Expert Sizes Up Palliative Care Medications

BY PATRICE WENDLING

AUSTIN, TEX. — Many new medications relevant to palliative care have come on the market recently or are about to, hospital pharmacist Mary Lynn McPherson, Pharm.D., said at the American Academy of Hospice and Palliative Medicine annual meeting.

Dr. McPherson described several new prescription drugs and over-the-counter therapies that may often be given to patients at the end of life.

Dr. McPherson commented on the following products:

► **Dexlansoprazole** (Kapidex) delayed-release capsules were approved in late January for the treatment of heartburn associated with gastroesophageal reflux disease. This *R*-isomer of lansoprazole (Prevacid) comes to market just as Prevacid is expected to go generic. Dexlansoprazole is the first proton pump inhibitor (PPI) with a dual delayed-release formulation, allowing doses of 30-60 mg a day, versus 15-30 mg a day for Prevacid. Costs per month are $150 for dexlansoprazole and $168 for Prevacid.

"We get the patient frequently in my practice in a hospice on a PPI they don't even need that's been advertised to death," said Dr. McPherson, a professor of pharmacy at the University of Maryland, Baltimore. "You know, the purple pill, [but] it doesn't work any better than the 80 cents a day over-the-counter omeprazole [Prilosec]. We only provide a PPI if the patient is on a steroid or nonsteroidal that we are also providing."

► **Sancuso** is a transdermal patch designed to deliver 3.1 mg of granisetron over 24 hours to prevent emesis caused by moderate- and high-risk emetogenic drugs. Approved by the Food and Drug Administration last fall, the patch is applied to the upper arm at least 24 hours before the first chemotherapy session and can be worn for up to 7 days. In clinical trials, it has been shown to have equal efficacy to 2 mg oral granisetron per day, Dr. McPherson said. Cost is $287 per patch.

The patch may be a better option for inpatient palliative care than for home-based hospice, where Haldol (haloperidol) is the mainstay for nausea, she said.

► **Zolpidem** (ZolpiMist) 5-mg and 10-mg oral spray was approved in late December 2008 for the short-term treatment of difficulties getting to sleep. The spray acts quickly, reaching therapeutic levels within the body in 15 minutes. Patients should be prepared to spend 7-8 hours in bed after receiving the drug.

► **Metoclopramide** products, which include Reglan (metoclopramide) tablets and injections, received a black box warning in February because chronic use has been linked to tardive dyskinesia. Patients at the end of life typically are treated with up to 40 mg a day of metoclopramide for less than 3 months, but caution should be used in elderly patients, especially women, and in those receiving both Reglan and Haldol because the combination doubles the risk of tardive dyskinesia, Dr. McPherson said.

► **Tapentadol,** a centrally acting analgesic with potency between those of morphine and tramadol, was approved at the end of 2008 for relief of moderate to severe acute pain in adults. Although not approved for chronic pain, it may be of use in hospice and palliative care, Dr. McPherson said. Tapentadol is under review by the Drug Enforcement Administration and is expected to be a scheduled drug.

► **Tramadol** is not a controlled substance at the federal level, but it may be heading that way, Dr. McPherson said. Arkansas and Kentucky have made it a schedule IV drug, and authorities in North Dakota, Ohio, and Wyoming are tracking tramadol usage through their prescription drug monitoring program as if it were controlled.

► **Propoxyphene** may be on the chopping block after two FDA advisory committees narrowly voted on Jan. 30 to recommend discontinued marketing of Darvon and Darvocet for mild to moderate pain. Propoxyphene is banned in the United Kingdom and is rarely used in Canada, but it is among the top 25 most prescribed drugs in the United States, Dr. McPherson said. She added that physicians like it because it causes less stomach upset than other opioids and can be taken by patients allergic to morphine and hydrocodone.

Propoxyphene is far from benign, Dr. McPherson said, noting that both the drug and its metabolite are cardiotoxic. Propoxyphene was a factor in 5.6% of drug-related deaths in the United States from 1981 to 1999, she said.

► **OTC products.** Emuprofen is a topically administered analgesic that contains ibuprofen and oil from the fat of the emu. It's being marketed as an anti-inflammatory and an alternative to systemic NSAID therapy for various painful conditions. Cost is about $35 for a small jar. The cream is about 10% ibuprofen. Rash and itching at the application site have been reported in up to 15% of patients.

Rain Dry Mouth Spray may be another therapeutic option for xerostomia, which affects 20% of the U.S. population and is common in people with head and neck cancer. The active ingredient is xylitol, a sugar alcohol, which can raise blood glucose if overused. Cost is about $14 for 4.5 ounces.

