Alzheimer's Video Affects Care Preferences

BY PATRICE WENDLING

CHICAGO — Elderly persons shown a video depiction of advanced Alzheimer's are less likely to opt for life-prolonging care, compared with those who listen to a verbal description.

A multicenter, prospective trial randomized 200 community-dwelling adults aged at least 65 years (mean 75 years) to one of two interventions and then compared their preferences for advanced care if they were in a state of dementia. In all, 106 participants listened to a standardized verbal description of stage 7 Alzheimer's, which is the final stage of the disease when individuals lose the ability to speak or respond to their environment, and ultimately their ability to control movement. The other 94 participants listened to the verbal description and viewed a 2-minute video of a real patient with features of stage 7 Alzheimer's and her family. (Video can be viewed online at www.ACPdecisions.com.)

Among those hearing only the verbal description, 68% preferred comfort care, 17% chose limited care, 13% wanted care that would prolong their life, and 2% were uncertain.

Among those receiving both the verbal narrative and the video, 87% preferred comfort care, 8% chose limited care, 4% desired life-prolonging care, and 1% were undecided, Dr. Angelo E. Volandes said at the annual meeting of the American Geriatrics Society.

"Most patients don't have experience with advanced disease," he said. "Video may promote preferences for comfort care by providing more realistic expectations of dementia."

Preferences also appear more stable when made with the assistance of video. After 6 weeks, 27 (29%) of 94 participants interviewed in the verbal group changed their preferences, compared with only 5 (6%) of 84 participants in the video group. The difference between groups was statistically significant, said Dr. Volandes, an internal medicine physician with Massachusetts General Hospital and Harvard University Medical School, both in Boston. Comfort care was significantly more likely to be selected as the new preference (86%) in the verbal group, whereas the percentage choosing this option remained constant in the video group.

COURTESY DR. ANGELO E. VOLANDES

Care preferences remained stable when viewers watched a video of a patient with stage 7 Alzheimer's, shown here.

"The use of innovative videos in end-of-life decision-making and advance care planning discussions is relatively new," Dr. Volandes said in an interview. "Further work and studies are needed to examine the implementation of these videos in clinical practice before they can become the standard of care for advance care planning."

Dr. Volandes acknowledged that the study did not use real patients with a dementia diagnosis, and did not include Hispanics or Asians, although he said that similar findings have been observed in his previous research with Hispanics.

The convenience sample, selected from two primary care and two geriatric clinics, was 58% female, 29.5% African American, and had a score of 7 or higher on the Short Portable Mental Status Questionnaire. Overall, 68% of the verbal group and 73% in the video group had a 9th-grade or higher level of health literacy on the Rapid Estimate of Adult Literacy in Medicine test.

One audience member remarked that advanced care directives are the most important thing he does as a geriatrician, and another acknowledged the struggle that often arises over goals of care with family members and health care power of attorney documents. The use of video in advance care planning has been evaluated in surrogate decision makers with similar results, Dr. Volandes said.

Dr. Volandes, who received a new investigator award for his work by the American Geriatrics Society, disclosed no conflicts of interest for himself or his associates. The study was sponsored by the Alzheimer's Association, the John A. Hartford Foundation, and the Foundation for Informed Medical Decision Making. ■

New Pain Guideline Takes Aim at NSAID Use in the Elderly

BY PATRICE WENDLING

CHICAGO — An updated guideline addressing persistent pain in older people takes a tough stance on the use of nonsteroidal anti-inflammatory drugs.

The American Geriatrics Society (AGS) guideline recommends that acetaminophen be considered for initial and ongoing treatment of persistent pain, particularly musculoskeletal pain. But in a significant departure from its 2002 guideline, the AGS recommends that nonselective NSAIDs and cyclooxygenase-2 (COX-2) selective inhibitors "be considered rarely, and with extreme caution, in highly selected individuals."

The AGS had recommended that seniors use over-the-counter or prescription NSAIDs, such as aspirin or ibuprofen, or COX-2 inhibitors before being prescribed an opioid. The current recommendation reflects recent good evidence that this is a risky strategy in older people, panel member Dr. James Katz said at the society's annual meeting, where the guidelines ("Pharmacological Management of Persistent Pain in Older Persons") were released.

