To Prescribe or Deprescribe: A Palliative Approach

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Objectives
• Identify drug classes most commonly added at the end of life to enhance patient comfort
• Describe the methodology used to determine whether to continue medications or drug therapy at the end of life
• Identify deprescribing opportunities on a patient’s active medication list as the patient declines

Disclosure
• The presenters have no disclosures, financial relationships or commercial support for the following presentation.

Palliative care
• Intended for persons with life-limiting illnesses and alleviation of suffering in all domains
• Can co-exist with aggressive therapies
• Goal to improve quality of life

Deprescribing definition
• The process of withdrawal or dose reduction of medications which are considered inappropriate, meaning that potential risks outweigh potential benefits
• Primary goal of deprescribing is to improve patient outcomes and reduce burden

What is shared decision-making?
• The process in which clinicians and patients work together to make decisions based on clinical evidence that balances risks and expected outcomes with patients’ preferences and values
Palliative care prescribing approach:

- **Adding** medications to enhance comfort and quality of life
- **Changing** medications over time especially in setting of worsening renal or hepatic function
- **Tapering/discontinuing** medications no longer beneficial for control of distressing symptoms or to reduce adverse drug reactions

Adverse outcomes if medication review is not performed:

- Reduced quality of life
- Increased falls
- Adverse drug reactions
- Non-adherence
- Hospitalization
- Increased mortality
- Heightened healthcare costs


Medication classes to add/change

- Consider adding:
  - Opioids for pain or air hunger
  - Anxiolytics to decrease anxiety or control nausea
  - Antipsychotics to manage distressing delirium or control nausea
  - Anticholinergics for visceral abdominal pain or secretions

- Consider adjusting:
  - Antihypertensives
  - Diabetic agents
  - Bowel medications

Which of the following drug classes would MOST commonly be added to enhance patient comfort at end of life?

- Diabetic medications
- Opioids
- Antihypertensives
- Antidepressants

Case study #1

- Mr. M. is a 67yo male with PMH of Type 2 DM with neuropathy, hyperlipidemia, BPH, PVD, & bipolar disease
- Diagnosed with gastric adenocarcinoma 2010; underwent extensive surgical resection and four lines of chemotherapy/immunotherapy
- One week ago found to have LFTs over 500 due to pembrolizumab for which therapy was discontinued and mycophenolate started
- Presented to clinic today with P 105, BP 94/57, poor PO intake, near falls, dizziness upon standing

Case study #1: active medications

- Mirtazapine 30mg po qhs
- Mycophenolate 500mg po bid
- Lisinopril 10mg po qam
- Terazosin 5mg po qhs
- Aspart 70/30 insulin 45 units sq qam and 35 units sq qpm
- Gabapentin 300mg po bid
- Polyethylene glycol prn
- ECASA 81mg po daily
- Prochlorperazine 10mg po q6h prn
- Ferrous sulfate 325mg po bid
- Vitamin B12 1000mcg po daily
- Docusate 200mg po bid
- Hyoscymine 0.125mg po bid prn
- Levotiroxine 0.075mg po qam
- Omeprazole 20mg po bid
- Hydrochlorothiazide 25mg po qam
What medication change(s) would you consider?

Barriers to change in practice
- Lack of awareness of potential harm of medications
- Uncertainty or lack of clarity regarding goals of care
- Practice structure/time limitations
- Knowledge deficit of research/evidence
- Commitment by provider to review medications
- Multiple healthcare providers
- Fear/worry regarding adverse outcomes with discontinuation

Elements of prescribing practices in palliative care
- Comprehensive history and physical
- Assessment of prognosis and goals of care
- Determination of a person's wishes/values
- Shared decision-making including education regarding rationale for change in medication profile
- Individualized review of medication list including determination of whether to add, change or discontinue medications
- Follow-up visit to assess outcomes

Which of the following BEST describes methodology used to determine which medications should be continued at the end of life?
- Dialogue occurs between provider and patient using shared decision making regarding benefit or burden of each medication: Correct
- Provider stops medication and tells patient at next visit: Incorrect
- All medications are discontinued once a person starts palliative care: Incorrect

General guidelines to stop Potentially Inappropriate Medications (PIMs):
- Limited compliance
- No clear clinical indication
- Intolerance to medication
- Used solely for primary prevention

Anticoagulants/aspirin
- Consider continuation for management of PAF, mechanical valve, previous thromboembolism
- Close examination to discontinue if time to benefit exceeds life expectancy
  - Discontinue warfarin if deteriorating liver function
  - Discontinue low molecular weight heparin if deteriorating renal function
Vignette

- 82yo male with stage IIIb lung cancer, untreated per patient preference, CAD/MI, right BKA, PAF, wheelchair bound, on warfarin. When would you consider d/c of anticoagulation?
  - At first visit?
  - With notable progression of lung cancer?
  - When he has a fall?
  - When he is homebound?