Tums QuickPak is a calcium carbonate powder that dissolves instantly on the tongue without the need for water and is the equivalent of two regular-strength Tums. It can be used as a daily calcium source, and for patients who can no longer swallow, she said.

Dr. McPherson disclosed that she is a consultant for Alpharma Inc. ■

Discuss Hospice and Palliative Care With Cancer Patients

BY PATRICE WENDLING

AUSTIN, TEX. — Some palliative chemotherapy regimens can cost up to $100,000 a year for end-of-life care. Yet oncologists and their patients often do not discuss less costly, alternative advanced-care options.

"This is going to come to the fore over the next year or two, as fewer and fewer people have insurance," Dr. Thomas Smith said at the annual meeting of the American Academy of Hospice and Palliative Care Medicine. "We spend twice as much as any other country for the same cancer results."

He noted that some insurance companies may soon be asking patients to pay more for third-line treatments because of their reduced possibility of benefit. If hospice is introduced early in treatment as an end-of-life option, moreover, patients tend to switch earlier and spend more time in hospice, thereby reducing patient and hospital costs. Currently, one-third of patients with cancer spend fewer than 7 days in hospice, he said.

A sea change may already be underway. Kaiser Permanente has put hospice and palliative care teams in all of its major markets, and many insurers (such as UnitedHealthcare) are expected to roll out their plans for concurrent oncology and palliative care later this year, said Dr. Smith, professor of palliative care research at Virginia Commonwealth University in Richmond.

Part of the problem is that neither oncologists nor patients want to talk about death. A recent study showed that oncologists discussed prognosis 39% of the time and impending death only 37% of the time (JAMA 2008;300:1665-73). Of 111 inpatients with cancer, only 23 said they wished to discuss their advanced-care preferences with their oncologists, and 64 said they would prefer to do so with an admitting doctor (J. Palliat. Med. 2000;3:27-35).

Reimbursement is also a thorny issue. The Medicare reimbursement for hospice and palliative care hasn't kept pace with inflation or current oncology practice trends, even though patients with cancer account for about 40% of Medicare drug costs, Dr. Smith said. Oncologists are reimbursed far more for administering chemotherapeutic agents than for having discussions about prognosis and palliative care options.

It's also hard to find good "bad" news, Dr. Smith said. He noted that treatment options for recurrent pancreatic cancer on the National Cancer Institute's Web site (www.cancer.gov) list chemotherapy, palliative surgery, palliative radiation therapy, and clinical trials.

"How about putting on there [that] in fact 95% of people are going to be dead within a year … and suggest hospice and palliative care?" he asked. "I've been beating on the NCI for 15 years on this, and will probably die before it happens."

If hospice is introduced early in treatment as an end-of-life option, patients tend to switch earlier and spend more time in hospice, thereby reducing patient and hospital costs.

For those who say patients can't handle the truth, Dr. Smith said it is nearly impossible to take away hope. Most cancer patients are overly optimistic about their prognosis and are willing to take a phase I drug, even if it has a 10% chance of killing them.

New data suggest that one of the biggest fears of the terminally ill is abandonment by their physician or nurse when disease-modifying therapy is no longer an option (Arch. Intern. Med. 2009;169:474-9).

Written treatment plans offer patients truthful information about prognosis and treatment effectiveness, Dr. Smith said. He has been using them in his practice for years, and noted that the American Society of Clinical Oncology now makes these plans available online (www.asco.org). The Centers for Medicare and Medicaid Services system is also starting demonstration projects, so physicians can get paid more if they write down their treatment plans, he said.

During the same presentation, Dr. Sarah E. Harrington offered suggestions for what oncologists should say about illness and patient options. They include being realistic about the goals of therapy; defining cure, remission, response, and what is likely to happen; and being negative, if appropriate.

"Language is important. Patients can easily mistake a 20% chance of response for a 20% chance of cure," said Dr. Harrington, also at Virginia Commonwealth.

The subject of hospice should be brought up early as part of routine oncologic care, rather than delayed until death is imminent. Oncologists should be especially realistic about nth-line chemotherapy. If no proof of benefit is available, don't offer it, she said. To avoid feelings of abandonment, oncologists should tell their patients they will not abandon them if they enroll in hospice.

Dr. Harrington and Dr. Smith referred the audience to a recent article in which they discussed questions patients should consider when asking about palliative chemotherapy, and what oncologists should or should not do or say about chemotherapy for advanced cancer (JAMA 2008;299:2667-78).

They reported no financial disclosures. ■