HospiLink™
Linking you to the most up to date clinical information.
Volume 8, Issue 1 January 12, 2016

This newsletter includes news briefs and abstracts of the current literature related to hospice and palliative care. Since abstracts are not always accurate reflections of the content of the article, please refer to the complete journal article before making changes to practice or patient care based on the information contained in this update. Editor: Bridget McCrate Protus, PharmD, CGP, druginformation@hospiscript.com

New Regulation in Florida on Controlled Substances
Yap D

The Florida Board of Pharmacy has adopted a rule revision—on standards of practice for the filling of controlled substance prescriptions, electronic prescribing, and 2 hours of mandatory continuing education—that went into effect December 24, 2015. The rule revision was prompted by the state board's feeling—based on testimony from the general public—that perhaps the 2002 rule "was guiding pharmacists towards making a presumption that the prescription is not good," according to Florida Pharmacy Association Executive Vice President and CEO Michael Jackson, BSPharm, CPh, who served on the board's controlled substance standards committee. "The board's philosophy now is: Let's make a presumption that the prescription was issued for a specific purpose and is valid. And let's write a rule in such a way to help the pharmacist confirm validity of the prescription rather than to look at a prescription and find reasons not to fill it."

The rule revision begins with a clear statement: "The Board of Pharmacy recognizes that it is important for the patients of the State of Florida to be able to fill valid prescriptions for controlled substances. In filling these prescriptions, the Board does not expect pharmacists to take any specific action beyond exercising sound professional judgment. Pharmacists should not fear disciplinary action from the Board or other regulatory or enforcement agencies for dispensing controlled substances for a legitimate medical purpose in the usual course of professional practice. Every patient's situation is unique and prescriptions for controlled substances shall be reviewed with each patient's unique situation in mind. Pharmacists shall attempt to work with the patient and the prescriber to assist in determining the validity of the prescription."

Visit www.flrules.org and search on "64B16-27.831" to learn more about the new Florida regulation.
Full text of this news brief is available at http://www.pharmacist.com/new-regulation-florida-controlled-substances

"I Didn't Know He Was Dying": Missed Opportunities for Making End-of-Life Care Decisions for Older Family Members
Izumi S, Son Catherine

Research is limited on end-of-life care decision-making for older adults with chronic conditions whose end-of-life trajectory is difficult to predict because of their complex and frail condition. Semistructured interviews were conducted with family members of 22 deceased older adults to explore their experiences with end-of-life decision-making with/for their loved ones. Participants did not identify a specific time they made an end-of-life care decision as they did not know the older adult was at the end of life, health care providers did not ask them to make a decision, or they had to make forced decisions, and subsequently they experienced regret about the end-of-life care their family member received. End-of-life care decisions were dependent on the awareness of approaching death by participants, their loved ones, and health care providers. Health care providers being aware of the possibility of approaching death and assisting family members to make decisions that would honor the older adult's preference by explaining possible care options and what each care options would mean to them are key to providing quality end-of-life care for these individuals. *J Hosp Palliat Nurs* 2016;18(1):74-81

This newsletter includes news briefs and abstracts of the current literature related to hospice and palliative care. Since abstracts are not always accurate reflections of the content of the article, please refer to the complete journal article before making changes to practice or patient care based on the information contained in this update. Editor: Bridget McCrate Protus, PharmD, CGP, druginformation@hospiscript.com

Survival After Suspected Urinary Tract Infection in Individuals with Advanced Dementia
Dufour A, Shaffer M, D'Agata E, et al

Objectives: To determine whether antimicrobial treatment for suspected urinary tract infections (UTIs) improves survival in nursing home residents with advanced dementia. Design: Prospective cohort study. Setting: Thirty-five nursing homes in Boston, Massachusetts. Participants: Nursing home residents who experienced at least one suspected UTI over a 12-month period (N = 110); mean participant age 86.4 ± 6.2, 84% female. Measurements: Analyses were at the level of the UTI episode. Antimicrobial treatment for each suspected UTI was categorized as none, oral, intramuscular, or intravenous or hospitalization. Survival was calculated from the date of suspected UTI episode until death or last known follow-up date. Covariates included resident and episode characteristics. Cox proportional hazards regression was used to examine the association between treatment group and risk of death after adjusting for covariates. Results: Residents experienced 196 suspected UTIs over the follow-up period; 33% (n = 36) died during follow-up. There was no antimicrobial use for 25.0% of the 196 suspected UTIs, oral antimicrobial use in 59.7%; intramuscular antimicrobial use in 9.2%, and intravenous antimicrobial use or hospital transfer in 6.1%. After multivariable adjustment, antimicrobial treatment was not significantly associated with mortality (oral, adjusted hazard ratio for death (AHR) = 1.09, 95% confidence interval (CI) = 0.43–2.75; intramuscular, AHR = 0.66, 95% CI = 0.08–5.66; intravenous or hospitalization, AHR = 1.83, 95% CI = 0.44–7.60). Conclusion: Although the majority of suspected UTIs that nursing home residents with advanced dementia experienced were treated with antimicrobials, treatment was not associated with survival. *J Am Geriatr Soc* 2015;63(12):2472-2477