Anti-hypertensives

- Liberalize parameters for blood pressure control to avoid orthostasis, falls, syncope, dizziness
- Sequential elimination if on multiple medications
- Discontinue in last days-weeks of life

Cardiac medications

- Continue:
  - Nitrates: prevent chest pain
  - Rate control: only if bothersome to patient
  - Diuretics: continue for symptomatic heart failure
- Discontinue:
  - Digoxin: negligible short term benefit and requires monitoring

Diabetic medications

- Increased risk of symptomatic hypoglycemia
  - Metformin/oral hypoglycemic agents: consider elimination earlier in the course of life-limiting illness
  - Insulin: preferred option as easy to taper/adjust as condition changes
  - May require up-titration if on steroids

Lipid-lowering agents

- No change in mortality at 60 days and 1 year in life-limiting illnesses
- Increased quality of life and reduced symptom burden in those that had statin therapy discontinued
- Stop for progressive hepatic or renal failure, weight loss
- “Choosing Wisely” campaign

Miscellaneous

- Bisphosphonates:
  - Bone metastasis or lytic lesions in myeloma – continue
  - Osteoporosis - discontinue
- Vitamins/minerals
- Urinary medications
  - Discontinue if requiring indwelling catheter or routine straight catheterization
### Miscellaneous

- **Dementia treatment**
  - no role for continuation in life-limiting illness
  - significant side effects
- **COPD**
  - continue with the exception of theophylline and leukotriene antagonists
- **Gastrointestinal**
  - Continue if GI bleed, symptomatic reflux or ulcers, steroid or NSAID prophylaxis

### Myth or fact?

- Discontinue all medications once patient is receiving palliative care?  
  - Myth
- Continue diuretic therapy for persons with heart failure  
  - Fact
- Treat symptomatic urinary tract infection  
  - Fact
- CMO = commence morphine overdose  
  - Myth

### STOPP: Screening Tool for Older Persons’ Prescriptions (STOPP) Criteria

<table>
<thead>
<tr>
<th>Persons over 65 with:</th>
<th>Consider discontinuation if:</th>
</tr>
</thead>
<tbody>
<tr>
<td>End stage disease</td>
<td>Risks outweigh benefits</td>
</tr>
<tr>
<td>Poor one year survival</td>
<td>Administration of medication is challenging</td>
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<tr>
<td>Severe functional and/or cognitive impairment or both</td>
<td>Monitoring medication is challenging</td>
</tr>
<tr>
<td>Symptom control is the priority rather than prevention of disease progression</td>
<td>Drug adherence or compliance is difficult</td>
</tr>
</tbody>
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### CEASE

- **Current medications**
- **Elevated risk**
- **Assess**
- **Sort**
- **Eliminate**

### Additional tools/resources

- **BEERs criteria for potentially inappropriate medication use in older adults**
  - May 2017 AGS (updated)
- **Drug Burden Index**
- **OncPal**

### Mr. J.

Mr. J. takes the following medications: oxycodone, isosorbide, simvastatin, sennosides. You are notified that Mr. J. has increased pain, is only eating about 20% of meals and his function has declined over the last week. Which of the above listed medications would be the MOST appropriate to discontinue based on the patient’s declining health:

- Sennosides  
  - Incorrect
- Oxycodone  
  - Correct
- Simvastatin  
  - Incorrect
- Isosorbide  
  - Incorrect
Case study #1

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What medication changes would you consider?

1. Stop mirtazapine?
2. Discontinue all PO medications?
3. Adjust diabetic medications?
4. Reduce antihypertensive regimen?

Our plan:

- Add: morphine immediate release prn
- Change: terazosin to tamsulosin
- Discontinue: lisinopril, hydrochlorothiazide, atorvastatin

- Improvement in transaminitis off pembrolizumab:
  - AST 509→28; ALT 750→61

Return visit one week later:

- No further falls
- Increased PO intake, weight up 4 pounds
- Stable vitals (BP 130/69, P 84)
- BUN 29→14
- Creatinine 1.4→0.9
- Weight 130→136
- Improved mood/affect
- Vastly improved quality of life overall!

Last weeks-months

<table>
<thead>
<tr>
<th>Add</th>
<th>Modify</th>
<th>Discontinue</th>
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<tr>
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<td>Anti-hypertensives</td>
<td>Anti-dementia meds</td>
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<td>Diuretics</td>
<td>Lipid lowering agents</td>
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<td>Insulin</td>
<td>Vitamins/nonessentials</td>
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<td>Anticholinergics</td>
<td>Anti-anginal therapy</td>
<td>Anti-coagulation</td>
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Conclusion

• Shared decision-making is essential in considering changes of medications to enhance comfort and quality of life
• Careful review of EACH medication to determine role in enhancing quality of life is key
• Review common medication categories and tools to guide your practice

Questions?

Additional References


Stander PE. Reducing polypharmacy in the palliative care setting. Phoenix VAMC.