

# If It Works, Test It Again

John J. Frey III, MD, Medical Editor

**Y**oung investigators often resist testing a hypothesis that has already been studied by someone else, believing that only “new” ideas have value. However, the whole basis of clinical guideline development rests on replicated studies in different populations or different settings that show similar results. Without such replication, we might still be using methods for screening or treatment that could harm patients, not improve their care. Even sports referees use instant replay to make sure they made the correct call.

The study by Pham and colleagues<sup>1</sup> on whether total postoperative parenteral nutrition for radical cystectomy improves patient outcomes reinforces with a large cohort study that it does not, and in fact adds both complications and cost to the care of bladder cancer patients. Their results add to the literature on this subject and should have an important effect on urologic practice. We all know that abandoning long held beliefs is hard, but it is necessary when evidence doesn't support it.

The article by Stiff and colleagues<sup>2</sup> on the effectiveness of applying an obesity prevention “toolkit” to a primary care practice setting is another example of repeating a study in a different population as a test of generalizability. The authors applied an evidence-based collection of training, screening, and counseling developed by an academic consortium in Vermont to a community-based practice in Appleton, Wisconsin. The question was whether it would work similarly to how it did in Vermont. The answer is “yes.” The other purpose of the study was to assess whether the intervention could be implemented in a busy practice and the answer to that was “yes it can, but it costs time and effort.” Implementing opportunistic

screening makes great sense—do the work while the patient is in front of you. But adding time to already busy primary care practices with a payoff that will be a long time coming has to be paid for. Relative Value Unit productivity is not the way to value this type of work. But the positive reviews by both patients and clinicians

about the process should have other effects on morale and motivation that make it worthwhile for everyone.

Zeal and colleagues<sup>3</sup> use targeted population data—in this case all the women who had babies in 1 Wisconsin County in a year—to examine some of the factors behind those who were obese, which has a known negative effect on maternal and fetal outcome. With the evolution of electronic health records, census data, and public health information, questions can be answered with much more sophistication and the potential for much more focused interventions. The answers they find are interesting and in some cases provocative. Neighborhoods have different rates of obesity in mothers—so neighborhoods, rather than practice-based programs, might have a greater degree of success in modifying risks. Education, at least in this county, did not have an effect on rates of obesity. But the stunning data, to me at least, was that over 70% of women who delivered babies in Dane County in 2011 had a college degree or some college education, and over 50% of

babies were born to women older than 30. But further investigation showed that these trends parallel national data. The bottom line from this study is that the methods the authors use can and should be replicated in every county in the state. We need to know what is similar and what is different before we try to apply methods for

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modifying maternal obesity at the local level.

The case study on BALT lymphoma in an unusual location from Pathak and colleagues<sup>4</sup> once again reinforces the tendency for lymphomas of all types to show up where one least expects them. With the rate of non-Hodgkin lymphomas rapidly rising for the 20 years prior to the turn of the century and leveling off but still high,<sup>5</sup> it is good to keep such tumors in one's differential for many clinical presentations, either new findings or complications of existing diagnoses.

The case series by Pfaff and colleagues<sup>6</sup> from the Western part of the state on incidence of blastomycosis continues to tell the story of this ubiquitous infection. The *WMJ* has published studies from northern Wisconsin, where it is endemic,<sup>7</sup> and urban areas, where it is not,<sup>8</sup> and now from a part of the state where blastomycosis is not often suspected, but found an average of a case a year in the region.

Finally, Bakken and Kindig<sup>9</sup> build on their previous article on the Affordable Care Act's requirement that hospitals annually report their

contributions to their communities that raised a number of questions about how “community benefit” was interpreted.<sup>10</sup> Their commentary in this issue argues that the community benefit be both more transparent to the communities the hospitals serve and be directed toward tangible benefits—programs that create conditions for improving health broadly—rather than being used to make up revenue shortfalls from public insurance programs like Medicaid which, one could argue, benefit the hospitals more than the community. Their suggestion about tying the amount of benefit a community should expect to the profit margin of the hospital, particularly for nonprofit hospitals, might help bring the term “community hospital” closer to its original meaning.

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