Use of Unnecessary Medications by Patients with Advanced Cancer
Fede A, Miranda M, Antonangelo D, Trevizan L, et al

Cancer patients at the end of life take numerous medications. However, it has not been assessed what proportion of patients take unnecessary medications and which patients are at risk for doing so.

Methods: Cross-sectional survey of medications utilized by terminally ill ambulatory cancer patients, with the aim of identifying medications considered unnecessary as per explicit criteria. The criteria took into account whether drugs could benefit patients with terminal cancer. Results: Among 87 patients, 21 (24%, 95% confidence interval [CI] 15.6–34.5%) were taking at least one unnecessary medication, the most common being gastric protectors. In multivariable analyses, patients with Charlson Comorbidity Index ≤ 1 (OR: 4.49, CI95% 1.32–15.26; p = 0.01) or whose medication list had not been reconciled by physicians (OR: 6.38, CI95% 1.21–33.40; p = 0.02) were more likely to use an unnecessary medication. Conclusion: Patients with advanced cancer take many medications considered unnecessary. Medication reconciliation should be performed routinely for these patients. Support Care Cancer 2011;19(9):1313-1318

The Impact of a Multidisciplinary Educational Intervention to Reduce PEG Tube Placement in Patients with Terminal-Stage Dementia: A Translation of Research into Practice
Campbell ML, Dove-Medows E, Walch J, Sanna-Gouin K, Colomba S

The purpose of this translation of research into practice (TRIP) project was to to determine the impact of a multidisciplinary education-consultation intervention to reduce percutaneous endoscopic gastrostomy (PEG) tube placement in patients with terminal-stage dementia at a single urban hospital in a city characterized by numerous health care transitions. We attempted a “just-in-time” approach to educate busy clinicians through explicit recommendations offered during routine and requested consultation. The project results showed that the intervention had a modest positive clinical impact.

We found no statistical significance between groups with regard to PEG tube placement, and this is certainly because of a very small sample, particularly in the intervention group. However, a clinical trend toward fewer PEG tube placements in this patient population can be predicted as we continue the intervention. The palliative care team is receiving requests for supportive documentation about the nonbenefit of PEG tubes that we have not received previously. Most of the physicians who admit patients to this hospital are academic faculty, and although the trainees rotate to other sites, the attending/faculty is relatively stable, which should enhance the enculturation of PEG tube evidence. J Palliat Med 2011;14(9):1017-1021
Nausea, Pain, Fatigue, and Multiple Symptoms in Hospitalized Children with Cancer
Miller E, Jacob E, Hockenberry MJ

Purpose/Objectives: To describe the prevalence, frequency, severity, and distress of multiple symptoms in hospitalized children with cancer and to examine the overall symptom scores and global distress in patients reporting nausea, pain, and fatigue. Design: Descriptive design with repeated measures. Setting: Inpatient pediatric hematology-oncology unit. Sample: 39 inpatients (ages 10-17) diagnosed with cancer. Methods: Five-day data collection using the Memorial Symptom Assessment Scale (MSAS) Pediatric 10-18. Main Research Variables: Thirty-one symptoms included in the MSAS Pediatric 10-18.Findings: The most common symptoms (prevalence greater than 34%) were nausea, fatigue, decreased appetite, pain, and feeling drowsy. Differences in symptom experiences occurred in the presence of nausea, pain, and fatigue compared to days when they were not reported (p < 0.001). Prevalence of pain and fatigue symptoms decreased over the five days (p < 0.05), but not nausea (p > 0.05). Conclusions: Nausea, pain, and fatigue were among the most prevalent symptoms in hospitalized children with cancer; however, the most prevalent symptoms were not always the most severe or distressing. The presence of these symptoms significantly impacted symptom experience, including total burden of symptoms experienced by the child (i.e., global distress). Implications for Nursing: Additional examination of symptom management is needed. Nausea and its related symptoms have received little attention and more effective interventions are warranted. Multidimensional scales and the use of handheld electronic devices to track symptoms may be used to provide a more comprehensive assessment and treatment of symptoms. *Oncol Nurs Forum* 2011; 38(5):E382-93

