TESTS AND MEDICATIONS I WISH YOU'D NEVER ORDERED

(CHOOSING WISELY ©)

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DISCLOSURES: NONE

WHEN YOU ARE YOUNG, YOU THINK YOU ARE BULLETPROOF, BUT…..

SOMEDAY, YOU WILL BE A PATIENT

MEDPAGE TODAY

DOCS, THINK ABOUT IT BEFORE YOU OVER ORDER.

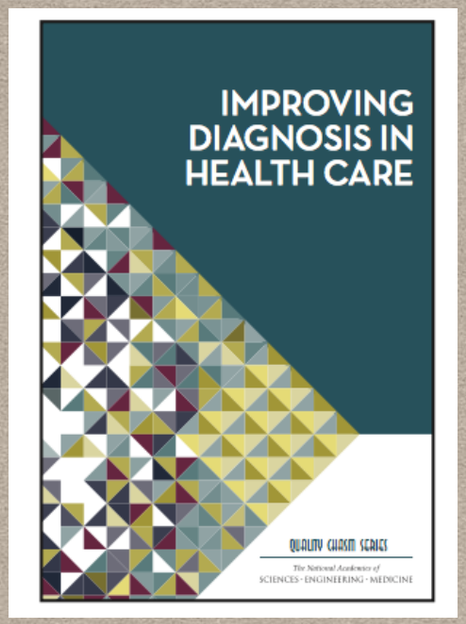
Why do doctors over-order? Physicians are prone to a standard of exactitude, which is not always reasonable, practical, or merciful. Do you ever stay awake nights because of the minute possibility that there is a tiny chance of a small probability that an obscure diagnosis might be missed because blood was not drawn, an x-ray not taken, or an orifice not invaded?

There is a great deal of pressure on doctors not only to overturn every stone but to dig five feet into the earth, no matter how unlikely a revelation or how probable a complicating scar.

Do patients and docs fail to ask the question before they stick in the needle or press the button, "Will the test help improve the quality of life?"

Medical error is the third leading cause of death in the United States, after heart disease and cancer……say authors Martin Makary, MD, MPH, professor of surgery, and research fellow Michael Daniel, from Johns Hopkins University School of Medicine.

BMJ 2016;353:i2139



Sept 22, 2015

…… a continuation of the landmark Institute of Medicine reports To Err Is Human: Building A Safer Health System (2000) and Crossing the Quality Chasm: A New Health System for the 21st Century (2001) finds that the occurrence of diagnostic errors—has been largely unappreciated…… The committee concluded that most people will experience at least one diagnostic error in their lifetime, sometimes with devastating consequences.

