A New Oral Antibiotic for Complicated UTI

NEJM Clinician

WEEK OF July 27th

GEORGE SAKOULAS, M.D.
JULY 21

Tebipenem is the first oral carbapenem approved to treat cUTI, including pyelonephritis.

In June 2026, the U.S. Food and Drug Administration approved the use of tebipenem pivoxil (Utebzi), an oral carbapenem, for the treatment of complicated urinary tract infection (cUTI), including pyelonephritis, in adults who have limited or no alternative oral therapeutic options.

Context

Clinicians have increasingly relied on carbapenems to treat cUTI because of a steady rise in extended-spectrum beta-lactamase (ESBL)–producing Enterobacterales in health care and community settings. ESBL-producing organisms are resistant to all oral cephalosporins and are often coresistant to quinolones and trimethoprim–sulfamethoxazole, leaving patients with cUTI with few or no oral treatment options. Carbapenems have traditionally been available only for parenteral administration; an oral carbapenem could facilitate earlier discharge of hospitalized patients and even allow some patients to avoid hospitalization altogether.

The Study Leading to Approval

Tebipenem's approval was based on a not-yet-published randomized, double-blind trial involving 1690 adults hospitalized with cUTI*, mostly in Europe. Half the patients received tebipenem 600 mg by mouth every 6 hours, and half received imipenem–cilastatin 500 mg intravenously every 6 hours. Both groups received treatment for 7 to 10 days, with test of cure around day 17.

Efficacy was evaluated in the 930 patients who had Enterobacterales pathogens isolated from their urine. Results were as follows:

- 7% of patients had concomitant bacteremia at baseline.
- 94% of the tebipenem group and 95% of the imipenem group achieved clinical cure; 58% and 60%, respectively, achieved both clinical cure and microbiological response.
- 37% of patients were infected with ESBL producers; their treatment response was similar to that of the overall study population.
- Diarrhea was slightly more common with tebipenem than imipenem (8% vs. 3%); otherwise, both drugs were well tolerated.

Other Considerations

- The dosage is two 300-mg tablets every 6 hours; a full treatment course is 7 to 10 days.
- Dose adjustment is recommended in patients with renal insufficiency.

Comment

This approval comes as bittersweet news to those of us who value timely treatment of ESBL-associated UTI but also worry about the consequences of increased carbapenem use, including selection for carbapenem-resistant Enterobacterales in the community. That said, having an oral carbapenem available for a patient with a cUTI on a Friday afternoon might spare them a weekend in the hospital awaiting outpatient parenteral treatment. Perhaps limiting dispensing by hospital pharmacies that are linked directly to urgent care centers and emergency rooms could help improve stewardship.

* In the study leading to approval, cUTI was defined as a symptomatic urinary infection with a documented pathogen in a patient who had an anatomic or functional urinary tract abnormality or was catheterized; any case of pyelonephritis was also considered a cUTI. In contrast, the Infectious Diseases Society of America recently defined cUTI as infection beyond the bladder, including pyelonephritis and febrile or bacteremic UTI.

Abstinence in Decompensated Alcohol-Related Cirrhosis: The Sooner, The Better

MOLLY S. BRETT, M.D.
REVIEWING: JOURNAL OF HEPATOLOGY
JULY 20

Clinical Takeaway: Abstinence-induced hepatic “recompensation” was associated with markedly improved survival.

Context

In patients with cirrhosis, the first decompensation is often considered a “point of no return,” but increasing evidence suggests liver disease can “recompensate” upon treatment for its cause. Hepatic recompensation — defined as removal of the cause of cirrhosis, resolution of decompensating events, and stable improvement in liver function (to Child-Pugh A or Model for End-Stage Liver Disease [MELD] <10) — is well-described in viral hepatitis but less studied in alcohol-related cirrhosis.

This multinational retrospective study followed ≈600 patients with decompensated alcohol-related cirrhosis (72% men; median MELD, 19; median age, 55) after they achieved abstinence from alcohol.

Key Results

- During a median 3 years of follow-up, 31% experienced hepatic recompensation (median time to recompensation, 15 months).
- Patients who achieved abstinence within 1 month of index decompensation had nearly double the incidence of recompensation as those with delayed abstinence (38% vs. 19%, respectively).
- No recompensated patient who maintained abstinence died of liver-related causes or developed hepatocellular carcinoma (HCC) during the 5-year study. In contrast, 17% of nonrecompensated patients died from liver-related causes and 4% developed HCC.

Comment

While it’s no surprise that abstinence improves outcomes in cirrhosis, I’m still struck by these results. Patients who achieved early abstinence were much more likely to experience recompensation, and those who did had dramatically better prognoses. Rather than viewing decompensation as a point of no return, I’ll use it as an opportunity to intensify counseling about abstinence, sharing these findings to reinforce my message.