Adherence to Clinical Guidelines for Opioid Therapy in Chronic Pain in Patients with Substance Use Disorder
Morasco BJ, Duckart JP, Dobscha SK

Patients with chronic non-cancer pain (CNCP) have high rates of substance use disorders (SUD). SUD complicates pain treatment and may lead to worse outcomes. Objective: Examine adherence to clinical guidelines for opioid therapy over 12 months, comparing patients with SUD diagnoses made during the prior year to patients without SUD. Administrative data were collected from veterans with CNCP receiving treatment within a US Veterans Affairs regional healthcare network who were prescribed chronic opioid therapy in 2008 (n = 5814). Key Results: 20% of CNCP patients prescribed chronic opioid therapy had a prior-year diagnosis of SUD. Patients with SUD were more likely to have pain diagnoses and psychiatric comorbidities. Patients with SUD were more likely than those without SUD to have had a mental health appointment (29.7% vs 17.2%) and a urine drug screen (UDS) (47.0% vs 18.2%) over 12 months. There were no significant differences between groups on receiving more intensive treatment in primary care, long-acting opioids, prescriptions for antidepressants among patients with depression, or participating in physical therapy. Only 35% of patients with SUD received substance abuse treatment. Conclusions: CNCP patients with SUD were more likely to have mental health appointments and receive UDS monitoring, but not more likely to participate in other aspects of pain care compared to those without SUD. Given data suggesting patients with comorbid SUD may need more intensive treatment to achieve improvements in pain-related function, SUD patients may be at high risk for poor outcomes. *J Gen Intern Med* 2011;26(9):965-971
The Intersection of the Medicare End Stage Renal Disease (ESRD) Benefit and Hospice: An Overview for Home Care and Hospice Clinicians
Castner D, Bednarski D

End-of-life care is underutilized in patients with kidney failure despite high mortality and multiple comorbid conditions. Recent revisions in the Medicare Benefit Policy Manual and the Conditions for Coverage for End-Stage Renal Disease provide a clearer understanding for referral to palliative and hospice care. Unfortunately, there is a significant underutilization of hospice with the ESRD population. The 2010 United States Renal Data System (USRDS) data demonstrate that of the 20,854 patients who withdrew from dialysis in 2009, only 13,502 used hospice. Of patients who withdrew from dialysis in 2009, 65% used hospice, compared with just 6% of patients who continued dialysis through death. Overall, only 21% of all dialysis patients who died in 2009 used hospice. There are many identified barriers to palliative and hospice care. One significant issue encountered surrounds the patient who chooses to continue dialysis treatments while in hospice. Although there are many hospices that do accept patients on dialysis, there are many that do not. There is also a failure to discuss or communicate prognosis and advanced care planning due to the inability to predict mortality reliably. Prognosis can also be unrealistic among providers. Without proper communication of realistic prognosis patients are unable to make informed decisions and avoid unnecessary and futile treatments and are not afforded an opportunity to benefit from advanced care planning and hospice services. To compound this issue, clinician education and experience on end-of-life content is not routinely included in basic training for nurses or physicians. For dialysis patients, the nurses are experts in dialysis care and not necessarily in advance care planning or comprehensive symptom control. There is also a lack of education of patients/families on the benefit of hospice. With the availability of technologies that can prolong life (dialysis, feeding tubes, etc.) there can be an expectation by the patient or family for a cure. To prevent delays or hesitation of a patient's transfer to the palliative care team, a comprehensive plan for the transfer of care should be established. CKD is a major public health problem and end-of-life care is underutilized in this patient population. Prognostication can be variable; however, there are several predictors to determine poor prognosis. Although a complicated population to care for, there are several resources available to assist healthcare providers. Obtaining specific education on this topic can improve outcomes for CKD end-of-life care and promote future research and best practices. *Home Healthcare Nurse* 2011;29(8):464-476