Sleep Problems and Associated Comorbidities Among Adults with Down Syndrome
Esbensen A

Sleep problems, including sleep apnoea and behavioural sleep disturbances, are common among adults with Down syndrome (DS). Despite a preliminary understanding of potential medical and behavioural comorbidities of these sleep problems among children with DS, little is known about comorbid conditions associated with these sleep problems among adults with DS. Understanding causes and sequelae of sleep problems in this ageing population is essential to providing quality health screening and treatment. The current study examines the physical health problems, mental health conditions, functional abilities and behavioural problems associated with sleep apnoea and behavioural sleep disturbances among adults with DS. Method: Family caregivers participated in clinical interviews and completed questionnaires, providing reports regarding 75 adults with DS. Caregivers reported on sleep problems, physical and mental health conditions, daily living skills and behaviours regarding their ageing family member with DS. Results: Sleep apnoea was associated with more common other respiratory concerns, and more frequent visits to physicians, but not with some expected medical comorbidities (cardiac). Behavioural sleep disturbances (delayed sleep onset, night-time awakenings and morning awakenings) were associated with poorer health, more frequent overnight hospital and emergency department visits, more common cardiac conditions, less common thyroid condition, more common mental health conditions (anxiety, depression and dementia) and a higher rate of daytime behaviour problems. Conclusion: The study findings suggest that there are differential correlates for the various sleep problems in adults with DS, which warrant attention when screening for medical and mental health comorbidities, assessing behavioural problems and in treatment planning for ageing adults with DS. *J Intellect Disabil Res* 2016;60(1):68-79

This newsletter includes news briefs and abstracts of the current literature related to hospice and palliative care. Since abstracts are not always accurate reflections of the content of the article, please refer to the complete journal article before making changes to practice or patient care based on the information contained in this update. Editor: Bridget McCrate Protus, PharmD, CGP, druginformation@hospiscript.com

Palliative Care Issues in Amyotrophic Lateral Sclerosis: An Evidenced-Based Review
Karam C, Paganoni S, Joyce N, et al

As palliative care physicians become increasingly involved in the care of patients with amyotrophic lateral sclerosis (ALS), they will be asked to provide guidance regarding the use of supplements, diet, exercise, and other common preventive medicine interventions. Moreover, palliative care physicians have a crucial role assisting patients with ALS in addressing health care decisions to maximize quality of life and cope with a rapidly disabling disease. It is therefore important for palliative care physicians to be familiar with commonly encountered palliative care issues in ALS. This article provides an evidenced-based review of palliative care options not usually addressed in national and international ALS guidelines. *Am J Hosp Palliat Med* 2016;33(1):84-92

Ethical Issues in Caring for Prison Inmates With Advanced Cancer
Lyckholm L, Glancey C

Prison life is difficult, and when a prisoner develops a serious illness, the difficulty is significantly compounded. The health care providers involved in the prisoners' care also face tremendous challenges in providing the best care possible while observing prison rules and the need for public safety, often in desperately underfunded, underresourced circumstances. This article includes a discussion of the ethical issues, especially justice issues, encountered in provision of care for prisoners that should, but often does not, approximate that of nonprisoner care. The history of the prison hospice movement is described. The case of a prisoner with extensive cancer and multiple symptoms is presented to highlight the ethical, existential, and practical issues encountered especially by the nurses, as well as other team members providing care for prisoners with advanced cancer. Then follows a discussion of the collaborative, compassionate approach to his care that maintained public and personal safety while optimizing symptom management and respect for his goals of care. Finally, suggestions for improving care of inmates with serious illness are provided. *J Hosp Palliat Nurs* 2016;18(1):7-12

Psychological Factors at Early Stage of Treatment as Predictors of Receiving Chemotherapy at End of Life
Fujisawa D, Temel J, Traeger L, et al