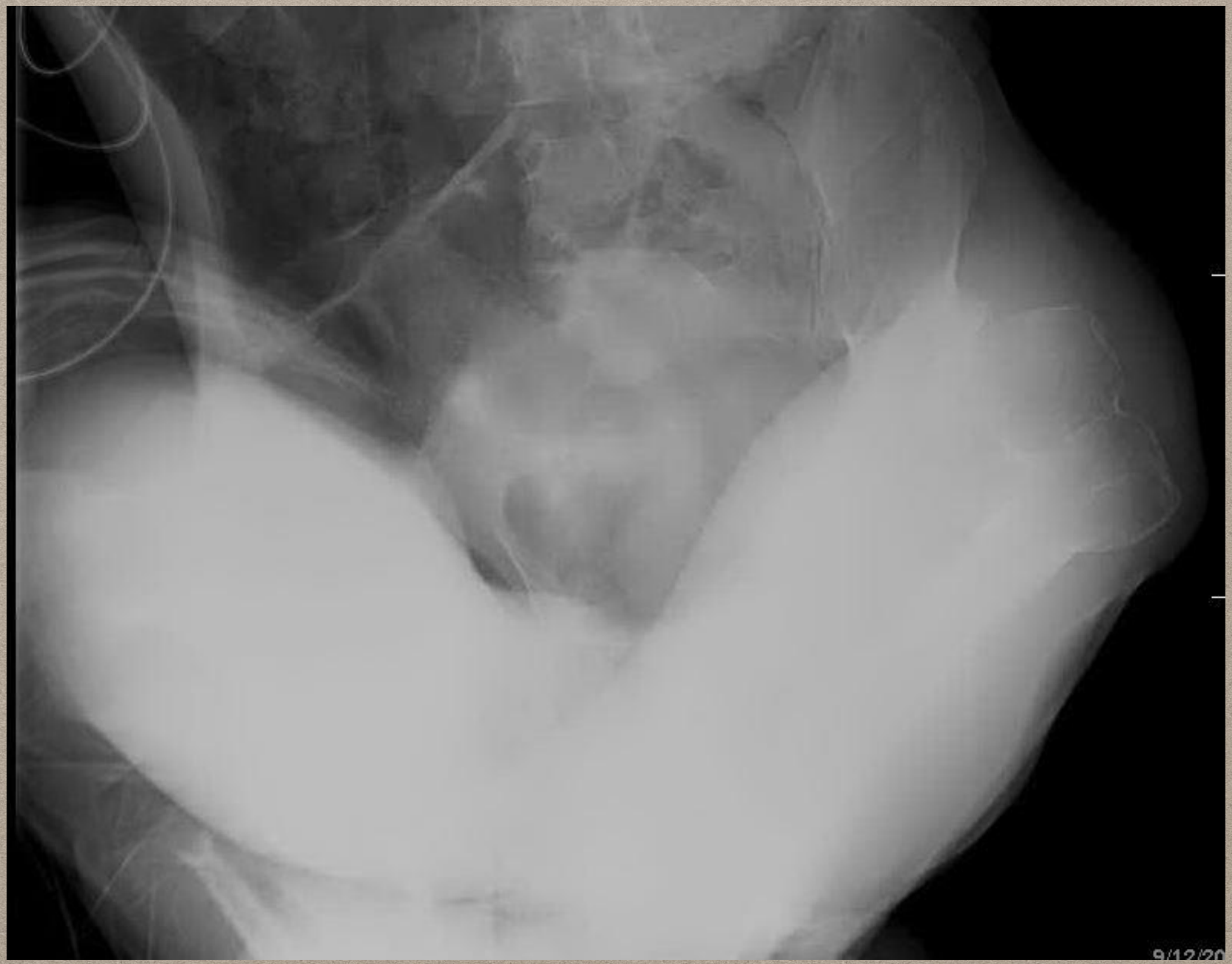
- This unfortunate special needs individual in his early 50s had lived his entire life in an extended care facility
- For reasons beyond me, the physician rounding in that ECF ordered a PSA
- Any guess as to the results of that test?

The PSA was elevated, prompting…….

