

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

Communication about Sexuality in Advanced Illness Aligns With a Palliative Care Approach to Patient-Centered Care

Leung M, Goldfarb S, Dizon D

Treatment-related sexual complications are common in cancer patients although rarely discussed in the palliative care setting. Sexuality is an important survivorship issue and remains relevant even in the terminal setting. There are multiple barriers in dialoguing about intimacy and sexual functioning from the patient and provider perspectives. Palliative care providers, while not expected to be sexual health experts, can provide comprehensive patient-centered care by including sexual health as part of their evaluation. They can explore how sexual dysfunction can impair functioning and utilize an interdisciplinary approach to manage symptoms. Palliative care providers can help patients identify their goals of care and explore what anticipated sexual changes and treat-related side effects are tolerable and intolerable to the patient's quality of life. Principles on addressing sexuality in the palliative setting and practical ways of incorporating sexual history into the palliative care assessment are provided. *Curr Oncol Rep* 2016;18(2):11

Pain in Amyotrophic Lateral Sclerosis: Patient and Physician Perspectives and Practices

Stephens H, Lehman E, Raheja D, et al

Our objective was to better understand the experience and impact of pain on ALS patients in the U.S., and to survey ALS physicians on their pain assessment and management practices. Individuals with ALS were invited to complete an online survey of pain in ALS. ALS specialist physicians were sent an e-mail survey about their experiences in evaluating and managing patients' pain. Nearly 75% of patients with ALS reported significant pain, and most thought that ALS was the source of at least some of this pain. Pain intensity scores (mean 3.9/10) and pain interference scores (mean 4.3/10) were moderate on average, but nearly 80% of participants were using pain medication, including 22% using opioids. Nearly 25% of patients thought they needed stronger pain medication than they were receiving. Physicians generally assess and manage pain in ALS patients, but few use standardized assessment tools. Nearly two-thirds felt that there is a need for better pain management practices and more than one-third felt better training was needed. In conclusion, pain in patients with ALS is not always well controlled. Improvement in care may be facilitated by a more standardized approach to evaluation, and by additional education and training of ALS health care professionals. *Amyotroph Lateral Scler Frontotemporal Degener* 2015;17(1-2)21-9

Survival Prognosis in Very Old Adults

Thinggaard M, McGue M, Jeune B, et al

Objectives: To determine whether simple functional indicators are predictors of survival prognosis in very old adults. Design: In-person survey conducted over a 3-month period in 1998; assessment of survival over a 15-year follow-up period. Setting: Denmark. Participants: All 3,600 Danes born in 1905 and living in Denmark in 1998, were invited to participate regardless of residence and health; 2,262 (63%) participated in the survey: 1,814 (80.2%) in person and 448 (19.8%) through a proxy. Measurements: Socioeconomic factors, medications and diseases, activities of daily living, physical performance, cognition, depression symptomatology, self-rated health, and all-cause mortality, evaluated as average remaining lifespan and chance of surviving to 100 years. Results: Men aged 92 to 93 had an overall 6.0% chance of surviving to 100 years, whereas the chance for women was 11.4%. Being able to rise without use of hands increased the chance for men to 11.2% (95% confidence interval (CI) = 7.7–14.7) and for women to 22.0% (95% CI = 18.9–25.1). When combining this with a Mini-Mental State Examination (MMSE) scores from 28 to 30, the chances were 21.7% (95% CI = 11.5–31.9) for men and 34.2% (95% CI = 24.8–43.5) for women. Conclusion: Chair stand score combined with MMSE score is a quick and easy way to estimate overall chance of survival in very old adults, which is particularly relevant when treatment with potential side effects for nonacute diseases is considered. *J Am Geriatr Soc* 2016; 64(1):81-88

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Progresses in Treating Agitation: a Major Clinical Challenge in Alzheimer's Disease