Hofer BS, et al. Incidence and implications of abstinence-induced recompensation in alcohol-related cirrhosis. J Hepatol 2026 Jun; 84:1077. DOI: 10.1016/j.jhep.2026.01.007. PubMed

Baxdrostat Approved for Uncontrolled Hypertension

NEJM | Clinician

WEEK OF July 27th

JENNIFER L. CLUETT, M.D.
JULY 13

This first-in-class aldosterone synthase inhibitor was approved for use with other antihypertensives.

In May 2026, the U.S. Food and Drug Administration approved baxdrostat (Baxfendy) as an add-on therapy for patients who have uncontrolled hypertension despite treatment with other antihypertensive agents. This drug directly inhibits the synthesis of aldosterone, whereas the other available agents inhibiting the effect of aldosterone (e.g., spironolactone and eplerenone) block its receptor. Baxdrostat is the third recently approved treatment for this population, alongside aprocitentan and renal denervation.

Studies Leading to Approval

The key evidence supporting baxdrostat's approval came from a randomized, placebo-controlled trial involving 794 adults who had a systolic blood pressure (BP) ≥135 mm Hg despite being prescribed at least two antihypertensive medications, including a diuretic. Ninety percent were taking an angiotensin-receptor blocker or angiotensin-converting–enzyme inhibitor, and 70% were taking a calcium-channel blocker; 75% were taking three or more background antihypertensives. Mean systolic/diastolic BP at baseline was 149/87 mm Hg.

Study participants received baxdrostat 1 mg, baxdrostat 2 mg, or placebo once daily. At 12 weeks:

- Both doses of baxdrostat significantly lowered systolic/diastolic BP — by 10/4 mm Hg **beyond** placebo for the 2-mg dose and 9/3 mm Hg for the 1-mg dose.
- The most common adverse events with 2-mg baxdrostat were hyperkalemia (8%), followed by hypotension (2%) and hyponatremia (2%); lower frequencies were seen for the 1-mg dose.

Similar BP reductions were seen in a smaller randomized trial comparing 24-hour ambulatory BP monitoring averages.

Other Considerations

- The recommended initial dose is 2 mg once daily — or for patients at increased risk for hyperkalemia or hyponatremia, 1 mg once daily.
- Baxdrostat is approved for use only with other antihypertensive agents, not as initial monotherapy.

- Baxdrostat is metabolized by CYP3A enzymes. As such, concomitantly prescribed CYP3A inducers (e.g. rifampin, phenytoin, phenobarbital) may reduce its efficacy, and CYP3A inhibitors (e.g. ketoconazole, clarithromycin, fluconazole, diltiazem/verapamil) may increase the risk of adverse effects.

Comment

Baxdrostat appears to offer more impressive BP lowering than other recently approved options for uncontrolled hypertension, although limited real-world experience remains an important caveat. Still, I'm excited about this medication because it's likely to be at least as effective as the mineralocorticoid receptor antagonists (MRAs) but with fewer side effects. Gynecomastia and erectile dysfunction can limit the use of spironolactone; eplerenone has fewer side effects but is less potent and requires twice-daily dosing. A major barrier to baxdrostat is cost — with online sources quoting its retail price at roughly $1000 per month — but it's a potentially promising alternative when MRAs aren't the right fit.

How to Treat Staph aureus Bacteremia: New Evidence

HANA M. EL SAHLY, M.D.
JULY 13

Clinical Takeaway: An open-label randomized trial supports cefazolin for methicillin-susceptible bacteremia and penicillin G for penicillin-susceptible cases.

Context

Although Staphylococcus aureus bacteremia is often fatal, only low-quality data currently guide treatment decisions. In 2022, researchers launched the S. aureus Network Adaptive Platform (SNAP), a randomized, open-label, multinational trial designed to answer multiple treatment questions simultaneously. The first two analyses were recently published and involved:

- 1340 patients with methicillin-susceptible S. aureus (MSSA) bacteremia who were randomized to cefazolin or an antistaphylococcal penicillin, either flucloxacillin or cloxacillin; infections were most often osteoarticular (32%).
- 280 patients with penicillin-susceptible S. aureus (PSSA) bacteremia who were randomized to penicillin G or flucloxacillin/cloxacillin

Key Results

- In the MSSA analysis, 90-day mortality was no different between cefazolin and flucloxacillin/cloxacillin (15% vs. 17%), and cefazolin met criteria for noninferiority. Acute kidney injury (AKI) was less common with cefazolin (14% vs. 20%).
- In the PSSA analysis, a higher incidence of AKI with flucloxacillin/cloxacillin than penicillin G (22% vs. 11%) led to early closure of the study arm. At 90 days, penicillin G was associated with numerically fewer deaths (14% vs. 21%) but did not meet criteria for noninferiority.