A urology consult, prompting……

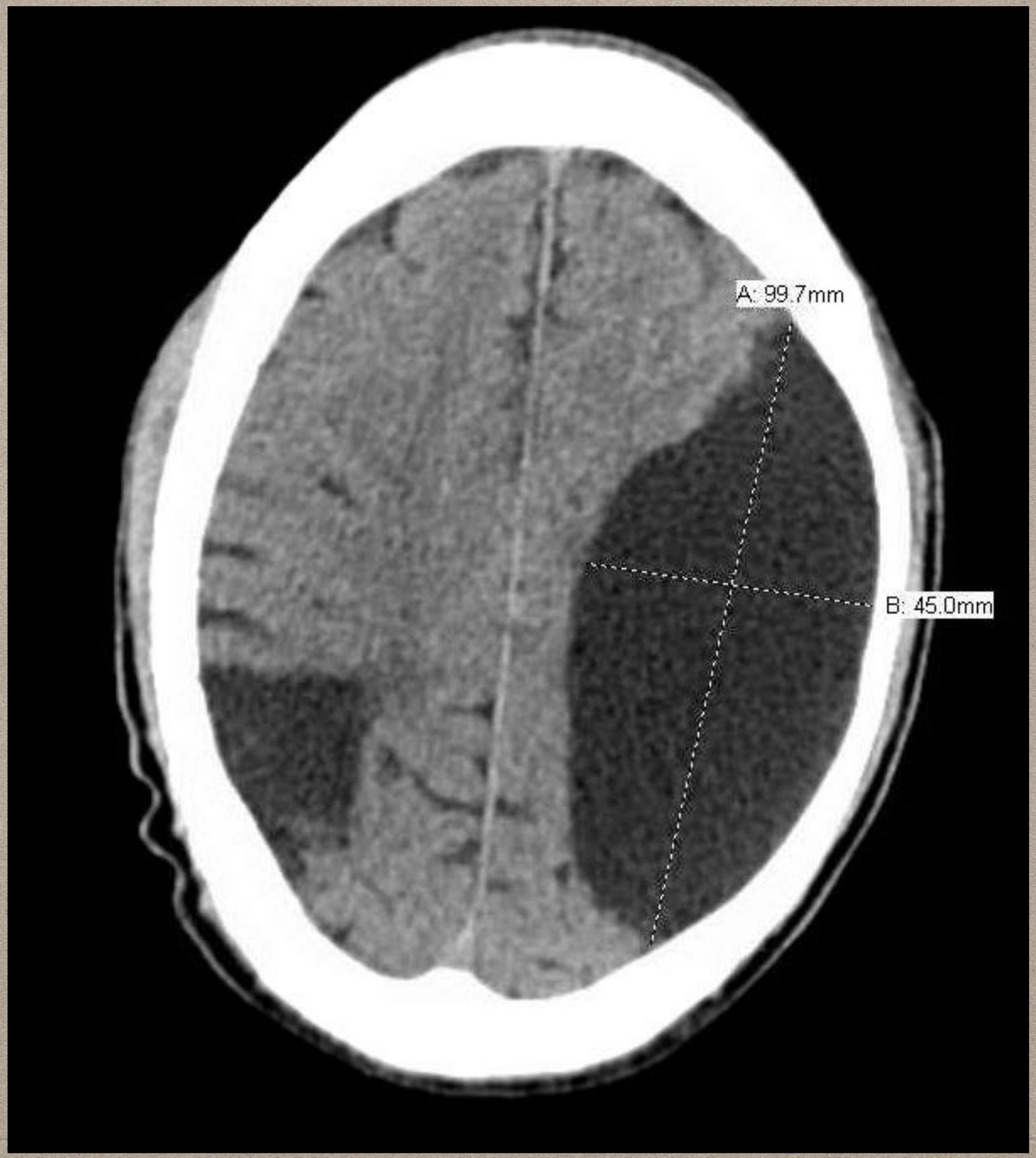
…..the patient to be scheduled for a prostate biopsy!

- What was the urologist thinking??
- How is it possible to obtain truly **informed** consent?



- Because of his severe contractures, positioning for the biopsy was challenging
- What do you think happened next?

- Unfortunately, while trying to position the patient, he fell off the table, striking his head
- So……what was next ordered?


A: 99.7mm
B: 45.0mm

- Not letting any of these issues stop him, the urologist managed to continue on with multiple biopsies
- Twelve specimens were submitted
- What do you think the pathology report said?

“Small portions of benign mostly stroma and focal areas of benign transitional mucosa noted. **There is no definite prostate glandular structures noted for evaluation.** Clinical correlation suggested.”

Primum non nocere……

Someday, YOU - and every single person you know and love - will be a patient

”the delivery of good medical care is to do as much nothing as possible”

….from Shem S. ***The House of God***. 1978

OUR DISTINGUISHED, HIGHLY OPINIONATED AND UNFILTERED PANEL

- Martin Burke DO, FACOI - Cardiology
- Kevin Hubbard DO, FACOI - Hematology/Oncology
- David Tessler DO, FACOI - Gastroenterology