Panza F, Solfrizzi V, Seripa D, et al

Treatment of neuropsychiatric symptoms (NPS) represents a major clinical challenge in Alzheimer's disease (AD). Agitation and aggression are frequently seen during institutionalization and increase patient morbidity and mortality and caregiver burden. Off-label use of atypical antipsychotics for treating agitation in AD showed only modest clinical benefits, with high side-effect burden and risk of mortality. Non-pharmacological treatment approaches have become the preferred first-line option. When such treatment fails, pharmacological options are often used. Therefore, there is an urgent need to identify effective and safe pharmacological treatments for efficiently treating agitation and aggression in AD and dementia. Areas covered: Emerging evidence on the neurobiological substrates of agitation in AD has led to several recent clinical trials of repositioned and novel therapeutics for these NPS in dementia as an alternative to antipsychotics. We operated a comprehensive literature search for published articles evaluating pharmacological interventions for agitation in AD, with a review of recent clinical trials on mibampator, dextromethorphan/quinidine, cannabinoids, and citalopram. Expert opinion: Notwithstanding the renewed interest for the pharmacological treatment of agitation in AD, progresses have been limited. A small number and, sometimes methodologically questionable, randomized controlled trials (RCTs) have produced disappointing results. However, recently completed RCTs on novel or repositioned drugs (mibampator, dextromethorphan/quinidine, cannabinoids, and citalopram) showed some promise in treating agitation in AD, but still with safety concerns. Further evidence will come from ongoing Phase II and III trials on promising novel drugs for treating these distressing symptoms in patients with AD and dementia. *Exp Opin Pharmacother* 2015;16(17):2581-2588

Full text of this article is freely available at <http://www.tandfonline.com/doi/full/10.1517/14656566.2015.1092520>

Why Do Home Hospice Patients Return to the Hospital? A Study of Hospice Provider Perspectives

Phongtankuel V, Scherban B, Reid M, et al

Hospice provides an opportunity for patients to receive care at home at the end of life (EOL); however, approximately 25% of patients who disenroll from hospice are hospitalized. Hospitalization can lead to poor care transitions and result in unwarranted care and adverse patient outcomes. Research examining reasons for hospitalization in this patient population is limited. Objective: The objective was to understand the reasons for hospitalization among home hospice patients through the perspectives of hospice interdisciplinary team (IDT) members. Methods: This was a qualitative study using a grounded theory approach. Seven semistructured focus group were conducted to solicit reasons for hospitalization among home hospice patients. Participants consisted of 73 home hospice IDT members from a not-for-profit hospice agency in New York City. Focus group recordings were transcribed and analyzed using content analysis. Results: Eight major themes were identified: (1) not fully understanding hospice, (2) lack of clarity about disease prognosis, (3) desire to continue receiving care from nonhospice physicians and hospital, (4) caregiver burden, (5) distressing/difficult-to-manage signs and symptoms, (6) caregivers' reluctance to administer morphine, (7) 911's faster response time compared to hospice, and (8) families' difficulty accepting patients' mortality. Conclusions: Reasons for hospitalization in home hospice patients are multifactorial and complex. Our study highlights barriers and challenges that patients, families, physicians, and hospices face around home hospice care and hospitalization. More research is needed to elucidate these issues and develop viable strategies to address them. *J Palliat Med* 2015;19(1):51-56

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Choosing a Wound Dressing Based on Common Wound Characteristics

Dabiri G, Damstetter E, Phillips T

Chronic wounds are a major healthcare burden. The practitioner should have an appropriate understanding of both the etiology of the wound as well as the optimal type of dressings to use. Fundamental wound characteristics may be used to guide the practitioner's choice of dressings. The identification of optimal dressings to use for a particular wound type is an important element in facilitating wound healing. Recent Advances: Researchers have sought to design wound dressings that aim to optimize each stage in the healing process. In addition, dressings have been designed to target and kill infection-causing bacteria, with the incorporation of antimicrobial agents. Critical Issues: Chronic wounds are frequently dynamic in presentation, and the numerous wound dressings available make dressing selection challenging for the practitioner. Choosing the correct dressing decreases time to healing, provides cost-effective care, and improves patient quality of life. Future Directions: Research into the mechanisms of wound healing has enhanced our ability to heal chronic wounds at a faster rate through the use of moisture-retentive dressings. Newer dressings are incorporating the use of nanotechnology by incorporating miniature electrical sensors into the dressing. These dressings are engineered to detect changes in a wound environment and alert the patient or practitioner by altering the color of the dressing or sending a message to a smartphone. Additional investigations are underway that incorporate biologic material such as stem cells into dressings. *Adv Wound Care* 2016;5(1):32-41