This complete text of this article is freely available from: http://journals.lww.com/homehealthcarenurseonline/Fulltext/2011/09000
Effects of Healing Touch in Clinical Practice: a Systematic Review of Randomized Clinical Trials
Anderson JG, Taylor AG

Hands-on healing and energy-based interventions have been found in cultures throughout history around the world. These complementary therapies, rooted in ancient Eastern healing practices, are becoming mainstream. Healing Touch, a biofield therapy that arose in the nursing field in the late 1980s, is used in a variety of settings (i.e., pain centers, surgical settings, and private practices) with reported benefits (i.e., decreased anxiety, pain, and depressive behaviors; increased relaxation and a sense of well-being). However, clinical trial data concerning the effectiveness of Healing Touch have not been evaluated using a systematic, evidence-based approach. Thus, this systematic review is aimed at critically evaluating the data from randomized clinical trials examining the clinical efficacy of Healing Touch as a supportive care modality for any medical condition. J Holistic Nursing 2011;29(3):221-228

Factors Predicting Requirement of High-dose Transdermal Fentanyl in Opioid Switching from Oral Morphine or Oxycodone in Patients with Cancer Pain
Kanbayashi Y, Hosokawa T, Okamoto K, et al

Objectives: To identify predictive factors requiring high-dose transdermal fentanyl in opioid switching from oral morphine or oxycodone to transdermal fentanyl in patients with cancer pain. Methods: The participants were 76 hospitalized terminal cancer patients who underwent opioid switching from oxycodone or morphine sustained-release tablet to transdermal fentanyl at our hospital between January 2009 and June 2010. The conversion dose was calculated as transdermal fentanyl (25 μg/h)/oral morphine (60 mg) or oxycodone (40 mg)=1. The response evaluated was the dose conversion ratio [transdermal fentanyl/oral morphine or oxycodone (conversion dose to fentanyl)]=Y and was taken to be 0 for Y≤1, 1 for 1<Y≤2, 2 for 2<Y≤3, and 3 for 3<Y. Predictors evaluated were factors potentially impacting pain. Ordered logistic regression analysis was carried out to identify the predictive factors requiring high-dose transdermal fentanyl in opioid switching. Results: Breast cancer [odds ratio (OR)=8.218], total protein level (OR=0.630), alanine minotransferase level (OR=1.017), advanced age (OR=3.700), and male sex (OR=3.702) were found to be significant predictive factors requiring high-dose transdermal fentanyl in opioid switching. Our results are considered likely to contribute to the establishment of evidence-based medicine in pain relief and palliative care. Clin J Pain 2011;27(8):664-667
Healthcare Experiences of Families Affected by Huntington’s Disease: Need for Improved Care
Etchegary H

Objectives: To explore the healthcare experiences of families affected by Huntington disease (HD), a fatal neurodegenerative genetic disorder, and elicit their suggestions for improvement in the quality of care provided to them. Methods: 24 semi-structured interviews were completed with members of families affected by HD in Eastern Canada. The sample was chosen to reflect a wide range of experiences with HD (e.g. patients, caregivers, family members at risk, but asymptomatic). Results: Complex needs for healthcare services and emotional supports were found. Participants expressed frustration at the lack of knowledge about HD displayed by their family physicians. They described numerous difficulties accessing appropriate healthcare and other supports, and anticipated access difficulties in the future. Participants offered several suggestions to improve the quality of care to their families, including better education of healthcare professionals about the complex nature of HD and the provision of regular follow-up support. Discussion: Health service planners and policy makers must recognize that HD is a debilitating, complicated illness requiring a high degree of care. Sustained follow-up support from knowledgeable healthcare professionals is required from the initial discovery of HD in the family, throughout a lengthy disease trajectory that normally ends with institutionalization. Chronic Illness 2011;7(3):225-238

Switching from oxycodone to methadone in advanced cancer patients
Mercadante S, Ferrera P, Villari P, Adile C, Casuccio A