Tests and Medications I Wish You'd Never Ordered 2019

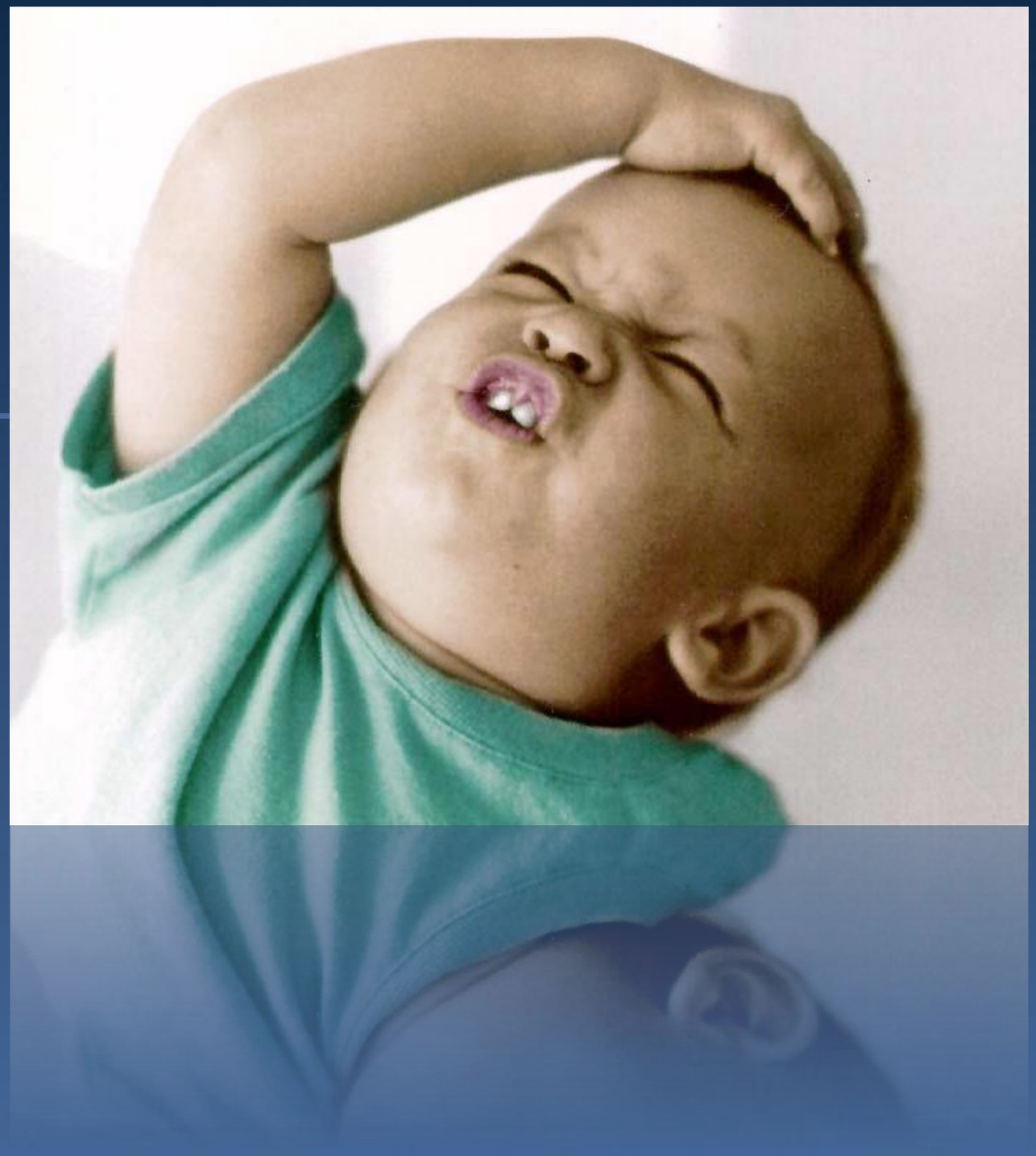
"Here We Go Again!!!"

Kevin P. Hubbard, DO, HMDC, MACOI

Chair - Department of Primary Care Medicine

Professor of Internal Medicine

Kansas City University - College of Osteopathic Medicine



Case History

- 89 y/o woman with Alzheimer dementia, Type II DM, HTN, A-fib on anticoagulants, GERD, chronic insomnia, multiple falls; family desiring to pursue comfort care with hospice
- Resides at ECF, primary care physician group with expertise in geriatrics oversees care, along with team of mid-levels
- BMI 25.31 (down from 32.06 six months ago; lost 21% of TBW); eating <50% of meals
- FAST 6e (fecal/urinary incontinence), sleeps 12-16 hours/day; total dependence in all ADLs, PPS=40% (50% six months ago)

Case History

- Medications
  - Omeprazole
  - Chlorthalidone
  - Citalopram
  - Lorazepam
  - Lovastatin
  - Ranitidine
  - Metoprolol
  - Trazodone
  - Donepezil
  - Metformin
  - Oxybutynin
  - Apixaban
  - Diphenoxylate/Atropine
  - Hydrocodone/APAP
  - APAP
  - Ondansetron

Case History

- Patient had consistent hypotension during initial time on service, along with frequent falls
- Patient lethargic much of the time, unable to say more than a few words

“Can we de-prescribe some of her meds?”

