10 Drugs to Think Twice About In Your Hospice Care

The NHPCO shared an article about a year ago regarding 10 drugs you should reconsider when a patient begins hospice care. In reviewing the drugs prescribed by all of our hospice clients, several of these drugs show up on a regular basis, so I thought it was worth summarizing for you. These drugs were identified by Richard Allen, MD, MPH as being commonly used, but providing little benefit to patients in a terminal state, and in some instances may cause harm. (Special Note: This information is my summary of the article. For the complete information and results, please consult the full NHPCO article.)

1) **Warfarin** is proven to cut the risk of stroke in half (2% vs. 4% one-year risk) for high functioning patients; however, an elderly debilitated patient has an 8% risk of major gastrointestinal or intracranial hemorrhage on warfarin. Avoiding the latter physical and psychological complication for a hospice patient by discontinuing Warfarin is appropriate.

2) **Statins** are widely used and inexpensive; however, according to the National Cholesterol Education Program, “patients with a limited life span from a concomitant illness are probably not good candidates for drug therapy.” Statins are unnecessary, extra pills for hospice patients.

3) **Clopidogrel** is indicated for patients who have undergone coronary stent procedures. The evidence for treatment is one to six months after the stent has been placed. The risk of bleeding makes this medication inappropriate post-stent, but many patients are left on because they lose follow up with their stenting physician and the medication is renewed indefinitely.

4) **Furosemide** is used for fluid retention and is indicated for acute decompensated heart failure. However, it is commonly used for asymptomatic heart failure, acute pulmonary edema or painful leg edema. While some patients may find some comfort with Furosemide, it may be inappropriate for long term use in some patients because it causes the circulatory system to feel as if it is in a constant state of stress.

5) **Bisphosphonates** prevent fractures in the elderly, but don’t have any value after three years. They are not recommended for patients with low creatinine clearance or those who cannot remain upright for 30 minutes after taking the medicine with 8 ounces of water. For these reasons, they should not be used for hospice patients.

6) **Donepezil** is used to treat mild to moderate Alzheimer’s dementia with a FAST score less than seven. Common side effects include hypotension, syncope, nausea and anorexia. Statistically, these medications are not helping hospice patients and should not be used as part of their comfort care.

7) **Sulfonylureas** stimulate beta-cell secretion of insulin in Diabetes Type 2 patients. Studies show that elderly patients are over-treated for diabetes which increases stroke and myocardial infarctions. Physicians should be cautious with the use of insulin in the elderly and sulfonylureas should not be used.
8) **Vitamins E, A, D** – Something to consider with hospice patients is the size of the pill and the number pills a hospice patient takes. Many vitamins add little to no benefit.

9) **Anti-hypertensives** are life-saving medications for ‘fit’ (ability to walk 6 meters in 8 seconds) patients. Among frail patients, there was no association between blood pressure and mortality. Frequently the adverse effects of these drugs such as orthostasis and fatigue outweigh the benefits in hospice patients.

10) **Psychogenic Medications** – While these are appropriate for comfort care, many are over-used and top the American Geriatrics Society “Beers list” of drugs to avoid. Polypharmacy is a significant problem, and drugs are often layered in symptom based management rather than pared back in appropriate long term care.

In summary, this was a great article provided by Dr. Richard Allen who is board certified in both hospice/palliative care and family medicine. I thought it was worth sharing. If you would like a copy of the full article, please contact me. Our goal is to provide you with valuable medication information to maximize your hospice pharmacy benefit. I hope this helps!

Kathy Dixon
Director of Hospice Rx

References:

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**A Randomized Crossover Clinical Trial to Evaluate the Efficacy of Oral Transmucosal Fentanyl Citrate in the Treatment of Dyspnea on Exertion in Patients with Advanced Cancer**

*From the American Journal of Hospice & Palliative Medicine*

**Background:** Morphine is the only opioid which has been clearly demonstrated as effective in the treatment of dyspnea. The role of other opioids has not been sufficiently substantiated.

**Objective:** To evaluate the efficacy of oral transmucosal fentanyl citrate (OTFC) in the treatment of dyspnea on exertion in patients with advanced cancer.

