1. Re-branding cannabis: The next generation of chronic pain medicine?.
Carter G.T., Javaher S.P., Nguyen M.H.V., Garret S., Carlini B.H.
Pain Management. 5 (1) (pp 13-21), 2015. Date of Publication: 01 Jan 2015.
AN: 2015643540
The field of pain medicine is at a crossroads given the epidemic of addiction and overdose deaths from prescription opioids. Cannabis and its active ingredients, cannabinoids, are a much safer therapeutic option. Despite being slowed by legal restrictions and stigma, research continues to show that when used appropriately, cannabis is safe and effective for many forms of chronic pain and other conditions, and has no overdose levels. Current literature indicates many chronic pain patients could be treated with cannabis alone or with lower doses of opioids. To make progress, cannabis needs to be re-branded as a legitimate medicine and rescheduled to a more pharmacologically justifiable class of compounds. This paper discusses the data supporting re-branding and rescheduling of cannabis.
Institution
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Publisher
Future Medicine Ltd.
Emtree Heading
analgesia; drug legislation; *drug marketing; drug safety; epidemic; human; *neuropathic pain/dt [Drug Therapy]; practice guideline; review; cannabinoid; dronabinol; *medical cannabis/dt [Drug Therapy]; nabilone; opiate.
Drug Trade Names and Manufacturers
cesamet, marinol

2. Rethinking COPD care in the UK: Who cares?.
The Lancet Respiratory Medicine. 3 (1) (pp 1), 2015. Date of Publication: 01 Jan 2015.
AN: 2015648918
Publisher Lancet Publishing Group
Emtree Heading aging; *chronic obstructive lung disease; comorbidity; editorial; health care cost; health care delivery; health care quality; human; medical audit; medical specialist; mortality; noninvasive ventilation; nurse; palliative therapy; *patient care; practice guideline; smoking cessation program; *United Kingdom.

3. Researching the rehabilitation needs of patients with life-limiting disease: Challenges and opportunities.
Leslie P., Sandsund C., Roe J.
Progress in Palliative Care. 22 (6) (pp 313-318), 2014. Date of Publication: 01 Dec 2014.
AN: 2014620977
People with life-limiting disease are among the most vulnerable groups accessing healthcare. Given this vulnerability, polarized views have been expressed in the literature regarding such individuals' involvement in research studies. This is further compounded when the research is focused on rehabilitation, the concept of which is often misunderstood by patients, carers, and medical professionals. A number of factors can affect how we conduct research to elicit the needs of people with life-limiting disease, including social, historical, and cultural influences. Despite advances in palliative care research, challenges remain for those working across the specialism. In this review, we discuss the challenges of conducting rehabilitation research in this distinct clinical specialism and important considerations when involving patients and carers. We highlight the opportunities for understanding patient rehabilitation needs through mixed methods research design for studies involving those undergoing potentially complex rehabilitation interventions across settings. Note: People with life-limiting disease will be referred to as 'patients' in the context of their being involved with the healthcare system and receiving care from a clinician. Institution
Marcus J.D., Mott F.E.  
AN: 2014967531  
Background: Communication is the cornerstone of good multidisciplinary medical care, and the impact of conversations about diagnosis, treatment, and prognosis is indisputable. Healthcare providers must be able to have difficult conversations that accurately describe diagnostic procedures, treatment goals, and the benefits and/or risks involved. Methods: This paper reviews the literature about the importance of communication in delivering bad news, the status of communication training, communication strategies, and psychosocial interventions. Results: Although many published guidelines address difficult communication, communication training is lacking. Consequently, many clinicians may have difficulties with, or in the worst-case scenario, avoid delivering bad news and discussing end-of-life treatment. Clinicians also struggle with how to have the last conversation with a patient and how to support patient autonomy when they disagree with a patient's choices. Conclusion: There is a clinical imperative to educate physicians and other healthcare workers on how to effectively deliver information about a patient's health status, diagnostic avenues to be explored, and decisions to be made at critical health junctions. Knowing how to implement the most rudimentary techniques of motivational interviewing, solution-focused brief therapy, and cognitive behavioral therapy can help physicians facilitate conversations of the most difficult type to generate positive change in patients and families and to help them make decisions that minimize end-of-life distress.  
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Publisher  
Ochsner Clinic  
Emtree Heading  
article; cognitive therapy; *communication skill; *conversation; doctor patient relation; health care personnel; *health care quality; human; information dissemination; *interpersonal communication; motivational interviewing; patient autonomy; patient decision making; practice guideline; psychotherapy; solution focused brief therapy; terminal care; training.
5.
LAM: Lymphangioleiomyomatosis: The patient and healthcare professional perspective.
Bassi I., Harari S.
Breathe. 10 (4) (pp 331-332), 2014. Date of Publication: 01 Dec 2014.
AN: 2014961117
Institution
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Publisher
European Respiratory Society
Emtree Heading
angiomyolipoma; anxiety disorder; bronchoscopy; chylothorax; clinical protocol; computer assisted tomography; coughing; diet therapy; disease course; disease marker; doctor patient relation; drug efficacy; dyspnea; emphysema; fatigue; fever; follow up; gender; health promotion; human; information dissemination; interdisciplinary communication; kinesiotherapy; lifestyle modification; lung biopsy; lung cyst; lung function test; *lymphangioleiomyomatosis/di [Diagnosis]; *lymphangioleiomyomatosis/th [Therapy]; *lymphangioleiomyomatosis/dt [Drug Therapy]; medical information; note; palliative therapy; panic; *patient attitude; *physician attitude; pneumothorax; prognosis; quality of life; symptomatology; thorax radiography; yoga; bronchodilating agent/dt [Drug Therapy]; rapamycin/dt [Drug Therapy]; vasculotropin D/ec [Endogenous Compound].