Case History

- Recommendations
  - Change apixaban to aspirin
    - Rationale: CHA_2DS_2-VASc Score is 5 (6% annual stroke risk) vs HAS-BLED score of 3 (high risk for bleeding)
    - This is a hospice patient…would ASA be “good enough” for the last six months of life?

Case History

- Recommendations
  - Discontinue chlorthalidone
    - Rationale: the patient has no edema or outward manifestations of CHF, has hypotension and frequent falls. Diuretics can cause electrolyte disturbances and can contribute to delirium.

Case History

- Recommendations
  - Taper and discontinue donepezil
    - Rationale: the patient has had a rapid functional decline and is now sleeping over 75% of each day. Her appetite is declining and she is now hospice eligible. A trial off therapy seems reasonable.

Case History

- Recommendations
  - Discontinue lovastatin
    - Rationale: Two major points…
      - Prospective trial of statin use in hospice patients…stopping statins led to higher QOL scores, fewer meds for management of side effects, and lower cost. (Kutner JS, et al; *JAMA Intern Med*. 2015 May; 175(5): 691–700)
      - If you only had six months left to live, would it matter what your cholesterol is?

Case History

- Recommendations
  - Discontinue metformin
    - Rationale: FSBS have been lower now that patient isn’t eating as much. We can monitor BS and re-start metformin if trending upward.

Case History

- Recommendations
  - Discontinue oxybutynin
    - Rationale: patient was now incontinent of both urine and feces, necessitating use of an adult diaper. Medication was no longer needed. Oxybutynin is associated with lethargy and delirium in older patients
  - Potential interaction between this med and donepezil (both are anticholinergics)

Case History

- Recommendations
  - Discontinue omeprazole
    - Rationale: patient on both H_2 blocker and PPI. No hx of bleeding, and GERD was managed well. Beers list 2019 indicated PPIs were potentially problematic in elderly. In 2015, H_2 blockers were as well, but subsequent data indicates no risk

Case History

- Medications De-prescribed…
  - Chlorthalidone
  - Lovastatin
  - Donepezil
  - Apixaban changed to ASA
  - Metformin
  - Oxybutynin

Outcome

- During the 90 day benefit period, the patient became more interactive, improved her PPS (from 40% to 50%), and gained 7 pounds of weight.
  - She was discharged from service toward the end of the first benefit period as she no longer met eligibility criteria for hospice
- Given her diagnosis, she will likely become eligible as her dementia progresses.

