2008
Issue 4 - MP

From the desk of:

Deb Blue, M.D.
Medical Director
Hospice of Wake County

On a monthly basis I am sending out a brief newsletter from Hospice of Wake County with information pertinent to end-of-life care.

WHAT MEDICATIONS SHOULD BE STOPPED WHEN SOMEONE ENTERS HOSPICE CARE?

The easiest way to think about this is to say *"what medications are going to keep the patient most comfortable?"* Typically, continuing medications such as diuretics, b-blockers, L-thyroxine, anti-hypertensives, bronchodilators, and pain medications do keep patients comfortable.

Medications like the statins offer nothing to someone with a life expectancy of less than six months and can be discontinued. Certainly, medications can be discontinued once someone loses the ability to swallow or no longer wants to take medication.

Cost can sometimes be a consideration in discontinuing medications or at least substituting a less expensive alternative. Once someone enters hospice, all of their diagnosis-related medications are covered under the Medicare Part A benefit (rather than Part D), and the dollars for these medications come out of the per diem paid for their care. Imprudent use of medications costing hundreds or sometimes thousands of dollars per month can unnecessarily erode the funds that make other types of care possible. While sometimes this is unavoidable, Hospice of Wake County is committed to ensuring patients receive the medications they need. Where there are less expensive, safe and reasonable alternatives, it makes good sense to consider switching.

We are committed to providing the highest quality hospice services to anyone with a prognosis of six months or less if the disease follows its natural progression.

For referrals or any questions, please call 919-828-0890.

Deb Blue, M.D.

Medical Director
Hospice of Wake County

Increasingly Late Referral to Palliative Care Found Among Cancer Patients

"Access to palliative care at our comprehensive cancer center is still occurring late in the trajectory of the disease, with a trend towards decrease rather than increase — which may provide neither enough beneficial time for our patients and their families nor a seamless transition to other community care programs such as hospice," the authors write.

The length of time between referral of patients with advanced cancer to palliative care services and their deaths is not only short, it is getting shorter, a team of researchers at the University of Texas M.D. Anderson Cancer Center in Houston has found. "Most referrals to palliative care and hospice occur late in the trajectory of the disease, although an earlier intervention could decrease patients' symptom distress," the researchers write in their report published in a recent issue of the *Journal of Palliative Medicine*.

The team reviewed the charts of 2,868 consecutive patients (female, 49%; white, 70%; median age, 60 years) who were diagnosed at the center with advanced cancer, and who had their first palliative care consult between April 2003 and September 2005.

Because the cancer center's palliative care department is involved in the care of patients, whether or not they are receiving chemotherapy or other cancer treatments, the investigators anticipated that the interval between access to acute palliative care and death would increase over the 30-month study period.

FINDINGS INCLUDE:

- Median length of time from first palliative care consult to death was 42 days.
- Over five half-year periods, this interval decreased from a median of 46 to 34 days.
- However, the number of patients accessing acute palliative care during the same period increased by 20%.

EARLIER ACCESS TO PALLIATIVE CARE WAS FOUND AMONG:

- Patients with solid tumor
- Younger patients (< 65 years old)
- Females

The median consult-to-death interval was more than three times longer in patients with solid cancers than in those with liquid tumors (48 vs 14 days). The authors suggest this could be because patients with hematologic malignancies (leukemia, lymphoma, myeloma) experience lower frequency of sentinel symptoms such as major pain syndromes and cachexia, and are thus often referred to palliative care services closer to death.

Further, there are viable treatment options available for patients with liquid tumors, even in advanced disease, but a lack of reliable indicators of refractory disease, the authors add. In a previous study at their cancer center, the investigators found hematologic malignancy to be the highest predictor of death in a hospital.

The authors recommend the development of palliative care programs targeted to the specific needs of patients with hematologic malignancies, and further studies to determine the trend of access to acute palliative care. "Prospective studies are needed to establish the appropriate timing of the first palliative care consultation."

Source: "Interval between First Palliative Care Consult and Death in Patients Diagnosed with Advanced Cancer at a Comprehensive Cancer Center," Journal of Palliative Medicine; January 2008; 11(1):51-57. El Osta B, Palmer JL, Paraskevopoulos T, Pei B, Roberts LE, Poulter VA, Chacko R, Bruera E; Department of Palliative Care and Rehabilitation Medicine, University of Texas M.D. Anderson Cancer Center, Houston.

Reprinted with permission from Quality of Life Matters®, copyright 2008.
Published by Quality of Life Publishing Co., Naples, FL.