Purpose: The aim of this study was to prospectively evaluate the outcomes and the conversion ratio of switching from oxycodone to methadone in advanced cancer patients admitted to an acute palliative care unit. Patients and methods: A prospective study was carried out on a cohort of consecutive sample of patients receiving oxycodone, who were switched for different reasons mainly because of an inconvenient balance between analgesia and adverse effects. An initial conversion ratio between oxycodone and methadone was 3.3:1. Intensity of pain and symptoms associated with opioid therapy were recorded, and a distress score (DS) was also calculated as a sum of symptom intensity. A successful switching was considered when the intensity of pain and/or DS or the principal symptom requiring switching decreased at least of 33% of the value recorded before switching. Results: Nineteen out of 542 patients admitted to the unit in 1 year underwent a switching from oxycodone to methadone. Almost all substitutions were successful. The prevalent indication for opioid switching was uncontrolled pain and adverse effects (12 patients). No significant changes between the initial conversion ratio and final conversion ratio between the two opioids were found. Conclusion: Switching from oxycodone to methadone is a reliable method to improve the opioid response in advanced cancer patients. A ratio of 3.3 appears to be reliable, even at high doses. Further studies should be performed to confirm these results in other settings and with very high doses of oxycodone. Support Care Cancer epub/onlinefirst: 2011
Treating Nausea and Vomiting in Palliative Care: A Review
Glare P, Miller J, Nikolova T, Tickoo R

Nausea and vomiting are portrayed in the specialist palliative care literature as common and distressing symptoms affecting the majority of patients with advanced cancer and other life-limiting illnesses. However, recent surveys indicate that these symptoms may be less common and bothersome than has previously been reported. The standard palliative care approach to the assessment and treatment of nausea and vomiting is based on determining the cause and then relating this back to the “emetic pathway” before prescribing drugs such as dopamine antagonists, antihistamines, and anticholinergic agents which block neurotransmitters at different sites along the pathway. However, the evidence base for the effectiveness of this approach is meager, and may be in part because relevance of the neuropharmacology of the emetic pathway to palliative care patients is limited. Greater awareness of drug interactions and QTc prolongation are emerging concerns for all age groups. The selective serotonin receptor antagonists are the safest antiemetics, but are not used first-line in many countries because there is very little scientific rationale or clinical evidence to support their use outside the licensed indications. Advances in interventional gastroenterology are increasing the options for nonpharmacological management. Despite these emerging issues, the approach to nausea and vomiting developed within palliative medicine over the past 40 years remains relevant. It advocates careful clinical evaluation of the symptom and the person suffering it, and an understanding of the clinical pharmacology of medicines that are available for palliating them. Clin Interventions Aging 2011;6:243-259

FDA Safety Communication: Abnormal Heart Rhythms May Be Associated with Zofran (Ondansetron)
September 15, 2011
The FDA notified healthcare professionals of an ongoing safety review and labeling changes for the anti-nausea drug ondansetron. Ondansetron may increase the risk of developing prolongation of the QT interval of the electrocardiogram, which can lead to an abnormal and potentially fatal heart rhythm, including Torsade de Pointes. Patients at particular risk for developing Torsade de Pointes include those with underlying heart conditions, such as congenital long QT syndrome, those who are predisposed to low levels of potassium and magnesium in the blood, and those taking other medications that lead to QT prolongation. Recommendations for ECG monitoring in patients with electrolyte abnormalities, CHF, bradyarrhythmias, or in patients taking other medications that can lead to QT prolongation, are being included in the labels.

Additional details pertaining to the FDA Safety Announcement can be found at:

For additional hospice and palliative care focused clinical information, including symptom management algorithms and medication dosing recommendations, please refer to the Palliative Care Consultant-3rd edition. The PCC was produced through a collaborative relationship with the Ohio Hospice & Palliative Care Organization (OHPCO), the Ohio Home Care Organization (OHCO), and Hospiscript Services, LLC. Your Hospiscript account manager can provide ordering information or visit www.hospiscript.com.

Follow us on Facebook and Twitter:
http://www.facebook.com/pallcare.hospice
http://www.twitter.com/Hospiscript

Please Note: This newsletter includes news briefs and abstracts of the current literature related to hospice and palliative care. Because 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