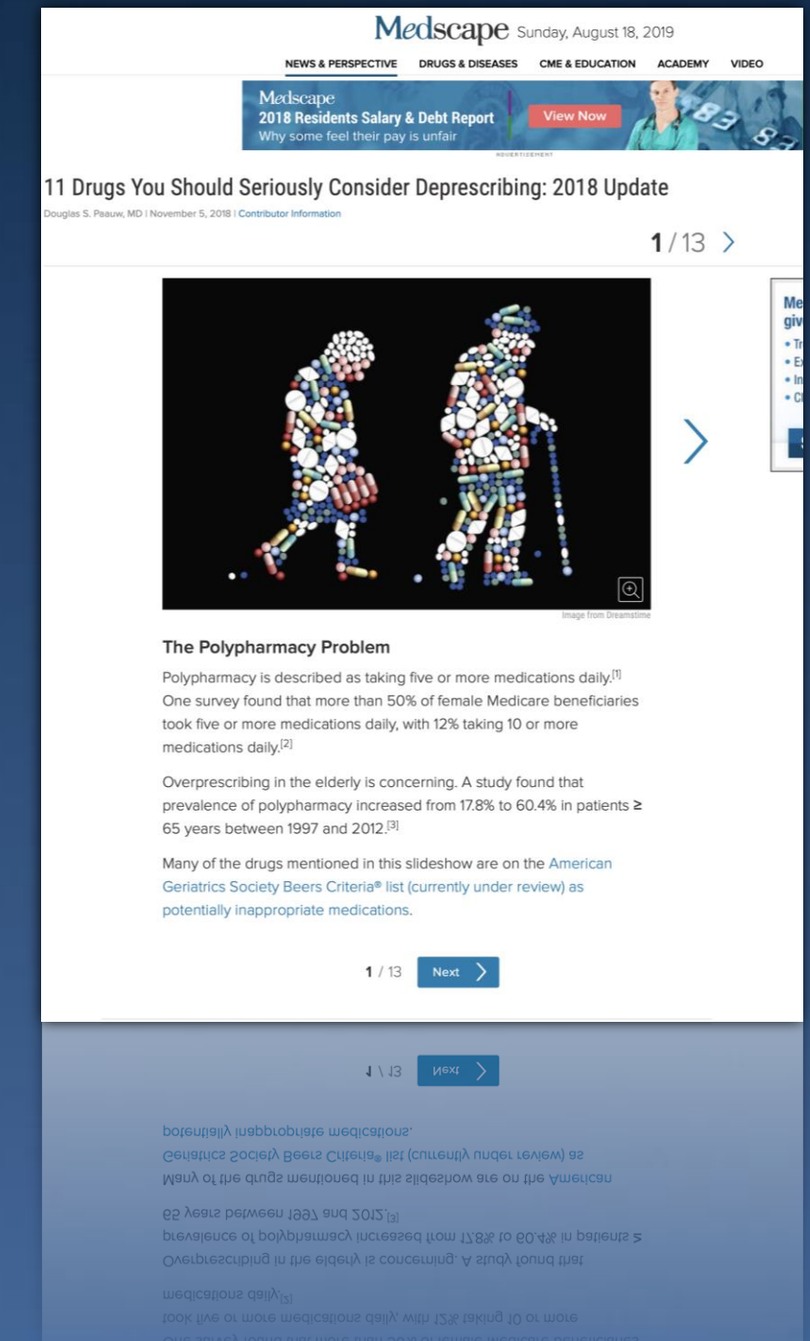
From the “Choosing Wisely” campaign…

- American Geriatrics Society
  - Don’t prescribe cholinesterase inhibitors for dementia without periodic assessment for perceived cognitive benefits and adverse gastrointestinal effects

From the Medical Press…

Medscape November 5, 2018

- On the list (elderly):
  1. Proton pump inhibitors.
  2. Statins (>75 years old).
  3. Benzodiazepines.
  4. Antimuscarinics for urinary incontinence.
  5. Cholinesterase inhibitors for Alzheimer dementia.
  6. Muscle relaxants for back pain.
  7. Supplements.



Medscape Sunday, August 18, 2019

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11 Drugs You Should Seriously Consider Deprescribing: 2018 Update

Douglas S. Paauw, MD | November 5, 2018 | Contributor Information

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Image from Dreamstime

The Polypharmacy Problem

Polypharmacy is described as taking five or more medications daily.[1] One survey found that more than 50% of female Medicare beneficiaries took five or more medications daily, with 12% taking 10 or more medications daily.[2]

Overprescribing in the elderly is concerning. A study found that prevalence of polypharmacy increased from 17.8% to 60.4% in patients ≥ 65 years between 1997 and 2012.[3]

Many of the drugs mentioned in this slideshow are on the American Geriatrics Society Beers Criteria® list (currently under review) as potentially inappropriate medications.

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Takeaways

- De-prescribing is part of the ongoing management of the patient
- Some patients may enjoy a substantial improvement in their quality of life with de-prescribing
- It isn’t an option for every patient, but every patient ought to be evaluated for the possibility
- Helpful algorithms: https://deprescribing.org/resources/deprescribing-guidelines-algorithms/

"To find health should be the object of the doctor. Anyone can find disease."

~A.T. Still MD, DO Philosophy of Osteopathy