Comment

These data are practice-changing, even here in the U.S., where nafcillin is used more often than flucloxacillin or cloxacillin but is similar enough for the results to apply. Although SNAP's open-label design is a limitation, mortality and AKI are relatively objective outcomes. I'll be watching closely to see what SNAP shows about other aspects of S. aureus bacteremia care, but this much is clear now: Cefazolin should be the drug of choice for patients with MSSA bacteremia, including those with deep-seated infection. For those with confirmed PSSA bacteremia, penicillin G is a safer choice than an antistaphylococcal penicillin.

The Staphylococcus aureus Network Adaptive Platform (SNAP) Trial Group. Cefazolin for methicillin-susceptible Staphylococcus aureus bacteremia. N Engl J Med 2026 Jun 18; 394:2329. DOI: 10.1056/NEJMoa2506905. PubMed
The Staphylococcus aureus Network Adaptive Platform (SNAP) Trial Group. Benzylpenicillin versus flucloxacillin or cloxacillin for the treatment of penicillin-susceptible Staphylococcus aureus bacteraemia (SNAP): An international, multicentre, open-label, non-inferiority randomised controlled trial. Lancet 2026 Jul 11; 408:141. DOI: 10.1016/S0140-6736(26)00761-0. PubMed

Routine Bicarb for Shock or Cardiac Arrest?

DANIEL D. DRESSLER, M.D., M.SC., M.H.M., M.A.C.P.
REVIEWING: NEW ENGLAND JOURNAL OF MEDICINE
JULY 14

Clinical Takeaway: In a word … no. Routine IV sodium bicarbonate did not improve outcomes in patients with these conditions.

Context

While metabolic acidosis is common in critical illness, studies to date have not shown a clear benefit of supplementing sodium bicarbonate (bicarb) in patients with shock requiring vasopressors or in patients during cardiac arrest. Despite the lack of evidence, bicarb is often administered to these patients. Two double-blind randomized trials now investigate whether IV sodium bicarbonate improves outcomes in patients with shock or cardiac arrest

Key Results

In one study, 500 adult ICU patients with shock requiring vasopressors and with metabolic acidosis (pH <7.3) were assigned to receive up to 5 hours of a bicarb drip or placebo.

- Bicarb did not significantly improve in-hospital mortality, need for renal-replacement therapy, or persistent renal dysfunction at 30 days.

The second study assessed nearly 800 adults with in-hospital cardiac arrest (roughly 90% with nonshockable rhythms) who were assigned to receive either bicarb IV push — 1 ampule (Amp) after the first epinephrine dose and 1 Amp after the second — or placebo.

- Bicarb did not significantly improve sustained return of spontaneous circulation, survival at 30 days, or survival at 30 days with a favorable neurologic outcome.

Comment

These studies should lay to rest the common — and usually unnecessary — practice of administering IV bicarb to some of the most critically ill ICU patients and to patients with in-hospital cardiac arrest. Bicarb did not improve outcomes, and in the case of cardiac arrest, these data support guidelines that recommend against routine bicarb administration; exceptions include when arrest is due to hyperkalemia or acidemia (e.g., ketoacidosis). I will continue to avoid routine use in patients with arrest or shock.

Citation(s):
The SODa-BIC Investigators and the Australian and New Zealand Intensive Care Society Clinical Trials Group. Sodium bicarbonate for critically ill adults with metabolic acidosis and shock. N Engl J Med 2026 Jun 12; [e-pub]. DOI: 10.1056/NEJMoa2600526. PubMed
Granfeldt A, et al. Sodium bicarbonate for in-hospital cardiac arrest: A randomized clinical trial. JAMA 2026 Jun 11; [e-pub]. DOI: 10.1001/jama.2026.10628. PubMed

Heavy Drinking and Fibrosis in MASLD

NOLAN J. MISCHEL, M.D.
REVIEWING: CLINICAL GASTROENTEROLOGY & HEPATOLOGY
JULY 10

Clinical Takeaway: Episodic heavy drinking is associated with increased risk of liver fibrosis in patients with MASLD, but current nomenclature fails to capture this high-risk group.

Context

Steatotic liver disease (SLD) is classified based on cardiometabolic risk factors and average weekly alcohol consumption as: 1) alcohol-associated liver disease (ALD); 2) metabolic and alcohol–associated liver disease (MetALD); or 3) metabolic dysfunction–associated steatotic liver disease (MASLD). Despite falling below the weekly alcohol intake threshold for MetALD,* people with MASLD may have increased risk for liver fibrosis from episodic heavy drinking

To further investigate, researchers used survey data from a nationally representative group of 8000 U.S. adults who underwent transient elastography. Episodic heavy drinking was assessed and defined as ≥4 drinks for women or ≥5 drinks for men on any day, occurring at least once per month.

