don’t order a routine ultrasound for children with undescended testes.
	Don’t delay referral for undescended testes beyond 6 months of age.
	Don’t delay testing for total and conjugated (direct) bilirubin in any newborn with persistent jaundice beyond 2 weeks of age.
Paediatrics	Don’t routinely use acid blockers or motility agents for the treatment of gastroesophageal reflux in infants.
	Don’t perform screening panels (IgE test) for food allergies without previous consideration of the pertinent medical history.
	Don’t administer psychostimulant medications to preschool children with Attention Deficit Disorder (ADD), but offer parent-administered behavioural therapy.
	Don’t routinely do a throat swab when children present with a sore throat if they have a cough, rhinitis, or hoarseness as they almost certainly have viral pharyngitis.
	Don’t recommend the use of cough and cold remedies in children under six years of age.
Palliative care	Don’t delay palliative care for a patient with serious illness who has physical, psychological, social or spiritual distress because they are pursuing disease-directed treatment.
	Don’t delay advance care planning conversations.
	Don’t use oxygen therapy to treat non-hypoxic dyspnea.
	Don’t use stool softeners alone to prevent opioid induced constipation.
	Don’t transfuse red blood cells for arbitrary hemoglobin or hematocrit thresholds in the absence of symptoms, or if no benefit was perceived from previous transfusions.
Pathology	Don’t perform population based screening for 25-OH-Vitamin D deficiency.
	Don’t screen women with Pap smears if under 21 years of age or over 69 years of age.
	Avoid routine preoperative laboratory testing for low risk surgeries without a clinical indication.
	Avoid standing orders for repeat complete blood count (CBC) on inpatients who are clinically/laboratorily stable.
	Don’t send urine specimens for culture on asymptomatic patients including the elderly, diabetics, or as a follow up to confirm effective treatment.
Pediatric Neurosurgery	Don’t order a CT to initially investigate macrocephaly (order an ultrasound or MRI).
	Don’t image a midline dimple related to the coccyx in an asymptomatic infant or child.
	Don’t use CT scans for routine imaging of children with hydrocephalus. Fast sequence non-sedated MRIs or ultrasounds provide adequate information to assess patients without exposing them to radiation or an anesthetic.
	Don’t recommend helmets for mild to severe positional flattening.
	Don’t do routine surveillance imaging for incidentally discovered Chiari I malformation.
Physical medicine and rehabilitation	Do not treat asymptomatic urinary tract infections in catheterized patients.
	Do not regularly prescribe bed rest and inactivity following injury and/or illness unless there is scientific evidence that harm will result from activity.
	Do not order prescription drugs for pain without considering functional improvement.
	Do not order CT scans for low back pain unless red flags are present.
	Do not use benzodiazepines for the treatment of agitation in the acute phase of traumatic brain injury after initial stabilization.
	Do not recommend carpal tunnel release without electrodiagnostic studies to confirm the diagnosis and severity of nerve entrapment.

Psychiatric	Don't use atypical antipsychotics as a first-line intervention for insomnia in children and youth.
	Don't use SSRIs as the first-line intervention for mild to moderately depressed teens.
	Don't use atypical antipsychotics as a first-line intervention for Attention Deficit Hyperactivity Disorder (ADHD) with disruptive behaviour disorders.
	Don't use psychostimulants as a first-line intervention in preschool children with ADHD.
	Don't routinely use antipsychotics to treat primary insomnia in any age group.
	Don't routinely order qualitative toxicology (urine drug screen) testing on all psychiatric patients presenting to emergency rooms.
	Don't routinely use antidepressants as first-line treatment for mild or subsyndromal depressive symptoms in adults.
	Don't routinely order brain neuroimaging (CT or MRI) in first episode psychoses in the absence of signs or symptoms suggestive of intracranial pathology.
	Don't routinely continue benzodiazepines initiated during an acute care hospital admission without a careful review and plan of tapering and discontinuing, ideally prior to hospital discharge.
	Don't routinely prescribe antidepressants as first-line treatment for depression comorbid with an active alcohol use disorder without first considering the possibility of a period of sobriety and subsequent reassessment for the persistence of depressive symptoms.
	Don't routinely prescribe high-dose or combination antipsychotic treatment strategies in the treatment of schizophrenia.
	Don't use antipsychotics as first choice to treat behavioural and psychological symptoms of dementia.
	Don't use benzodiazepines or other sedative-hypnotics in older adults as first choice for insomnia.
Radiology	Don't do imaging for lower-back pain unless red flags are present.
	Don't do imaging for minor head trauma unless red flags are present.
	Don't do imaging for uncomplicated headache unless red flags are present.