6.
Assessing and treating depression in palliative care patients.
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Publisher
Quadrant Healthcom Inc.
Emtree Heading
advanced cancer; algorithm; article; cancer patient; critically ill patient; death; *depression/di [Diagnosis]; *depression/dt [Drug Therapy]; *depression/si [Side Effect]; *depression/th [Therapy];
The perspectives of educators, regulators and funders of massage therapy on the state of the profession in British Columbia, Canada.

Shroff F.M., Sahota I.S.


AN: 2013093630

Background: Registered Massage Therapists (RMTs) are valuable members of the healthcare team who assist in health promotion, disease prevention, treatment, rehabilitation and palliation. RMT visits have increased across Canada over the past decade with the highest increase in British Columbia (BC). Currently, RMTs are private practitioners of healthcare operating within a largely publicly funded system, positioning them outside of the dominant system of healthcare and making them an important case study in private healthcare. In another paper we examined the perspectives of RMTs themselves. Here, we offer perspectives of regulators, educators and funders of Massage Therapy (MT) on advancement of the profession.

Methods: We interviewed 28 stakeholders of MT in BC - including members of the MT regulatory board, representatives from MT colleges in BC and public and private health insurers.

Results: All three groups identified research, particularly on efficacy of MT, as playing a vital role in enhancing the professional credibility of MT. However, participants noted that presently research is not a large feature of the current MT curricula and we analyze why this may be and how it can improve. Finally, conferral of baccalaureate degree status could assist RMTs in gaining recognition with the general public and other healthcare professionals.

Conclusion: RMTs have potential to ameliorate population health in a cost-effective manner. Their role in British Columbia’s healthcare landscape could be expanded if they produce more research and earn degree status. 2013 Shroff and Sahota; licensee BioMed Central Ltd.
8. Heart failure readmissions.
Shah K.B., Rahim S., Boxer R.S.
Current Treatment Options in Cardiovascular Medicine. 15 (4) (pp 437-449), 2013. Date of Publication: August 2013.
AN: 2013487767

Opinion statement: Heart failure readmissions (HFR) represent a personal burden for patients and a large financial burden for the healthcare system. As such, strategies to decrease HFR are avidly sought and studied. There are many reasons for HFR that challenge programs aimed to reduce the frequency of HFR. Large pharmacological and device trials often incorporate hospital admission as an endpoint, and many programs have been developed in varied settings to address HFR. Some of the most successful programs use a multidisciplinary team approach, intensive patient education and system commitment. Many risk factors for HFR have been identified although prediction tools are limited. The reduction of HFR should incorporate a multidisciplinary approach with 1) evidenced-based physician-guided medical and device therapy; 2) institutional programs for effective care transitions; 3) strategies aimed to improve disease management; and 4) engage patients in self-care. 2013 Springer Science+Business Media New York.