Traditional NSAIDs are associated with adverse gastrointestinal events in 20% of patients, with 107,000 hospitalizations and 16,500 deaths yearly attributed to NSAID-related GI complications.

COX-2 inhibitors seem to produce fewer upper GI events than do other NSAIDs, but "all nonsteroidals, whether they are [COX-2 inhibitors] or not, have a significant portfolio of adverse effects that is noteworthy for the elderly population," said Dr. Katz, director of rheumatology at George Washington University in Washington. "They can aggravate hypertension, they can cause renal impairment by a variety of mechanisms, [they can cause] edema [and] gastrointestinal problems, and now we know cardiovascular and cerebrovascular disease can be attributed to nonsteroidal interaction."

Last year's study of 336,906 community-dwelling Medicaid beneficiaries by the Veterans Affairs Tennessee Valley Healthcare System extended concerns about COX-2 selective inhibitors to cerebrovascular disease, said Dr. Katz. The study suggested an increased risk of stroke with rofecoxib (Vioxx) and valdecoxib (Bextra), compared with the effects of nonselective agents (Stroke 2008;39:2037-45). The finding was not statistically significant, but both drugs have been withdrawn from the market.

Recent evidence also showed that combining a traditional NSAID with low-dose aspirin therapy increases the risk of GI bleeding beyond that of the traditional NSAID alone (Curr. Opin. Rheumatol. 2008;20:239-45). In 2006, the Food and Drug Administration warned against taking aspirin and ibuprofen together.

More research is needed to determine whether other NSAIDs interfere with the cardioprotective benefits of low-dose aspirin, said Dr. Katz, who was part of a panel unveiling the guidelines at the meeting. Panel members also said that more data are needed on the safety of topical preparations of NSAIDs.

The revised guideline recommends the eradication of *Helicobacter pylori* prior to initiating NSAIDs for pain, and the use of a proton pump inhibitor or misoprostol for gastrointestinal protection in older persons taking nonselective NSAIDs or in patients taking a COX-2 selective inhibitor with aspirin.

The guideline recommends that physicians consider opioid therapy for patients with moderate to severe pain, pain-related functional impairment, or diminished quality of life because of pain. People with continual or frequent daily pain may be treated with around-the-clock, time-contingent dosing aimed at achieving steady-state opioid therapy, said Dr. Perry Fine of the pain management center at the University of Utah, Salt Lake City.

He noted the guideline's caution concerning methadone, and recommended that only clinicians who are well versed in its use and risks initiate and titrate the drug. "That doesn't mean you don't do it," said Dr. Fine, "but hook yourself up to someone who has a lot of experience in this when you believe this drug is indicated, if you don't have the experience."

Methadone-related deaths during pain treatment have risen up to eightfold in recent years, largely because methadone is attractive as a relatively inexpensive drug, but it has an unpredictable and long half-life. That the drug stays active is a blessing, but is also a problem because it accumulates in the body, Dr. Fine said.

Earlier this year, the American Pain Society and the American Academy of Pain Medicine released clinical guidance on the management of opioid therapy for chronic noncancer pain (J. Pain 2009; 10:113-30). Like the AGS guidelines, that document stressed the need for clinicians to regularly assess patients for pain intensity, functional status, side effects, and safe and responsible medication use.

The updated AGS guideline also provides new references and discussions of the use of newer adjuvant, topical, and other drugs for recalcitrant pain. "Persistent pain isn't a normal part of aging and should not be ignored," Dr. Cheryl Phillips, AGS president, said in a statement. "As seniors become susceptible to more complex health ailments, the need for a clear and precise pain management plan is key."

The AGS published its first pain guideline in 1998. For the 2009 recommendations, a panel of experts conducted a systematic review of 2,400 abstracts and 240 data-based, full-text articles. It focused on pharmacotherapy because it is the most common strategy used for pain management among elderly people, as well as the area of greatest risk, said panel chair Dr. Bruce Ferrell of the University of California, Los Angeles. The 2009 update is to be published in an upcoming issue of the Journal of the American Geriatrics Society.

Dr. Katz disclosed that he has served as a paid consultant for the American Academy of CME Inc. and for UCB Pharma Inc. Dr. Fine said he is as a paid consultant or speaker for numerous pharmaceutical companies and has commercial interests in Johnson & Johnson and Cephalon Inc. Dr. Ferrell disclosed no relevant conflict of interest. ■

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