	Don't do computed tomography (CT) for the evaluation of suspected appendicitis in children until after ultrasound has been considered as an option.
	Don't do an ankle X-ray series in adults for minor injuries.
Rheumatology	Don't order ANA as a screening test in patients without specific signs or symptoms of systemic lupus erythematosus (SLE) or another connective tissue disease (CTD).
	Don't order an HLA-B27 unless spondyloarthritis is suspected based on specific signs or symptoms.
	Don't repeat dual energy X-ray absorptiometry (DEXA) scans more often than every 2 years.
	Don't prescribe bisphosphonates for patients at low risk of fracture.
	Don't perform whole body bone scans (e.g., scintigraphy) for diagnostic screening for peripheral and axial arthritis in the adults.
Spine	Don't perform fusion surgery to treat patients with mechanical axial low back pain from multilevel spine degeneration in the absence of: - leg pain with or without neurologic symptoms and/or signs of concordant neurologic compression - structural pathology such as spondylolisthesis or deformity.
	Don't routinely image patients with low back pain regardless of the duration of symptoms unless: - there are clinical reasons to suspect serious underlying pathology (i.e., red flags) - imaging is necessary for the planning and/or execution of a particular evidenced-based therapeutic intervention on a specific spinal condition.
	Don't use epidural steroid injections (ESI) for patients with axial low back pain who do not have leg dominant symptoms originating in the nerve roots.
	Don't miss the opportunity to brace the skeletally immature patient with adolescent idiopathic scoliosis (AIS) who has more than one year of growth remaining and a curve magnitude greater than 20 degrees.
	Don't order peri-operative antibiotics beyond a 24-hour post-operative period for non-complicated instrumented cases in patients who are not at high risk for infection or wound contamination. Administration of a single pre-operative dose for spine cases without instrumentation is adequate.
Sport and exercise medicine	Don't order an MRI for suspected degenerative meniscal tears or osteoarthritis (OA).
	Don't prescribe opiates as first line treatment for tendinopathies.
	Don't order orthotics for asymptomatic children with pes planus (flat feet).
	Don't order an MRI as an initial investigation for suspected rotator cuff tendinopathy.
	Don't immobilize ankle inversion sprains with no evidence of bony or syndesmotic injury.

Transfusion medicine	Don’t transfuse blood if other non-transfusion therapies or observation would be just as effective.
	Don’t transfuse more than one Red cell unit at a time when transfusion is required in stable, non-bleeding patients.
	Don’t transfuse plasma to correct a mildly elevated (<1.8) international normalized ratio (INR) or activated partial thromboplastin time (aPTT) before a procedure.
	Don’t routinely transfuse platelets for patients with chemotherapy-induced thrombocytopenia if the platelet count is greater than 10 X 109/L in the absence of bleeding.
	Don’t routinely use plasma or prothrombin complex concentrates for non-emergent reversal of vitamin K antagonists.
	Don’t use immunoglobulin therapy for recurrent infections unless impaired antibody responses to vaccines are demonstrated.
	Don’t order unnecessary pre-transfusion testing (type and screen) for all pre-operative patients.
	Don’t routinely order perioperative autologous and directed blood collection.
	Don’t transfuse O negative blood except to O negative patients and in emergencies for female patients of child-bearing potential of unknown blood group.
	Don’t transfuse group AB plasma to non-group AB patients unless in emergency situations where the ABO group is unknown.
Urology	Don’t order a routine bone scan and CT scan of the pelvis in men with low-risk prostate cancer.
	Don’t order serum testosterone in men without symptoms of hypogonadism.
	Don’t prescribe testosterone to men with erectile dysfunction who have normal testosterone levels.
	Don’t use antimicrobials to treat asymptomatic bacteriuria in the elderly.
	Don’t perform ultrasound on boys with cryptorchidism.
Vascular surgery	Don’t perform percutaneous interventions or bypass surgery as first line therapy in patients with asymptomatic peripheral arterial disease (PAD) and in most patients with claudication.
	Don’t perform carotid endarterectomies or stenting in most asymptomatic high risk patients with limited life expectancy.
	Don’t perform open or endovascular repair in most asymptomatic patients with small abdominal aortic aneurysms (<5cm in women, <5.5cm in men).
	Don’t perform endovascular repair of abdominal aortic aneurysms in most asymptomatic high-risk patients with limited life expectancy.
	Don’t perform unnecessarily frequent ultrasound examinations in asymptomatic patients with small abdominal aortic aneurysms. Aneurysms smaller than 4.5cm in diameter should undergo ultrasound surveillance every 12 months.