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Publisher
Springer Healthcare

Emtree Heading
acute heart failure/dt [Drug Therapy]; article; cardiac resynchronization therapy; device therapy; drug efficacy; drug mechanism; health care cost; health care planning; health program; *heart failure/dt [Drug Therapy]; *heart failure/th [Therapy]; *hospital readmission; human; invasive procedure; lifestyle modification; medical ethics; practice guideline; prediction; risk assessment; sodium restriction; systolic heart failure; telemonitoring; terminal care; ultrafiltration; water
9.
In patients receiving end-of-life care, medications used to treat co-morbid diseases should be discontinued when appropriate.
Adis Medical Writers
Drugs and Therapy Perspectives. 30 (12) (pp 432-434), 2014. Date of Publication: 15 Nov 2014.
AN: 2014919067
Pharmacological treatment in end-of-life care should focus on minimizing symptoms and relieving suffering. Therefore, the continued use of chronic medications for co-morbid conditions should be evaluated on an individualized basis.
Institution
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Springer International Publishing
Emtree Heading
article; comorbidity; deep vein thrombosis; dying; human; interpersonal communication; life expectancy; *palliative therapy; practice guideline; quality of life; *terminal care; *treatment withdrawal; antidiabetic agent; antihypertensive agent; antiinfective agent; hydroxymethylglutaryl coenzyme A reductase inhibitor.

10.
The role of the keyworker in breaking down professional culture barriers to providing high-quality palliative care: A literature review.
Feuz C.
AN: 2014908314
Background Palliative cancer care is by definition multi-professional in nature. An interdisciplinary approach to disease management emphasising continuity of care results in increased quality of life for patients and families. Complex disease management demands the provision of a full spectrum of high-quality care; requiring both specialist and generalist services. Appointed keyworkers are knowledgeable about patient preferences enabling effective coordination of care.
and promotes collaborative team-working. The need for diversity in the provision of palliative care is recommended but can challenge effective interdisciplinary collaboration by creating tension and limiting the interdisciplinary team (IDT) from reaching its full potential resulting in adverse outcomes. Purpose The purpose of this paper is to review the literature available regarding how IDTs and keyworkers influence high-quality palliative care; evaluate how professional culture barriers can influence team collaboration; discuss the keyworker role in minimising these barriers and clinical implications. Methodology A review of the English literature from 2003 to 2013 was performed using the databases PubMed (NML), OVID Medline and Google Scholar. Results and conclusion Keyworkers can help overcome professional culture barriers that result from ineffective team communication. Facilitating improved communication regarding professional roles fosters mutual understanding among team members. The dissemination of relevant and timely information minimises fragmentation, prompting team decision-making and promotes continuity of high-quality palliative care.

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Cambridge University Press

Emtree Heading
*cancer palliative therapy; cancer patient; comprehension; coordination; *cultural factor; decision making; foster care; health care personnel; health care quality; human; information dissemination; interdisciplinary education; medical specialist; patient care; practice guideline; quality of life; review; teamwork.

11. Cancer care delivery in India at the grassroot level: Improve outcomes.
Sirohi B.
Indian Journal of Medical and Paediatric Oncology. 35 (3) (pp 187-191), 2014. Date of Publication: 01 Sep 2014.
AN: 2014872632
Institution
(Sirohi) Department of Medical Oncology, Kiran Mazumdar-Shaw Cancer Centre, Narayana Health, Bengaluru, Karnataka, India
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Medknow Publications (B9, Kanara Business Centre, off Link Road, Ghatkopar (E), Mumbai 400 075, India)

Emtree Heading
breast cancer/[Prevention]; cancer center; cancer prevention; cancer research; cancer survival; communication skill; cost effectiveness analysis; data base; head and neck cancer/[Prevention]; *health care delivery; *health care quality; human; India; lung cancer/[Prevention]; medical education; oncology nursing; outcome assessment; practice guideline; review; terminal care; uterine cervix cancer/[Prevention].
The DOMUS study protocol: A randomized clinical trial of accelerated transition from oncological treatment to specialized palliative care at home.
BMC Palliative Care. 13 (1) , 2014. Article Number: 44. Date of Publication: 09 Sep 2014.
AN: 2014855872