Administration of chemotherapy in the last 14 days of life is a widely recognized indicator of poor end-of-life (EOL) care. The current study aimed to investigate predictors of this outcome, focusing on patients' self-reported psychological symptoms. Methods and Materials: This is a secondary analysis of a randomized controlled trial that examined the efficacy of early palliative care integrated with standard oncology practice in patients with metastatic non-small cell lung cancer (NSCLC). We analyzed associations between receipt of chemotherapy within 14 days of death and demographic, clinical, and quality-of-life variables in the 125 patients who received chemotherapy in the course of their illness and died during the 50-month follow-up. Results: Twenty-five patients (20%) received chemotherapy within the last 14 days of their life. Among demographic and clinical variables, only route of chemotherapy was significantly associated with receipt of chemotherapy within 14 days of death (oral 34.1% vs. intravenous (IV) 12.3%, $p < 0.05$). In the subsample of participants who received IV chemotherapy as their last regimen, greater anxiety and depression and lower quality of life in emotional, social, and existential domains were associated with greater likelihood of receiving chemotherapy at the EOL. These associations were not observed in patients who received oral chemotherapy as their last regimen. Conclusion: Anxiety, depression, and worse psychological quality of life at early stage of treatment may be associated with the receipt of IV chemotherapy at the EOL. Further research is needed to examine how these factors might influence decision-making about the discontinuation of chemotherapy at the EOL. *Psycho-Oncol* 2015;24(12):1731-1737

This newsletter includes news briefs and abstracts of the current literature related to hospice and palliative care. Since abstracts are not always accurate reflections of the content of the article, please refer to the complete journal article before making changes to practice or patient care based on the information contained in this update. Editor: Bridget McCrate Protus, PharmD, CGP, druginformation@hospiscript.com

Consensus Recommendations on Initiating Prescription Therapies for Opioid-Induced Constipation
Argoff C, Brennan M, Camilleri M, et al

Objective: Aims of this consensus panel were to determine (1) an optimal symptom-based method for assessing opioid-induced constipation in clinical practice and (2) a threshold of symptom severity to prompt consideration of prescription therapy. Methods: A multidisciplinary panel of 10 experts with extensive knowledge/experience with opioid-associated adverse events convened to discuss the literature on assessment methods used for opioid-induced constipation and reach consensus on each objective using the nominal group technique. Results: Five validated assessment tools were evaluated: the Patient Assessment of Constipation–Symptoms (PAC-SYM), Patient Assessment of Constipation–Quality of Life (PAC-QOL), Stool Symptom Screener (SSS), Bowel Function Index (BFI), and Bowel Function Diary (BF-Diary). The 3-item BFI and 4-item SSS, both clinician administered, are the shortest tools. In published trials, the BFI and 12-item PAC-SYM are most commonly used. The 11-item BF-Diary is highly relevant in opioid-induced constipation and was developed and validated in accordance with US Food and Drug Administration guidelines. However, the panel believes that the complex scoring for this tool and the SSS, PAC-SYM, and 28-item PAC-QOL may be unfeasible for clinical practice. The BFI is psychometrically validated and responsive to changes in symptom severity; scores range from 0 to 100, with higher scores indicating greater severity and scores >28.8 points indicating constipation. Conclusions: The BFI is a simple assessment tool with a validated threshold of clinically significant constipation. Prescription treatments for opioid-induced constipation should be considered for patients who have a BFI score of ≥30 points and an inadequate response to first-line interventions. *Pain Med* 2015;16(12):2324-2337
Full text of this article is freely available at http://onlinelibrary.wiley.com/doi/10.1111/pme.12937/epdf

Time to Death after Terminal Withdrawal of Mechanical Ventilation: Specific Respiratory and Physiologic Parameters May Inform Physician Predictions
Long A, Muni S, Treece P, et al

Discussions about withdrawal of life-sustaining therapies often include family members of critically ill patients. These conversations should address essential components of the dying process, including expected time to death after withdrawal. Objectives: The study objective was to aid physician communication about the dying process by identifying predictors of time to death after terminal withdrawal of mechanical ventilation. Methods: We conducted an observational analysis from a single-center, before–after evaluation of an intervention to improve palliative care. We studied 330 patients who died after terminal withdrawal of mechanical ventilation. Predictors included patient demographics, laboratory, respiratory, and physiologic variables, and medication use. Results: The median time to death for the entire cohort was 0.58 hours (interquartile range (IQR) 0.22–2.25 hours) after withdrawal of mechanical ventilation. Using Cox regression, independent predictors of shorter time to death included higher positive end-expiratory pressure (per 1 cm H2O hazard ratio [HR], 1.07; 95% CI 1.04–1.11); higher static pressure (per 1 cm H2O HR, 1.03; 95% CI 1.01–1.04); extubation prior to death (HR, 1.41; 95% CI 1.06–1.86); and presence of diabetes (HR, 1.75; 95% CI 1.25–2.44). Higher noninvasive mean arterial pressure predicted longer time to death (per 1 mmHg HR, 0.98; 95% CI 0.97–0.99). Conclusions: Comorbid illness and key respiratory and physiologic parameters may inform physician predictions of time to death after withdrawal of mechanical ventilation. An understanding of the predictors of time to death may facilitate discussions with family members of dying patients and improve communication about end-of-life care. *J Palliat Med* 2015;18(12):1040-1047