Our results show that DNAR status or chart orders may not predict family wishes at the exact time of death or accurately assess the efficacy of ACP, particularly in PPC. A better outcome marker for palliative care may be documentation of a holistic ACP discussion between clinicians and family members, regardless of the specific orders that result.

We acknowledge that the retrospective methodology limited the ability to fully explore some hypotheses, e.g., whether families began with one set of goals and then changed to another. Although the overall 15-year study cohort included patients who also received care at home and in hospital, there was insufficient information about interventions at the end of life, especially for those children who died at home or in community hospitals, and they were therefore not included in the analysis. As a result of this limitation, it has been difficult to assess the impact of the hospice environment, along with specialized pediatric palliative nursing and counseling support, on parent decisions at the end of life.

Regular ACP discussions appear to have a significant impact on outcome at least in the inpatient hospice setting. We do not minimize the importance of the AD DNAR order. We believe, however, that far more important, and more likely to determine what happens at the time of impending death, is the inclusion of ACP discussions as an integral part of the treatment plan. These findings have implications for clinical practice, program evaluation, and outcomes research.

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Should the Treatment of Hypothyroidism Be Withdrawn in Hospice Care?

To the Editor:

Approximately one-quarter of patients enrolled in hospice continue to be on disease-focused therapies at the end of life.1 Medications often cited include anticoagulants, antidepressants, and proton pump inhibitors, medications not directly palliating symptoms.1 In a recent article published in this journal, “The burden of polypharmacy in patients near the end of life,” McNeil et al.2 looked at the significant medication load among patients near the end of life. The study showed there was no significant difference with the amount of pill burden patients with a life expectancy of less than one month (47.5% of whom had a primary diagnosis of malignancy) were on during hospice enrollment compared with the time of death and/or study termination (11.5 [standard deviation 5] vs. 10.7 [standard deviation 5], respectively). The study also showed that levothyroxine was a commonly prescribed medication.
I recently saw a patient who had terminal dementia and was enrolled in hospice. She was a 92-year-old female with advanced Alzheimer’s dementia residing in a nursing home. She had a slow, steady decline medically and functionally for months and was deemed appropriate for hospice enrollment as her life expectancy was predicted to be less than six months. Her medical history was significant for a low-grade papillary thyroid cancer that was treated by thyroidectomy 30 years earlier. She had been on levothyroxine since then. More recently, levothyroxine was dosed at 200 μg daily. On her enrollment in hospice, her medications including levothyroxine were discontinued. Laboratory orders before hospice enrollment to monitor her thyroid function were missed and not discontinued upon hospice enrollment. This was unfortunately carried out two months after hospice enrollment. Her serum thyroid-stimulating hormone was noted to be 78 uIU/mL (N, 0.3–4.2 uIU/mL), which was 0.07 uIU/mL three months earlier. She remained confused and cognitively impaired without acute changes in her previous mental status despite biochemical evidence of overt hypothyroidism.

This case illustrates that patients who are nearing the end of life and, thus, appropriately enrolled in hospice services should have a thorough clinical review of their co-morbidities and medications. Aside from this, the unforeseen laboratory evaluation, which other providers may deem inappropriate for a hospice patient, fortuitously confirmed the presence of overt biochemical hypothyroidism in the patient. Although no clinically evident alterations in mentation occurred, such occurrence may have happened or will happen had she remained overtly hypothyroid for a longer period of time. Furthermore, clinical effects of hypothyroidism may be difficult to establish in a patient who has advanced dementia at baseline.

Hypothyroidism, particularly in the oldest old, is highly prevalent. Patients with hypothyroidism have impairment in cognition and mood. Overt hypothyroidism, although usually not deemed a life-threatening condition, could sometimes be associated with confusion, disorientation, and psychosis, previously described as “myxedematous madness.” Thyroid hormone replacement may ameliorate some of these symptoms. This factor may be of importance in managing hospice-enrolled patients as these symptoms affect quality of life, which is a foremost goal with symptom palliation. Unfortunately, studies addressing this issue are lacking.

It may be prudent to pursue treatment of hypothyroidism among hospice patients on a high doses of levothyroxine, those who have hypothyroidism with clear indications for treatment (i.e., history of Hashimoto’s thyroiditis, surgically induced hypothyroidism), and most importantly, those who are projected to have a longer survival on hospice enrollment (i.e., months). This may result in palliation of hypothyroid symptoms. Normalization of thyroid-stimulating hormone occurs much later (at least four weeks, possibly much longer, usually in six to eight weeks). Although it is true that the weight of polypharmacy in patients near the end of life is high and that “deprescribing” needs to happen as the life-limiting condition advances, clinicians need to be judicious, always putting this in the context of the patient’s terminal disease. A portion of patients enrolled in hospice may still benefit from treating their comorbidities, such as hypothyroidism; addressing this may still affect quality of life, even in a dying patient. The pill burden of an extra levothyroxine tablet may potentially negate risks of clinical hypothyroidism in a hospice-enrolled patient. Future studies are needed to address this issue.

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