Key Results

- 48% of participants were classified as having MASLD, 5% MetALD, and 2% ALD.
- 1 in 6 people with MASLD reported episodic heavy drinking; reclassifying this group as MetALD increased its prevalence from 5% to 13%.
- People with MASLD plus episodic heavy drinking had higher prevalence of fibrosis than those without episodic heavy drinking.

Comment

An important question remains unanswered: Does episodic heavy drinking increase the risk of progression of liver fibrosis the way sustained higher average intake does? If so, reclassification of these patients would aid in prognostication. Nevertheless, these results suggest we should be careful to identify binge drinking in patients with suspected MASLD and advise them about the increased risk.

*10–25 standard drinks per week for women and 15–30 for men (standard drink sizes: 12 oz. beer, 5 oz. wine, and 1.5 oz. liquor)

Su Y, et al. Episodic heavy drinking and implications for steatotic liver disease nomenclature: A national cross-sectional study. Clin Gastroenterol Hepatol 2026 Apr 2; [e-pub]. DOI: 10.1016/j.cgh.2026.03.004.

Exercise for Hypertension: What Works Best?

NEJM Clinician

WEEK OF July 13th

JEFFREY KOHLWES, M.D., M.P.H.

REVIEWING: JOURNAL OF THE AMERICAN HEART ASSOCIATION
JULY 1

Clinical Takeaway: In adults with prehypertension or hypertension, exercise lowers blood pressure, but benefits depend on the type and amount.

Context

Many forms of exercise lower blood pressure (BP) in patients with prehypertension or hypertension. This network meta-analysis, which incorporated data from 6700 participants in 105 randomized, controlled trials, addressed which type of exercise — and how much of it — best reduces BP.

Key Results

- In trials lasting at least 4 weeks, each of the following exercise modalities reduced average systolic BP by ~10 mm Hg: combined training (aerobic and resistance), high-intensity interval training, yoga, tai chi, aerobic exercise, resistance training, and isometric resistance training.
- Reductions were greater among patients with higher baseline BPs.
- When analyzed by weekly exercise volume, BP reductions became statistically significant at ~50 metabolic equivalent (MET)-minutes per week (equivalent to a 10-minute brisk walk each week) with the most pronounced effects at ~800 MET-minutes per week (equivalent to a 20-minute brisk walk each day).

Comment

In this analysis, all modalities had a clinically meaningful effect — roughly equivalent to starting a new BP medication. Practically, the best exercise plan is whichever one a patient will do consistently. Clinically, I explore the types of exercise my patients enjoy and use the WHO guidelines to recommend how much time they should move each week. This study reassures us that any form of exercise, even in small doses, can help us guide effective exercise prescriptions for our patients.

Xin X, et al. Optimal exercise modalities and dosages for blood pressure reduction in adults with prehypertension and established hypertension: A network meta-analysis and dose–response relationship study. J Am Heart Assoc 2026 May 14; 15:e044003. DOI: 10.1161/JAHA.125.044003.

Are E-Cigarettes Really Safe?

SARA TURBOW, M.D., M.P.H.
REVIEWING: NATURE MEDICINE
JULY 8

Clinical Takeaway: In a population-based study, lung cancer risk was similar in ex-smokers who used e-cigarettes and in current smokers.

Context

Electronic cigarettes (e-cigarettes) might help people quit smoking; however, their effect on lung cancer risk remains unclear. To explore the association between e-cigarette use and lung cancer, researchers conducted a retrospective cohort study of 4.5 million current and ex-smokers in the Korean national health insurance program. The investigators used 2018 survey data to define baseline smoking and e-cigarette use, and they examined lung cancer outcomes through 2023.

Key Results

- Risks for lung cancer and lung cancer–specific death were similar among ex-smokers who used e-cigarettes and current smokers.
- Former smokers who used e-cigarettes had a 50% higher risk for developing lung cancer and had twice the risk for lung cancer–related death than did ex-smokers who didn't use e-cigarettes.

Comment

As a primary care and preventive medicine physician, I have fielded a lot of patients' questions about the safety of e-cigarettes, and I certainly have had patients who felt strongly that e-cigarette use helped them quit. This study strengthens the link between e-cigarette use and cancer risk, and moving forward, I plan to encourage patients who are interested in using these products for smoking cessation to consider other options first.

