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We want to update our records, can you help?

Please reference the information below and send us an email so we can make sure and keep our records current.

- **Would you like to unsubscribe to the Clinical News?**
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- **Did we misspell your name or send this newsletter to the wrong address?**
- **Do you have questions or recommendations for topics we can cover in the next issue?**

Please contact Alyssa Hampson at (970) 683-4921 or e-mail ahampson@HopeWestCO.org.

Thank you!

Clinical News

Spring 2015

Christy Whitney
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Profoundly changing the way our community experiences serious illness and grief – one family at a time.

HopeWest

HopeWest is here

to partner with you and your patients. We know that together we can help patients and families facing serious illness live the best life possible. If you have questions about how we can work together, please call, anytime.

A Reminder of How We Can Help...

- **Serious illness strikes, and your patient needs care and support and isn't sure where to turn for help.** HopeWest Transitions will help provide the right care by the right providers at the right time to best help you. Our physicians offer expert consultations and coordinate the best plan for care.
- **A patient needs the care a hospital provides, but wants to be in a place that feels like home.** Our HopeWest Hospice Care Center is the next best thing with beautiful and comfortable patient and family care rooms, a living room, family kitchen and chapel. Families and even pets are always welcome. At-home caregivers also can schedule a patient to stay a few days while they take a break.
- **A patient is suffering with a life-threatening illness, and he or she deserves a break from all the medical bills.** The comprehensive hospice benefit stops those bills. Compassionate HopeWest Hospice doctors, nurses, counselors, chaplains and volunteers will take care of your patients and their families. Hospice is not about giving up hope. It's about choosing to live well.
- **A patient is diagnosed with cancer, and would benefit from continued care.** HopeWest Living with Cancer is a program of survivorship – here to help manage difficult symptoms and coordinate the care needed – while bringing hope to your patients and their families.
- **A patient is losing or has lost a significant someone.** Grief always is difficult and doesn't end when the funeral flowers have faded. HopeWest Support offers professional counselors to walk with your patients along the path toward healing with one-on-one or group sessions, family programs and continued support for as long as it takes.
- **A child or teen is finding it difficult to cope with the loss of someone near and dear to them.** HopeWest Kids counselors and volunteers understand children and teens grieve differently than adults. We help them understand that grief is a natural response to loss experienced by everyone at some point. They come away with the ability to cope and find hope for the future.

We are here when your patients need help!
Just call us 24-hours a day, seven days a week.

David West, MD
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Below is an excerpt from an article by Dr. Richard Allen featured in May 2014 on NHPCO Newsline. My colleagues and I agree with the article and its stance on the medications below. The full article can be viewed online. If you need more information or have questions, please feel free to call or email me. - Dr. West

10 Drugs to Reconsider

By Richard Allen, MD, MPH

By definition, when patients enroll in hospice, they are no longer seeking life-sustaining treatments. Yet many may still be taking medications that are no longer helpful to them – neither beneficial for sustaining life nor effective at providing comfort. In this article, I review 10 commonly-prescribed medications that may provide little benefit to patients in a terminal state – and may possibly cause harm.

Helping patients and caregivers understand the negligible effect and potential danger of these medications is also part of this review.

While I also provide the evidence to support the disuse of these medications, please note that my recommendations are meant only as a guide. Each hospice medical director must take an individualized approach, weighing the risks and benefits for each patient as well as the patient and family's goals of care.

1. Warfarin

This drug is commonly used to prevent clotting in atrial fibrillation, thromboembolic disease, and artificial heart valves. It is measured by the Protime (International Normalized Ratio or INR) and patients are familiar with monitoring via monthly blood draws. The one-year risk of stroke with atrial fibrillation is 2 percent in patients treated with warfarin, and 4 percent in untreated patients. Cutting the stroke risk in half may be important in high-functioning patients, as determined by the CHADS2 scoring system. In contrast, an elderly debilitated patient has an 8% risk of major gastrointestinal or intracranial hemorrhage on warfarin.

Patients and their families are hesitant to stop warfarin due to fears of a non-lethal stroke. They may picture a "vegetative state" and want to avoid the condition of total debility. However, these patients are already in a state of debility, relying on caregivers for all of their activities of daily living. Also, a cerebrovascular accident during this stage will likely be fatal, and may be a welcome exit from terminal suffering. Finally, gastrointestinal hemorrhage is a physically and psychologically difficult demise, and avoiding this complication by discontinuing warfarin is an appropriate choice for hospice patients.

2. Statins

These are the wonder drugs of our age, inhibiting cholesterol synthesis and helping to reduce atherosclerosis and early death. Statins are generic, cheap, and now widely used. However, in a longitudinal study of 4,066 elderly men and women, death from coronary heart disease actually increased at serum cholesterol levels below 160 mg/dL.

