Geri-ality

WITH DR. NAZIR

EVIDENCE IS CONFIDENCE

a Signature HealthCARE publication

July, 2017 EDITION

The Role of Antipsychotics; Is there any more Confusion?

A recent JAMA publication[1] highlighted the successful partnership between CMS and health systems to decrease prevalence of psychotropic medications in patients with dementia.

In the same context, a study explored if the use of antipsychotic agents including risperidone and haloperidol had a role to play in the distressful symptoms for patients suffering from delirium while receiving palliative care.[2] In this double-blind, randomized trial in Australia, patients on hospice/ hospital palliative care were given Q12 hour doses of one of the two agents based on their need. They continued to receive supportive care for delirium and other symptoms. When the outcomes (delirium severity, midazolam use, extrapyramidal effects, sedation, and survival) were studied, it was clear that patients who received the two agents had more delirium severity and extrapyramidal symptoms and duration of symptoms was longer. Mortality was higher but not statistical significance. The authors concluded that individualized, supportive care was the evidence based approach rather than antipsychotic medications for palliative care patients who have distressful delirium.

This study provides me more guidance when I take care of frail patients receiving palliative/ hospice care in the post-acute and long stay settings. It provides me another reason to refrain from prescribing antipsychotic medications for distressful delirium symptoms unless non-pharmacologic strategies have been tried and have not sufficed

1 *Gurwitz JH et al. Excessive Use of Antipsychotic Agents in Nursing Homes. JAMA. Published online June 15, 2017. doi:10.1001/jama.2017.7032*

2 *Agar MR et al. Efficacy of Oral Risperidone, Haloperidol, or Placebo for Symptoms of Delirium Among Patients in Palliative Care. A Randomized Clinical Trial. JAMA Intern Med. 2017;177(1):34-42.*

Adjusting Anticoagulant Doses

Older patients with atrial fibrillation are high risk for embolic stroke. Direct acting oral anticoagulants (DOACs) provide an excellent option to manage this risk but require dose-adjustments based on renal impairment, and failure to do so may lead to higher risk of bleeding.

In their retrospective study, a research team explored DOAC dosing patterns and associated outcomes, i.e., stroke (ischemic stroke and systemic embolism) and major bleeding in more than 15,000 patients utilizing claims data.[1] The results were concerning as among patients with renal impairment only 43% of the patients received adjusted dose. This potential overdosing resulted in higher risk of major bleeding. No significant increase in incidence of strokes was found. Among the patients without renal impairment more than 13% received a lower than standard dosing. This under-dosing resulted in more than five times higher risk of stroke for patients that were receiving apixaban but not for other agents. The authors concluded that these prescribing patterns may be associated with worse safety with no benefit in effectiveness in patients with severe kidney disease and worse effectiveness with no benefit in safety in apixaban-treated patients with normal or mildly impaired renal function. The study found that risk of dose discrepancy was higher in older patients.

I am hopeful that DOACs will improve my ability to manage frail nursing home patients who require anticoagulation for atrial fibrillation. This study also cautions me to prescribe renally adjusted doses based on guidelines.

1 *Yao X et al. Non-Vitamin K Antagonist Oral Anticoagulant Dosing in Patients With Atrial Fibrillation and Renal Dysfunction. J Am Coll Cardiol. 2017 Jun 13;69(23):2779-2790*

Signature HealthCARE

High Quality Transition, Not Just a Passing Thought!

Strategies to improve transitions and reducing hospitalization are a huge focus for the health care system and many incentives/ disincentives are being created to facilitate better outcomes. Many teams have attempted to define and describe best practices in transitional care but there is still confusion around: 1) components of a successful transition, and 2) how to implement these components.

A recent article by Dr. Naylor and her team published a list of evidence-based key components of comprehensive and effective transitional care for hospitalized frail patients that are at risk for post-discharge readmission.[1] This work was carried by an interdisciplinary workgroup that included patients, caregivers and transitional care experts.

After an exhaustive review and debates, the workgroup settled on eight components including patient engagement, caregiver engagement, complexity management, patient education, caregiver education, well-being, care on continuity, and accountability (team, clinician and organizational).

Though many categories are self-explanatory, well-being means that health systems recognize and addresses the patient/ caregiver's emotional reactions to the stressful situations and focus on enhancing patient quality of life. Accountability of the clinician requires a firm partnership between them and patients; team accountability addresses responsible contribution to care planning by all members; and organizational accountability requires that the healthcare organization ensures an environment/ services conducive to best patient/ caregiver experiences through transitions.

As an attending in the post-acute setting, I am required to provide the best transitional care. This study will encourage me to think and act as a member of a team to achieve much more than just managing diseases in my patients. As a team member, I will assure that I facilitate patient/ caregiver engagement, education and am accountable to each step of the transition.

[1] *Naylor, M. et al (2017). Components of Comprehensive and Effective Transitional Care. J Am Geriatr Soc, 65: 1119–1125*

Cranberry Pills for UTI Prevention; Not a Berry Good Idea!

The debate on use of cranberry in UTI prevention in nursing homes had raged on for decades[1] until recently when one study emphatically put an end to this debate. In their randomized clinical trial Dr. Mehta and her team addressed this issue most specifically in the older women residents of nursing homes.[2] They prescribed two oral capsules (36 mg of the active ingredient proanthocyanidin; 72 mg total, equivalent to 20 ounces of cranberry juice) vs placebo, administered once a day in 92 treatment and 93 control group participants. Over the next year they studied urine samples from these patients every two months. Any positive finding on urine samples was the primary outcome and secondary outcomes were symptomatic urinary tract infection (UTI), all-cause death, all-cause hospitalization, all multidrug antibiotic–resistant organisms, and total antimicrobial administration.

Results were loud and clear; there was no significant difference in the presence of bacteriuria plus pyuria between the treatment group vs the control group (29.1% vs 29.0%) and no differences were found for other outcomes. The authors concluded that cranberry use did not lead to preventing pyuria or bacteriuria in older female patients.

So how does this study help me? I now have a serious argument to decline the prescription of cranberry juice/ capsules when my nurses or family request it on a patient without history of recurrent UTIs or who has not previously had perceived benefit from this intervention. I may still order daily cranberry juice if a patient/ family firmly believe in the value of this intervention based on past history. But I will do this in context of preserving patient choice and autonomy, understanding that it may not impact UTI outcomes.

[1] *Gurwitz JH et al. Excessive Use of Antipsychotic Agents in Nursing Homes. JAMA. Published online June 15, 2017. doi:10.1001/jama.2017.7032*

[2] *Agar MR et al. Efficacy of Oral Risperidone, Haloperidol, or Placebo for Symptoms of Delirium Among Patients in Palliative Care. A Randomized Clinical Trial. JAMA Intern Med. 2017;177(1):34-42.*

Dr. Arif Nazir *Chief Medical Officer*