Kim YW, et al. Electronic cigarette use after smoking cessation and lung cancer risk. Nat Med 2026 Jun 8; [e-pub]. DOI: 10.1038/s41591-026-04469-5. PubMed

Updates on Colorectal Cancer Screening from the ACS

NEJM Clinician

WEEK OF July 6th

CHRISTOPHER W. GOODMAN, M.D.
REVIEWING: CA: A CANCER JOURNAL FOR CLINICIANS
JUNE 24

Clinical Takeaway: New blood-based tests are included, but these are not first-line options.

An overview of Colorectal Cancer Screening: An Update to the American Cancer Society Guideline, 2026

Background

Since the last American Cancer Society (ACS) guideline on colorectal cancer screening published in 2018, data have emerged on new stool- and blood-based screening tests. As part of an updated guideline, the ACS also commissioned a systematic review on these new tests. Here, we consolidate their recommendations and findings from the systematic review.

Key Recommendations

- Colorectal cancer screening should start at age 45; however, a separate recommendation notes that the evidence for benefit outweighing harm is stronger starting at age 50.
- After age 75, screening should be individualized; clinicians should "discourage" screening after age 85.
- Preferred screening options include direct visual examination (colonoscopy every 10 years; CT colonography or flexible sigmoidoscopy every 5 years) or stool-based tests (fecal immunochemical or hemoccult testing annually; multitarget DNA or RNA testing every 3 years).
- Newer blood-based tests should be reserved for patients who decline or do not complete a preferred screening option. One blood test ("Shield") is currently FDA-approved, and another test ("SimpleScreen") is under review. The recommended screening interval is every 3 years.

Findings for Newer Blood and Stool Tests

- The updated multitarget DNA stool-based test ("Cologuard Plus") and a new multitarget RNA stool-based test ("ColoSense") were approved based on results from single trials. Both detected 94% of cancers. ColoSense was slightly more sensitive for precancerous lesions (46% vs. 43%), but Cologuard Plus had better specificity (91% vs. 86%).
- For Shield, the only FDA-approved blood test, in a single trial, the sensitivity was 88% for colorectal cancer and 13% for advanced adenomas. SimpleScreen showed similar performance to Shield but slightly lower sensitivity for cancer.

Comment

Whether to start screening at age 45 or 50 remains a matter of some debate, and this guideline gave a little to both sides. In my own practice, I offer people the option to start screening at age 45 with the caveat that this recommendation is based on studies that simulated the effects of screening at this age. Clinical trials generally started at age 50, which is also a reasonable starting point. This nuanced approach is consistent with the ACS guideline.

As for other recommendations, preferred screening options and intervals are basically unchanged, but the guidance on new stool- and blood-based tests is timely, as patients are increasingly learning about them through media coverage and advertisements. The ease of a blood test may be appealing compared with colonoscopy or stool testing, but given its poor performance at detecting precancerous lesions, blood testing should be considered only as a last resort.

Citation(s):
Wolf AMD, et al. Colorectal cancer screening: An update to the American Cancer Society guideline, 2026. CA Cancer J Clin 2026; 76:e70083. DOI: 10.3322/caac.70083.

Choosing an Antihypertensive Class in Older Adults

JENNIFER L. CLUETT, M.D. AND ALLAN S. BRETT, M.D.
REVIEWING: JOURNAL OF THE AMERICAN GERIATRICS SOCIETY
JUNE 30

Clinical Takeaway: Angiotensin-receptor blockers may have a slight edge over calcium-channel blockers.

Context

Hypertension guidelines emphasize achieving blood pressure (BP) targets but do not recommend one first-line antihypertensive class over another, and clinicians have little evidence to guide that choice in older adults. In this observational study in Japan, investigators compared outcomes after initial treatment with an angiotensin-receptor blocker (ARB) and a calcium-channel blocker (CCB) among 30,000 adults aged 75 years or older.

They adjusted for baseline differences between groups, including use of other antihypertensive medications.

Key Results

- The estimated 5-year risk of death was significantly lower with ARBs than CCBs (13% vs. 15%) despite a minimal between-group difference (<1 mm Hg) in achieved systolic BP.
- ARB use was associated with lower estimated 5-year risk for heart failure hospitalization, myocardial infarction, and stroke, with absolute differences of roughly 1 percentage point.
- Serious adverse events (decline in kidney function, hypotension requiring hospitalization, and electrolyte disorders) were infrequent in both groups.

Comment

These results suggest that ARBs may be preferable to CCBs for older adults — barring an underlying clinical reason to initiate one particular class. The 2 percentage-point difference in mortality is impressive, but keep in mind that this study was observational and not randomized. The better outcomes with ARBs may partly reflect the cardiovascular protective

Citation(s):
Noma H, et al. Angiotensin receptor blockers versus calcium channel blockers for first-line antihypertensive therapy and survival in adults aged 75 years or older. J Am Geriatr Soc 2026 Apr 26; [e-pub]. DOI: 10.1111/jgs.70463.