Background: The focus of Specialized Palliative Care (SPC) is to improve care for patients with incurable diseases and their families, which includes the opportunity to make their own choice of place of care and ultimately place of death. The Danish Palliative Care Trial (DOMUS) aims to investigate whether an accelerated transition process from oncological treatment to continuing SPC at home for patients with incurable cancer results in more patients reaching their preferred place of care and death. The SPC in this trial is enriched with a manualized psychological intervention. Methods/Design: DOMUS is a controlled randomized clinical trial with a balanced parallel-group randomization (1:1). The planned sample size is 340 in- and outpatients treated at the Department of Oncology at Copenhagen University Hospital. Patients are randomly assigned either to: a) standard care plus SPC enriched with a standardized psychological intervention for patients and caregivers at home or b) standard care alone. Inclusion criteria are incurable cancer with no or limited antineoplastic treatment options. Discussion: Programs that facilitate transition from hospital treatment to SPC at home for patients with incurable cancer can be a powerful tool to improve patients' quality of life and support family/caregivers during the disease trajectory. The present study offers a model for achieving optimal delivery of palliative care in the patient's preferred place of care and attempt to clarify challenges. Trial registration: Clinicaltrials.gov Identifier: NCT01885637.

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Publisher
BioMed Central Ltd.

Emtree Heading
adult; advanced cancer; article; bereavement; cancer chemotherapy; cancer mortality; *cancer palliative therapy; cancer survival; *cancer therapy; caregiver; clinical protocol; controlled study;
cost effectiveness analysis; *home care; human; major clinical study; metastasis; quality of life; randomized controlled trial.

13. Uchunguzi: (Journal Watch/Montre de journal).
Wachira B.W.
AN: 2014784659
Institution
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Publisher
African Federation for Emergency Medicine
Emtree Heading
antibiotic prophylaxis; article; chest tube; childhood disease/diagnosis; *clinical assessment; clinical observation; *clinical protocol; conservative treatment; *death; death certificate; diagnostic value; doctor patient relation; *echography; *emergency care; emergency health service; extrapulmonary tuberculosis/diagnosis; family; first aid; grief; health care organization; health care policy; hospital readmission; human; infection rate; *injury; ionizing radiation; *laceration; law enforcement; leg; length of stay; lung tuberculosis/diagnosis; nurse; *patient care; patient transport; physician; pleura effusion; *pneumothorax; premature labor; *rescue personnel; respiratory distress; resuscitation; risk factor; stab wound; *standardization; terminal care; thorax injury; thorax radiography; traumatic brain injury; antibiotic agent.

14. The clinical and integrated management of COPD. An official document of AIMAR (Interdisciplinary Association for Research in Lung Disease), AIPO (Italian Association of Hospital Pulmonologists), SIMER (Italian Society of Respiratory Medicine), SIMG (Italian Society of General Medicine).
Multidisciplinary Respiratory Medicine. 9 (1) , 2014. Article Number: 25. Date of Publication: May 2014.
AN: 2014393335
COPD is a chronic disease of the respiratory system characterized by persistent and partially reversible airflow obstruction, to which variably contribute remodeling of bronchi (chronic
bronchitis), bronchioles (small airway disease) and lung parenchyma (pulmonary emphysema). COPD can cause important systemic effects and be associated with complications and comorbidities. The diagnosis of COPD is based on the presence of respiratory symptoms and/or a history of exposure to risk factors, and the demonstration of airflow obstruction by spirometry. GARD of WHO has defined COPD "a preventable and treatable disease". The integration among general practitioner, chest physician as well as other specialists, whenever required, assures the best management of the COPD person, when specific targets to be achieved are well defined in a diagnostic and therapeutical route, previously designed and shared with appropriateness. The first-line pharmacologic treatment of COPD is represented by inhaled long-acting bronchodilators. In patients with FEV1 < 60% of predicted and with a clinical history of proven bronchial hyperreactivity or with frequent exacerbations (>3/last 3 years) inhaled corticosteroid should be added. Long term oxygen therapy (LTOT) is indicated in stable patients, at rest while receiving the best possible treatment, and exhibiting a PaO2 < 55 mmHg (SO2 < 88%) or PaO2 values between 56 and 59 mmHg (SO2 < 89%) associated with pulmonary arterial hypertension, cor pulmonale, or edema of the lower limbs or hematocrit > 55%. Respiratory rehabilitation is addressed to patients with chronic respiratory disease in all stages of severity who report symptoms and limitation of their daily activity. It must be integrated in an individual patient tailored treatment as it improves dyspnea, exercise performance, and quality of life. Acute exacerbation of COPD is a sudden worsening of usual symptoms in a person with COPD, over and beyond normal daily variability that requires treatment modification. The pharmacologic therapy can be applied at home and includes the administration of drugs used during the stable phase by increasing the dose or modifying the route, and adding, whenever required, drugs as antibiotics or systemic corticosteroids. In case of patients who because of COPD severity and/or of exacerbations do not respond promptly to treatment at home hospital admission should be considered. Patients with "severe" or "very severe" COPD who experience exacerbations should be carried out in respiratory unit, based on the severity of acute respiratory failure. An integrated system is required in the community in order to ensure adequate treatments also outside acute care hospital settings and rehabilitation centers. This article is being simultaneously published in Sarcoidosis Vasc Diffuse Lung Dis 2014, 31(Suppl. 1);3-21. 2014 Bettoncelli et al.
Medicare Part D plans burdened by hospice payment reform.
Altenburger S., Miller M., Weingart W.
American Journal of Pharmacy Benefits. 6 (4) (pp 154-160), 2014. Date of Publication: July/August 2014.
AN: 2014561319

