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End-of-Life Care in Imprisoned Persons



To the Editor,

In 2014, there were 2,224,400 incarcerated people in the U.S.¹ In 2013, 4446 inmates died while in custody of local or state prisons. Suicide and heart disease were the top two causes of death, at 34% and 27%, respectively.² While the age distribution of imprisoned persons has not changed over time, the age of prison populations has increased by 80% between 2000 and 2009.^{2,3} In addition, deaths of incarcerated people have been demonstrated to occur at a younger chronological age when compared to the general population.⁴

As offenders age behind bars, the population of elderly patients and the number of deaths in prison increase, and correctional facilities must develop ways to provide end-of-life care.³ We describe a case to highlight some of the challenges to providing care to this population.

Case Description

A 53-year-old man with HIV/AIDS and cirrhosis presented to another hospital with persistent fevers and was found to have pancytopenia. Through multiple hospitalizations, hematology and infectious disease consultations revealed a diagnosis of HIV/AIDS, hepatitis C, and presumptive acquired hemophagocytic lymphohistiocytosis. During his last hospitalization, he became hypoxic and required ICU admission. As his mental status deteriorated and his kidneys and liver began to fail, palliative care was consulted to help discuss goals.

At the time of the palliative care consultation, the patient had been incarcerated for seven months for a nonviolent crime. He was eligible for bail but was unable to afford the bond. He had remained in police custody during that time.

The palliative care consultant determined that the patient's prognosis was very poor. He was comatose, had irregular breathing, and his urine output was less than 100 mL/day. A family meeting was held, and with the family's agreement, he was to be offered

comfort care at the end of life. Symptom management at this point was provided with morphine, haloperidol, and glycopyrrolate. Social work supported the family.

Throughout his hospitalization, he was handcuffed at both wrists to the bed and had two guards stationed at the bedside at all times. His family was only allowed to be at the bedside for 15-minute increments, one person at a time, for a maximum of one hour a day. The prison warden and patient's attorney were contacted to advocate for leniency in these rules, and after much discussion, we were able to transition to soft one-wrist restraint. The family was unable to spend more than one hour at the bedside. The patient died restrained and under supervision of two armed guards.

Comment

As populations behind bars age, the need for expert end-of-life care in prisons increases. In 2011, there were 69 prison-based hospice programs in the U.S., many based on the system at Louisiana State Penitentiary.⁵ The hospice program at Louisiana State Penitentiary has been in operation since 1998, caring for 227 patients between 1998 and 2014. The program is a "peer-care model," whereby trained inmate volunteers provide much of the care, including assistance with activities of daily living, monitoring of symptoms, and providing social and spiritual support.

Multiple organizations have published guidelines for prison-based hospice units, including the National Prison Hospice Association, the National Hospice and Palliative Care Organization, and the Guiding Responsive Action for Corrections in End-of-Life Care project. These guidelines highlight the increasing call from the medical community to provide compassionate end-of-life care to prison populations.^{5,6} Encouragingly, prison-based hospice units have been found to generally follow the Guiding Responsive Action for Corrections in End-of-Life Care project guidelines, although there is variation among units with respect to visitation policies and opioid use.⁶

This progress notwithstanding, there continue to be few correctional institutions with hospice facilities and most prisoners continue to use community hospitals for end-of-life care. This may burden patients and families and incurs costs related to transportation and security.⁶ In California, for example, 745 prisoners died in community hospitals between 2009 and 2013.⁷

In all sites of care, inmate visitation policies may impede psychosocial support at the end of life. A survey of prison-based hospice units found that only 29% of prison-based hospice programs permit unlimited

visits by nonincarcerated family members, regardless of the patient's condition, and an additional 11% allow daily visits as the patient's condition worsens.⁶ Visitation policies are similarly limited for younger family members and incarcerated family members.⁶ Visitation policies for inmates not in hospice programs vary among states, with some states promoting visitation and offering, for example, six visitation hours everyday, and others far more restrictive, for example, allowing only one visitor a day for a limited number of days a year.⁸ Although the visitation policies may be more relaxed for prisoners in hospice units, they too do not provide unlimited access at the end of life. Although most prison-based hospices do permit vigils, only 40% offer family members around-the-clock access to patients.⁶

Pain management also can be a challenge in the end-of-life care provided to incarcerated persons, a population with a high rate of substance abuse history. Providers may not adequately treat pain due to concerns about abuse or diversion of opioid drugs.⁶ They provide more "conservative" pain management, fearing the adverse consequence of opioids filtering through the prison population.⁹ In prison-based hospice units, 92% use sustained-release opioid medications and 18% use patient-controlled analgesia pumps, further demonstrating the variation in practices.⁶ Incarcerated patients with a history of substance abuse also may be hesitant about using opioid pain medication for fear of relapsing or feeling they are losing their sobriety.

Establishing trust is another challenge to providing end-of-life care to this population. The relationship between the patient and physician is fundamental to effective end-of-life care, particularly when moving toward increased focus on symptom management, as the patient and family must trust the provider that this is the most appropriate treatment strategy. Prisoners, however, are less likely to trust the system and are more skeptical about decisions to pursue comfort care.^{10,11} That is, there is an inherent distrust in the recommendation that they should pursue comfort care at the end of life, which may explain why approximately half of prison-based hospices require neither cessation of curative treatment nor a do-not-resuscitate order.⁶

The patient described previously provides further insight into end-of-life care in imprisoned patients. During the final days of his life, the patient received appropriate pain and symptom management, as well as psychosocial support for his family from our interdisciplinary team. Unfortunately, however, permissible visitation hours were suboptimal and the family felt restricted. In addition, although there are safety concerns when patients are in a community hospital, the question remains of the role of handcuffs and

restraints in these patients, particularly in obtunded patients who cannot interact with their environment.

Although there is increasing awareness of the need to provide compassionate end-of-life care to incarcerated persons, as highlighted by the development of prison hospice units, this case highlights some of the ongoing challenges and the work that still needs to be done in delivering this essential and humane medical care to inmates.

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Difficulties in Pain Management Using Oxycodone and Fentanyl in Enzalutamide-Treated Patients With Advanced Prostate Cancer



To the Editor:

Pain treatment in patients with bone-metastasized advanced prostate cancer is often challenging. A range of treatment modalities are available to control prostate cancer-specific pain, such as androgen deprivation therapies, taxane-based chemotherapy, radionuclide therapy with radium-223, or palliative radiotherapy. In addition, analgesics are commonly used for direct symptom management.

We describe three cases which show difficulties of pain management in enzalutamide-treated patients with metastatic bone disease due to castration-resistant prostate cancer (CRPC). The potential illustrations of drug-drug interactions noted in these cases are of important clinical relevance.

Patient A is a 70-year-old CRPC patient with progressive bone disease despite second-generation androgen deprivation therapy with enzalutamide (160 mg per day). The urologist started fixed-dose paracetamol and oxycodone 5 mg immediate release if needed and referred the patient to the radiotherapist for palliative radiotherapy with single-dose treatment of 8 Gy for painful iliac bone metastases. The analgesic treatment was insufficient, and the patient was referred to our outpatient clinic. We added a low dose of controlled-release oxycodone. This was also ineffective and we therefore increased the dose to twice-daily 20 mg plus escape medication for breakthrough pain. Unfortunately, these interventions did not result in any clinical benefit, even after addition of dexamethasone. Enzalutamide is known to be a strong inducer of hepatic drug metabolism via induction of the cytochrome P450 (CYP) enzyme group, so to optimize analgesia, we initiated opioid rotation, specifically morphine sulfate 30 mg twice daily because of non-CYP-mediated drug metabolism.