Are Monoclonal Antibody Therapies Worth the Risk in Mild Dementia?

JOHN C. PROBASCO, M.D.
REVIEWING: COCHRANE DATABASE OF SYSTEMATIC REVIEWS
JUNE 26

Clinical Takeaway: In this Cochrane review, amyloid-beta–targeting monoclonal antibodies had few if any cognitive or functional benefits while increasing the risk of cerebral edema.

Context

Amyloid-beta–targeting monoclonal antibody therapies (Ab-mAbs) reduce the build-up of amyloid proteins in the brain. Some Ab-mAbs (donanemab and lecanemab) are FDA-approved for the treatment of mild cognitive impairment (MCI) and mild dementia due to Alzheimer's disease (AD); however, other international agencies' decisions regarding these treatments and others in this class have been discordant. To assess clinical benefits and harms of Ab-mAbs, researchers conducted a Cochrane review of randomized controlled trials that compared a total of seven Ab-mAbs to placebo or no treatment in patients with MCI or mild AD-related dementia. They included 17 studies with more than 20,000 participants total; mean age ranged from 70 to 74 years.

Key Results

At 12 to 18 months, treatment with Ab-mAbs resulted in:

- little to no differences in cognitive function (13 studies with 10,000 participants; moderate certainty of evidence) and dementia severity (9 studies with 8,000 participants; low certainty);
- little to no difference in functional activity in 3 studies (3500 participants; moderate certainty) and small improvements in 5 studies (4000 participants; low certainty); and
- increased occurrence of one amyloid-related imaging abnormality (ARIA) with edema (107 per 1000 patients), but not ARIA with brain hemorrhage, and no increase in rates of serious adverse events or overall mortality.

Comment

At 18 months, Ab-mAbs have disappointingly minor benefits for patients with MCI or mild AD-related dementia, and they increase risk for ARIA, which can manifest with symptomatic cerebral edema or hemorrhage. Although only two studies of the two FDA-approved therapies were included, their outcomes were similar to those observed in studies of other therapies. Several ongoing studies may update the findings of this systematic review. For now, I would counsel patients on the limited expected benefits and clear risks of Ab-mAbs. I look forward to the development of treatments with different mechanisms of action and targets for Alzheimer's disease modification.

Nonino F, et al. Amyloid-beta-targeting monoclonal antibodies for people with mild cognitive impairment or mild dementia due to Alzheimer's disease. Cochrane Database Syst Rev 2026 Apr 16; 4:CD016297. DOI: 10.1002/14651858.CD016297.

Updated Cervical Cancer Screening Guidelines

NEJM | Clinician

WEEK OF June 29th

Clinical Takeaway: The WPSI now recommends primary high-risk human papillomavirus testing every 5 years as the preferred screening strategy for women 30 to 65 years of age who have an average risk of cervical cancer.

An overview of Screening for Cervical Cancer: A Recommendation from the Women's Preventive Services Initiative (2026)

Background

In January 2026, the Women's Preventive Services Initiative (WPSI), a multidisciplinary expert panel supported by the Health Resources and Services Administration, issued updated cervical cancer screening guidelines. These guidelines apply to women at average risk for cervical cancer; they do not apply to patients with HIV infection, immunosuppression, in utero diethylstilbestrol exposure, or a history of grade 2 or higher cervical dysplasia, which require individualized management. This update from the 2021 guidelines draws primarily on the evidence review commissioned for the 2024 U.S. Preventive Services Task Force cervical cancer screening recommendations, which remain in draft form. Starting in 2027, most health insurance plans must cover care in line with the new recommendations.

Key Recommendations

- All women 21 to 65 years of age should undergo cervical cancer screening.
- For women 21 to 29 years of age, cytology every 3 years remains the preferred strategy; this age group should **not** receive cytology and high-risk human papillomavirus (hrHPV) cotesting.
- For women 30 through 65 years of age, primary hrHPV testing every 5 years is now the preferred strategy. Cotesting with cytology and hrHPV every 5 years remains an acceptable alternative, as is cytology alone every 3 years where hrHPV testing is unavailable.
- Patient-collected hrHPV testing is an appropriate screening option for women 30 through 65 years of age; accuracy of patient-collected samples is equivalent to clinician-collected specimens.