Background: In an effort to reform the current hospice payment system, CMS has taken steps to address its concerns through guidance and proposed rule making, focusing on proper determination and payment of drugs for beneficiaries during a hospice enrollment. That is, should the Part A hospice benefit or Part D pay for prescribed drugs obtained at a pharmacy?

Objectives: To outline the key Medicare Part D provisions of the CMS 2014 guidelines and the proposed new rules for the hospice program, and to describe the resultant impacts of these changes to Medicare Part D plans. Description: Part D plans need to be aware of and prepare for changes to the process of handling drug claims for hospice beneficiaries as a result of the 2014 guidelines and the proposed rule for 2015 hospice payments. Conclusions: Medicare Part D plans are being affected by new guidance and face additional administrative burdens if proposed rules are finalized, as CMS attempts to implement reforms and better determine payment responsibility for drugs used by hospice beneficiaries.

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(Miller) From Visante Inc, Washington, DC, United States

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Managed Care and Healthcare Communications (666 Plainsboro Road, Suite 300, Plainsboro NJ 08536, United States)

Emtree Heading
Implementing palliative care in the ICU: Providing patient- and family-centered care.
Hartjes T.M., Meece L., Horgas A.
Nursing Critical Care. 9 (4) (pp 17-22), 2014. Date of Publication: July 2014.
AN: 2014542134
ICU patients, who face serious and often lifelimiting illnesses, are at risk for severe physical symptoms as well as psychological and spiritual concerns that can be alleviated with PC. Due to the success of PC programs in the last 10 years, it's anticipated that the next decade will bring even greater support for PC programs as well as improved outcomes for seriously ill patients and their families. Copyright 2014 Lippincott Williams & Wilkins.

Intensive care unit and lung cancer: When should we intubate?.
AN: 2014497898
Lung cancer still remains the leading cause of cancer death among males. Several new methodologies are being used in the everyday practise for diagnosis and staging. Novel targeted therapies are being used and others are being investigated. However; early diagnosis still remains the cornerstone for efficient treatment and disease management. Lung cancer patients requires in many situations intensive care unit (ICU) admission, either due to the necessity for supportive care until efficient disease symptom control (respiratory distress due to malignant pleural effusion) or disease adverse effect management (massive pulmonary embolism). In any case guidelines indicating the patient that has to be intubated have not yet been issued. In the current review we will present current data and finally present an algorithm based on the current published information for lung cancer patients that will probably benefit from admission to the ICU.
18.
Towards a standardised approach for evaluating guidelines and guidance documents on palliative sedation: Study protocol.
Abarshi E., Rietjens J., Caraceni A., Payne S., Deliens L., Van Den Block L.
BMC Palliative Care. 13 (1), 2014. Article Number: 34. Date of Publication: 07 Jul 2014.
AN: 2014475833
Background: Sedation in palliative care has received growing attention in recent years; and so have guidelines, position statements, and related literature that provide recommendations for its practice. Yet little is known collectively about the content, scope and methodological quality of these materials. According to research, there are large variations in palliative sedation practice, depending on the definition and methodology used. However, a standardised approach to comparing and contrasting related documents, across countries, associations and governmental bodies is lacking. This paper reports on a protocol designed to enable thorough and systematic comparison of guidelines and guidance documents on palliative sedation. Methods and design. A multidisciplinary and international group of palliative care researchers, identified themes and clinical issues on palliative sedation based on expert consultations and evidence drawn from the EAPC (European Association of Palliative Care) framework for palliative sedation and AGREE II (Appraisal Guideline Research and Evaluation) instrument for guideline assessment. The most relevant themes were selected and built into a comprehensive checklist. This was tested on people working closely with practitioners and patients, for user-friendliness and comprehensibility, and modified where necessary. Next, a systematic search was conducted for guidelines in English, Dutch, Flemish, or Italian. The search was performed in multiple databases (PubMed, CancerLit, CNAHL, Cochrane Library, NHS Evidence and Google Scholar), and via other Internet
resources. Hereafter, the final version of the checklist will be used to extract data from selected literature, and the same will be compiled, entered into SPSS, cleaned and analysed systematically for publication. Discussion. We have together developed a comprehensive checklist in a scientifically rigorous manner to allow standardised and systematic comparison. The protocol is applicable to all guidelines on palliative sedation, and the approach will contribute to rigorous and systematic comparison of international guidelines on any challenging topic such as this. Results from the study will provide valuable insights into common core elements and differences between the selected guidelines, and the extent to which recommendations are derived from, or match those in the EAPC framework. The outcomes of the study will be disseminated via peer-reviewed journals and directly to appropriate audiences. 2014Abarshi et al.; licensee BioMed Central Ltd.