Chemotherapy Use, Performance Status, and Quality of Life at the End of Life

Prigerson H, Bao Y, Shah M, et al

Although many patients with end-stage cancer are offered chemotherapy to improve quality of life (QOL), the association between chemotherapy and QOL amid progressive metastatic disease has not been well-studied. American Society for Clinical Oncology guidelines recommend palliative chemotherapy only for solid tumor patients with good performance status. Objective To evaluate the association between chemotherapy use and QOL near death (QOD) as a function of patients' performance status. Design, Setting, and Participants A multi-institutional, longitudinal cohort study of patients with end-stage cancer recruited between September 2002 and February 2008. Chemotherapy use (n = 158 [50.6%]) and Eastern Cooperative Oncology Group (ECOG) performance status were assessed at baseline (median = 3.8 months before death) and patients with progressive metastatic cancer (N = 312) following at least 1 chemotherapy regimen were followed prospectively until death at 6 outpatient oncology clinics in the United States. Main Outcomes and Measures Patient QOD was determined using validated caregiver ratings of patients' physical and mental distress in their final week. Results Chemotherapy use was not associated with patient survival controlling for clinical setting and patients' performance status. Among patients with good (ECOG score = 1) baseline performance status, chemotherapy use compared with nonuse was associated with worse QOD (odds ratio [OR], 0.35; 95% CI, 0.17-0.75; P = .01). Baseline chemotherapy use was not associated with QOD among patients with moderate (ECOG score = 2) baseline performance status (OR, 1.06; 95% CI, 0.51-2.21; P = .87) or poor (ECOG score = 3) baseline performance status (OR, 1.34; 95% CI, 0.46-3.89; P = .59). Conclusions and Relevance Although palliative chemotherapy is used to improve QOL for patients with end-stage cancer, its use did not improve QOD for patients with moderate or poor performance status and worsened QOD for patients with good performance status. The QOD in patients with end-stage cancer is not improved, and can be harmed, by chemotherapy use near death, even in patients with good performance status. *JAMA Oncol* 2015;1(6):778-784

Full text of this article is freely available at <http://oncology.jamanetwork.com/article.aspx?articleid=2398177>

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Family Perspectives on Aggressive Cancer Care Near the End of Life

Wright A, Keating N, Ayanian J, et al

Patients with advanced-stage cancer are receiving increasingly aggressive medical care near death, despite growing concerns that this reflects poor-quality care. Objective To assess the association of aggressive end-of-life care with bereaved family members' perceptions of the quality of end-of-life care and patients' goal attainment. Design, Setting, and Participants Interviews with 1146 family members of Medicare patients with advanced-stage lung or colorectal cancer in the Cancer Care Outcomes Research and Surveillance study (a multiregional, prospective, observational study) who died by the end of 2011 (median, 144.5 days after death; interquartile range, 85.0-551.0 days). Exposures Claims-based quality measures of aggressive end-of-life care (ie, intensive care unit [ICU] admission or repeated hospitalizations or emergency department visits during the last month of life; chemotherapy ≤ 2 weeks of death; no hospice or ≤ 3 days of hospice services; and deaths occurring in the hospital). Main Outcomes and Measures Family member–reported quality rating of “excellent” for end-of-life care. Secondary outcomes included patients' goal attainment (ie, end-of-life care congruent with patients' wishes and location of death occurred in preferred place). Results Of 1146 patients with cancer (median age, 76.0 years [interquartile range, 65.0-87.0 years]; 55.8% male), bereaved family members reported excellent end-of-life care for 51.3%. Family members reported excellent end-of-life care more often for patients who received hospice care for longer than 3 days (58.8% [352/599]) than those who did not receive hospice care or received 3 or fewer days (43.1% [236/547]) (adjusted difference, 16.5 percentage points [95% CI, 10.7 to 22.4 percentage points]). In contrast, family members of patients admitted to an ICU within 30 days of death reported excellent end-of-life care less often (45.0% [68/151]) than those who were not admitted to an ICU within 30 days of death (52.3% [520/995]) (adjusted difference, -9.4 percentage points [95% CI, -18.2 to -0.6 percentage points]). Similarly, family members of patients who died in the hospital reported excellent end-of-life care less often (42.2% [194/460]) than those who did not die in the hospital (57.4% [394/686]) (adjusted difference, -17.0 percentage points [95% CI, -22.9 to -11.1 percentage points]). Family members of patients who did not receive hospice care or received 3 or fewer days were less likely to report that patients died in their preferred location (40.0% [152/380]) than those who received hospice care for longer than 3 days (72.8% [287/394]) (adjusted difference, -34.4 percentage points [95% CI, -41.7 to -27.0 percentage points]). Conclusions and Relevance Among family members of older patients with fee-for service Medicare who died of lung or colorectal cancer, earlier hospice enrollment, avoidance of ICU admissions within 30 days of death, and death occurring outside the hospital were associated with perceptions of better end-of-life care. These findings are supportive of advance care planning consistent with the preferences of patients. *JAMA* 2016;315(3):284-292