Cholesterol is important in cell structure, and this combined with aging is one thought on the value of conservative mid-range cholesterol targets for the elderly. Another trial compared over 10,000 patients with stable coronary artery disease using atorvastatin at low versus high dose. The high-dose group had an increase in non-cardiovascular mortality, primarily cancer. Like most studies, the mean follow up for these patients was five years, well beyond the predicted hospice span.

The National Cholesterol Education Program states that "patients with a limited life span from a concomitant illness are probably not candidates for drug therapy." Statins are unnecessary extra pills for hospice patients to take.

3. Clopidogrel

This drug is indicated in patients who have undergone coronary stent procedures. The evidence for treatment is for one to six months after the stent is placed. While there is some data for stable coronary artery disease treatment, in general the risk of bleeding makes this medication inappropriate beyond the post-stent period. Many elderly patients are inadvertently left on clopidogrel as they lose follow-up with the stenting physician, especially if they reside in a long-term care facility where renewal of the medication is routine and indefinite. A trial of 15,000 patients showed

no coronary artery disease benefit, and double the risk of gastrointestinal bleeding on clopidogrel combined with aspirin. Another trial of 19,000 patients reported that 200 patients would need to be treated for two years to prevent one single stroke, and in the meantime many of those patients would experience bleeding.

4. Furosemide

Widely used for fluid retention, this drug is officially indicated for acute decompensated heart failure, but it is usually continued chronically for stable asymptomatic heart failure. Furosemide is also commonly used for benign disease states such as leg edema.

Furosemide increases norepinephrine, renin, and vasopressin, causing the circulatory system to feel that it's in a constant state of stress. Diuretics cause decreased renal blood flow, elevated creatinine, and relative dehydration. Orthostasis, falls and electrolyte abnormalities are common, especially in the elderly. Hospice patients with acute pulmonary edema or painful leg edema may find some comfort with the use of furosemide, but it may be inappropriate for chronic long-term use in some patients.

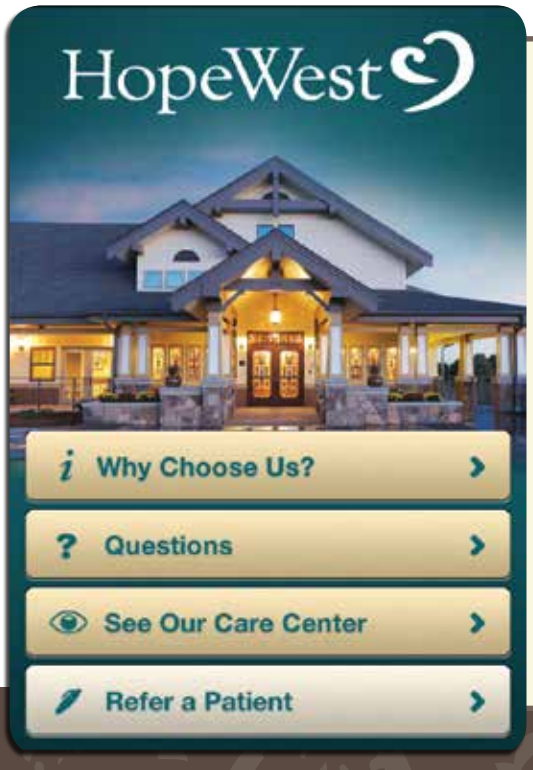
5. Bisphosphonates

These drugs, such as alendronate, are underutilized medications that could prevent tens of thousands of fractures in the elderly. One trial of 2,000 women aged 55 - 81 demonstrated a 50 percent reduction in vertebral, wrist and hip fractures in the treated group. The medications were well tolerated with no incidence of osteonecrosis, and generally low adverse effects.

Long-term studies of bisphosphonates, however, have failed to demonstrate additional benefit beyond three years of initial treatment. In other words, a patient treated for three years would have the same protection as someone taking the drug for 10 years. These drugs are also not recommended for patients with low creatinine clearance, or who are unable to remain upright for 30 minutes after ingesting the medicine with 8 ounces of water. For these reasons, oral bisphosphonates should be discontinued in hospice patients. The risks of esophagitis and osteodystrophy are high, and any treatment benefit has already been gained if they've previously taken the medicine.

The rest of the drugs are listed below but to read the full article with references, visit **HopeWestCO.org/Education-Resources**

6. Donepezil
7. Sulfonylureas
8. Vitamins E, A and D
9. Anti-hypertensives
10. Psychogenic Medications



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