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Publisher
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Emtree Heading
article; checklist; Cochrane Library; content analysis; human; Internet; Medline; *palliative therapy; physician; *practice guideline; *sedation; systematic review; weakness.

19. Discussing prognosis and end-of-life care in the final year of life: A randomized controlled trial of a nurse-led communication support programme for patients and caregivers.
Walczak A., Butow P.N., Clayton J.M., Tattersall M.H.N., Davidson P.M., Young J., Epstein R.M.
AN: 2014444454
Introduction: Timely communication about life expectancy and end-of-life care is crucial for ensuring good patient quality-of-life at the end of life and a good quality of death. This article describes the protocol for a multisite randomised controlled trial of a nurse-led communication support programme to facilitate patients’ and caregivers’ efforts to communicate about these issues with their healthcare team. Methods and analysis: This NHMRC-sponsored trial is being conducted at medical oncology clinics located at/affiliated with major teaching hospitals in Sydney, Australia. Patients with advanced, incurable cancer and life expectancy of less than 12
months will participate together with their primary informal caregiver where possible. Guided by the self-determination theory of health-behaviour change, the communication support programme pairs a purpose-designed Question Prompt List (QPL—an evidence-based list of questions patients/caregivers can ask clinicians) with nurse-led exploration of QPL content, communication challenges, patient values and concerns and the value of early discussion of end-of-life issues. Oncologists are also cued to endorse patient and caregiver question asking and use of the QPL. Behavioural and self-report data will be collected from patients/caregivers approximately quarterly for up to 2.5 years or until patient death, after which patient medical records will be examined. Analyses will examine the impact of the intervention on patients’ and caregivers’ participation in medical consultations, their self-efficacy in medical encounters, quality of life, end-of-life care receipt and quality-of-death indicators. Ethics and dissemination: Approvals have been granted by the human ethics review committee of Royal Prince Alfred Hospital and governance officers at each participating site. Results will be reported in peer-reviewed publications and conference presentations. Trial registration number: Australian New Zealand Clinical Trials Registry ACTRN12610000724077.

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Publisher
BMJ Publishing Group
Emtree Heading
adult; article; Australia; cancer mortality; *cancer patient; *cancer prognosis; *caregiver; controlled study; evidence based medicine; health behavior; *health program; human; interpersonal communication; life expectancy; malignant neoplastic disease/di [Diagnosis]; malignant neoplastic disease/dm [Disease Management]; medical education; medical ethics; medical oncologist; medical record review; nurse; nurse attitude; *nurse patient relationship; nursing intervention; nursing protocol; parallel design; prognosis; quality of life; randomized controlled trial; self concept; *terminal care.