**Design:** This is a randomized, double-blind crossover clinical trial to evaluate the efficacy of OTFC in dyspnea on exertion after the completion of a 6-minute walk test (6MWT). All patients were attended in 2011 by the Palliative Care Supportive Team from Badajoz. In visit 1, patients were randomly assigned to 1 of the 2 treatment groups. In visit 2, the patients who had been receiving the investigational product were given placebos and vice versa.

**Results:** Thirteen patients were recruited (26 6MWT), with a mean age of 65 years. Of the patients, 11 (76%) were males and lung cancer was the most frequently represented etiology. The patients were classified into 3 categories: better response in the first period, the same response in both the periods, and better response in the second period. No differences between the treatments were demonstrated (P: 1). There were no differences in changes in oxygen saturation (P: .7541) nor in the distance walked in the different sequences (P: .6550). No significant differences were found in relation to the Edmonton Symptom Assessment System, either before or after the 6MWT (P: .1234). No secondary effects associated with the medication were observed.

**Conclusion:** It could not be demonstrated that the OTFC improved exertion dyspnea in patients with advanced cancer. A placebo effect was observed in all the patients.

Opioid Use in the Last Year of Life Among Medicare Beneficiaries with Advanced Illness: A Retrospective Cohort Study

From the Journal of Hospice & Palliative Nursing

Abstract: The presence of refractory dyspnea is often associated with illness progression to advanced stages. Opioid medications are the first-line pharmacological treatment for the palliation of refractory dyspnea, and indication for this intervention could signal the need for palliative care or hospice. The aims of this study were to describe opioid use and enrollment in hospice care among Medicare beneficiaries with heart failure, chronic obstructive pulmonary disease, or lung cancer during their last year of life. Using Medicare data, we conducted a retrospective cohort study of beneficiaries with heart failure, chronic obstructive pulmonary disease, or lung cancer who died in 2009. Slightly more than one-third of the 110,218 decedents used an opioid medication during the last year of life. Beneficiaries with lung cancer had the most opioid and hospice use. Hospice was initiated in the last month of life, whereas opioids were first prescribed 9 to 12 months before death. Findings suggest that the symptoms experienced by this population in the last year of life may not be well managed. The introduction of an opioid medication to manage refractory dyspnea could be used as an indicator to begin discussions about palliative care or hospice among patients with advanced illnesses.


Symptom Management of Bone Metastasis at End of Life

From the Journal of Hospice & Palliative Nursing

Abstract: Caring for persons with bone metastasis at the end of life is complex. There are a variety of pharmacologic and nonpharmacologic measures that have been shown to provide patients with relief and comfort. Through the use of a case narrative, this article demonstrates the complexity of palliative care as it relates to the pain management of bone metastasis at end of life from both the pharmacological and psychosocial perspectives. Treatment interventions for pain in each of these domains is explored, illustrating that metastatic bone pain at end of life is a multifaceted experience and therefore requires a multimodal approach to care. (C) 2015 by The Hospice and Palliative Nurses Association.


New DEA Rules Expand Options for Controlled Substance Disposal

From the Journal of Pain & Palliative Care Pharmacotherapy

Abstract: Prescription drug abuse and overdose are rapidly growing problems in the United States. The United States federal Disposal of Controlled Substances Rule became effective 9 October 2014, implementing the Secure and Responsible Drug Disposal Act of 2010 (Disposal Act). These regulations target escalating prescription drug misuse by reducing accumulation of unused controlled substances that may be abused, diverted or accidentally ingested. Clinical areas that can now participate in collecting unused controlled substances include retail pharmacies, hospitals or clinics with an onsite pharmacy, and narcotic treatment programs. Collection methods include placing a controlled substance collection receptacle or instituting a mail-back program. Because prompt onsite destruction of collected items is required of mail-back programs, collection receptacles are more likely to be used in clinical areas. Retail pharmacies and hospitals or clinics with an onsite pharmacy may also place and maintain collection receptacles at long-term care facilities. The Act and Rule are intended to increase controlled substance disposal methods and expand local involvement in collection of unused controlled substances. Potential barriers to participating in controlled substance collection include acquisition of suitable collection receptacles and liners, lack of available space meeting the necessary criteria, lack of employee time for verification and inventory requirements, and program costs.