Comment

The American College of Obstetricians and Gynecologists has endorsed the WPSI recommendations with qualifications, notably recommending patient-collected hrHPV testing every 3 years rather than 5 years, and only where systems for appropriate notification and follow-up are in place. This shift is already visible in clinical practice: In my own practice, self-collection has become so popular that a colleague recently remarked he could not recall the last time a patient opted for speculum-based examination. We have yet to see whether expanded access to self-sampling will translate into measurable reductions in cervical

cancer incidence and mortality among these populations, but I find the early signals encouraging.

Vosooney A, et al. Screening for Cervical Cancer: A Recommendation From the Women's Preventive Services Initiative. Obstet Gynecol 2026 Jul; 148:e3. DOI: 10.1097/AOG.0000000000006315.

Revisiting the Early Days of the Texas Measles Outbreak

ANNA WALD, M.D., M.P.H.
REVIEWING: MMWR: MORBIDITY AND MORTALITY WEEKLY REPORT
JUNE 22

Clinical Takeaway: About 20% of patients required hospitalization, and none had been vaccinated.

Context

Measles is resurging in parts of the United States where vaccine coverage has declined. In early 2025, a major outbreak in west Texas resulted in 325 cases reported in just 2 months, including 60 hospitalizations (18%). A new CDC report focuses on the 54 hospitalized patients whose medical records were available for review

Key Results

- All the patients were unvaccinated or had unknown vaccination status, and most (91%) were children.
- Some 70% of patients required supplemental oxygen, and four needed ICU care — all children.
- One child died during the study period; another died later in the outbreak from measles-related complications.
- Only 11% of patients had an underlying condition.
- Nearly one third of patients had bacterial or viral coinfections; half of all patients received antibiotics.
- Four of the five adults hospitalized were pregnant women, all in their third trimester, and two delivered infants with measles infection; one newborn developed acute measles meningoencephalitis.

Comment

This report, focusing on the first 2 months of what eventually became a 7-month outbreak involving >750 people, confirms that even in modern times, measles is a morbid disease with a high rate of complications. We have a measles vaccine that is safe and effective as shown by decades of data. I find myself in moral distress — these children are paying a high price for their parents' vaccine hesitancy.

Wang D, et al. Characteristics of patients hospitalized with measles during an outbreak — West Texas, January–March 2025. MMWR Morb Mortal Wkly Rep 2026 May 28; 75:252. DOI: 10.15585/mmwr.mm7520a1.

Updated Guidelines for Managing Migraine in the ED.

NEJM | Clinician

WEEK OF June 22nd

Clinical Takeaway: Intravenous prochlorperazine and greater occipital blocks emerged as first-line interventions.

An overview of the 2025 Guideline Update to Acute Treatment of Migraine for Adults in the Emergency Department: The American Headache Society Evidence Assessment of Parenteral Pharmacotherapies

Background

Severe headache and migraine are leading causes of emergency department (ED) presentations. During the past 10 years, more than 25 clinical trials on parenteral migraine therapies have been published, prompting the American Headache Society to release updated guidelines on adult migraine management in the ED. The guidelines are based on systematic review and meta-analysis, with expert discussion and consensus as needed. They include not only intravenous (IV) and subcutaneous (SC) medications but also nerve blocks. Recommendations for each intervention are based on the level of evidence available for improving treatment outcomes when contraindications do not exist, the consistency and magnitude of benefit, the associated costs, and the potential for harm.

Key Points

- IV prochloperazine and greater occipital nerve block have the greatest evidence supporting their use and are considered “must-offer” interventions for patients without contraindications
- IV ketorolac and IV metoclopramide should also be offered, along with SC sumatriptan and supraorbital nerve block.
- Strong evidence supports not offering IV hydromorphone.

Comment

Patients seeking ED care for migraine attacks are often in debilitating pain, and these evidence-based guidelines help clarify which treatments are most likely to help. In particular, IV prochlorperazine should now be considered before metoclopramide. Although IV diphenhydramine alone is not recommended, it should still be used as a premedication before infusion of antidopaminergic drugs. Greater occipital nerve blocks offer an appealing alternative to systemic treatment but will require clinician education and insurance coverage. Similarly, eptinezumab (MOA: CGRP; infusion q3 months) is an intriguing option because of its rapid onset and potential to reduce moderate-to-severe migraine attacks, but we need more evidence before we can routinely recommend it. Finally, the evidence against hydromorphone has become much stronger, reinforcing that it should no longer have a role in routine migraine care.

Recommendations for the Use of Various Parenteral Interventions for Treating Migraine in the Emergency Department

Recommendation	Intervention*
Must Offer	Prochlorperazine IV Greater occipital nerve blocks
Should Offer	Ketorolac IV Metoclopramide IV Sumatriptan SC Supraorbital nerve blocks
May Offer	Chlorpromazine, haloperidol, or droperidol IV Dexamethasone IV Valproate IV
May NOT Offer	Paracetamol IV Diphenhydramine IV† Morphine IV Octreotide SC/IV
Must NOT Offer	Hydromorphone IV
No recommendation	Caffeine, granisetron, ibuprofen, ketamine, lidocaine, normal saline, propofol, sphenopalatine ganglion blocks Eptinezumab (limited to clinical trials)

IV: intravenous; SC: subcutaneous

* See article for complete list of interventions, including drugs unavailable in the United States.

† Although IV diphenhydramine alone is not recommended, it should still be used as a premedication before infusion of antidopaminergic drugs.

Robblee J, et al. 2025 guideline update to acute treatment of migraine for adults in the emergency department: The American Headache Society evidence assessment of parenteral pharmacotherapies. Headache 2026 Jan; 66:53. DOI: 10.1111/head.70016.

Management of Benign Prostatic Hyperplasia: A New Guideline

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Clinical Takeaway: Although written primarily for urologists, this guideline has useful information for primary care clinicians.

An overview of Management of Lower Urinary Tract Symptoms Attributed to Benign Prostatic Hyperplasia: AUA Guideline (2026)

Background

This three-part guideline from the American Urological Association addresses (1) evaluation, (2) medical management, and (3) procedural/surgical management of benign prostatic hyperplasia (BPH). Although the target readership is urologists, the nonsurgical sections contain useful information for primary care clinicians.

Useful Points

- BPH often presents with both voiding symptoms (abnormal stream, straining, hesitancy, dribbling) and storage symptoms (frequency, urgency, nocturia, and incontinence). Isolated storage symptoms — in the absence of voiding symptoms — aren't typically BPH-related.
- Initial evaluation of men with suspected BPH should include rectal examination and urinalysis (the latter to detect infection, microscopic hematuria, and glycosuria, which might suggest other causes of lower urinary tract symptoms).
- Nonpharmacologic measures (e.g., evening fluid restriction, timed voiding, double-voiding, pelvic floor muscle training) should be recommended routinely.
- When drug therapy is initiated, alpha-blockers (tamsulosin, alfuzosin, silodosin) are nearly always first-line, and all are available as generics. Although tamsulosin is the most widely prescribed alpha-blocker, ejaculatory dysfunction is considered least likely with alfuzosin and orthostatic hypotension is considered least likely with silodosin; when orthostasis is a concern, one might consider using silodosin instead of tamsulosin. Alpha-blockers are associated with "floppy iris syndrome," a condition that complicates cataract surgery; in patients considering cataract surgery, clinicians should delay alpha-blocker therapy until after the procedure.
- The 5-alpha-reductase inhibitors (5-ARIs; finasteride and dutasteride) are effective mainly in patients with substantial prostate enlargement. Large prostate size and prostate-specific antigen (PSA) level >1.5 are predictors of response to 5-ARIs.
- Three other drug classes are discussed: phosphodiesterase-5 inhibitors (tadalafil), anticholinergics, and beta-3 agonists (i.e., vibegron, mirabegron). Tadalafil is especially useful in men with concomitant erectile dysfunction, and the other two classes are reserved for patients with predominant storage symptoms.

- In patients with substantial prostate enlargement, the combination of alpha-blocker plus 5-ARI can be more effective than either one alone; the evidence supporting other two-drug combinations among the five available drug classes (compared with monotherapies) is less compelling.

Comment

My sense is that many of us in primary care are quick to diagnose BPH in middle-aged and older men with nonacute lower urinary tract symptoms and to reflexively prescribe an alpha-blocker to most of them without further deliberation. This approach often works out, but we can improve BPH management by keeping the above-noted recommendations in mind; in fact, you might want to read fully the first two parts of the guideline, which contain additional valuable information. The third part (procedural/surgical management) reviews the various procedural options that are now being offered to patients whose symptoms aren't controlled adequately with medical management.

Citation(s):
Goueli R, et al. Management of lower urinary tract symptoms attributed to benign prostatic hyperplasia: AUA Guideline (2026) Part I: Presentation and evaluation. J Urol 2026 May 7; [e-pub]. DOI: 10.1097/JU.0000000000005097.
Goueli R, et al. Management of lower urinary tract symptoms attributed to benign prostatic hyperplasia: AUA Guideline (2026) Part II: Medical management. J Urol 2026 May 7; [e-pub]. DOI: 10.1097/JU.0000000000005098.
Goueli R, et al. Management of lower urinary tract symptoms attributed to benign prostatic hyperplasia: AUA Guideline (2026) Part III: Procedural/surgical management. J Urol 2026 May 7; [e-pub]. DOI: 10.1097/JU.0000000000005099.