| 20. Decision-making in the implementation or withdrawal of dialysis in the old complex patient. Panocchia N., Bossola M., Tazza L. 
| Italian Journal of Medicine. 8 (1) (pp 6-10), 2014. Article Number: 172. Date of Publication: 2014. AN: 2014358974 
| In the last years the population of patients with end-stage renal disease has been growing and the number of patients over 74 years old on renal replacement therapy is rising. However, an increasing number of studies have shown that dialysis is not always associated with a longer life |
expectancy and a better quality of life for elderly patients with severe chronic comorbidity. Moreover, in selected patients conservative therapy provides a survival and quality of life comparable or even superior to that offered by dialysis. These situations pose new ethical and clinical issues. Nephrologists are increasingly faced with difficult decisions about the optimal therapeutic strategies and what is in the best interest of each patient. The new edition of the Renal Physician Association's guideline on Shared Decision-Making in the Appropriate Initiation of and Withdrawal from Dialysis takes into account these changes. For this reason the guideline advocates the use of specific parameters and tools for the prognosis assessment in order to identify the classes of patients with very poor prognosis. The importance of discussing the diagnosis, prognosis and treatment options with the patient is emphasized. Shared decision-making is the model for the physician-patient relationship. Treatment options include renal replacement therapy, not starting or stopping dialysis, and continuing medical management or palliative care. Palliative care should be offered to all patients with end-stage renal disease, whether they start or refuse dialysis and whether they continue or withdraw from dialysis. Furthermore, palliative care should be provided throughout the course of the disease, not only at the end of life. Copyright N. Panocchia et al., 2014 Licensee PAGEPress.
AN: 2014315161
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Publisher Health and Medical Publishing Group
Emtree Heading *brain tumor; cancer prognosis; cancer survivor; child; *child health care; clinical decision making; clinical feature; clinical practice; clinical protocol; craniopharyngioma; *health care quality; human; medical ethics; medulloblastoma; neuropathology; note; palliative therapy; public-private partnership; South Africa; spinal cord tumor; terminal care.

23. Carlos Fernandez-del Castillo confronts the challenge of pancreatic cancer: Although progress has been slow, a renowned expert on the disease sees reasons for hope. McCain J. P and T. 39 (4) (pp 281-289), 2014. Date of Publication: April 2014.
AN: 2014268991
Publisher Medi Media USA Inc

Background: Corticosteroids are a potent group of medicines, with many adverse effects, that are widely prescribed in palliative care for both specific and non-specific indications. The aim of this study was to document current patterns of corticosteroid prescribing in New Zealand palliative care settings and to reflect on whether they were in line with international experience. Methods. A retrospective review of inpatient use of corticosteroids was undertaken in a sample of six New Zealand hospices. Data were collected on numbers of patients prescribed corticosteroids, indications for use, choice of agent, doses and dosage changes, duration of course, incidence of adverse effects, method of stopping, use of guidelines, and processes for monitoring and review. Results: The case notes of 1179 inpatients were reviewed and 768 patients (65.1%) had received at least one course of corticosteroids. There was a marked consistency in the proportion of patients prescribed corticosteroids among the sample hospices (61-69%). Detailed information was recorded for a sample of 260 patients. Corticosteroids were prescribed most commonly for non-specific reasons (40.4% of prescribing events), followed by neurological (25.3%) and soft tissue infiltration symptoms (14.4%). The agent of choice was dexamethasone with a dose range of 1 mg to 40 mg and a median dose of 8 mg. The median course duration for all corticosteroid prescribing events was 29 days. Abrupt stopping occurred in 72 (23.2%) cases, of these 35 (49%) had been on a course of corticosteroids for more than three weeks. Guidelines were only available in one hospice. Monitoring and review was documented in 135 (52%) of cases, and adverse effects were recorded in 82 (32%); these are likely to be underestimates due to a high level of non-recording. Conclusions: This New Zealand study showed that corticosteroids are
widely prescribed in palliative care, most commonly for non-specific indications. These findings are consistent with the international literature in this area and this large, multi-site study adds weight to the findings and the need for ongoing discussion about the place of these drugs in palliative care. 2014 Denton and Shaw; licensee BioMed Central Ltd.

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Publisher
BioMed Central Ltd. (34 - 42 Cleveland Street, London W1T 4LB, United Kingdom)

Emtree Heading
adult; age; aged; article; cancer diagnosis; *corticosteroid therapy; drug indication; drug monitoring; drug withdrawal; female; gender; general practitioner; hospice care; hospital patient; hospital physician; human; inflammation/dt [Drug Therapy]; major clinical study; male; *New Zealand; *palliative therapy; practice guideline; *prescription; retrospective study; soft tissue disease/dt [Drug Therapy]; swallowing; tenesmus/dt [Drug Therapy]; treatment duration; treatment withdrawal; unspecified side effect/si [Side Effect]; *corticosteroid/ae [Adverse Drug Reaction]; *corticosteroid/dt [Drug Therapy]; dexamethasone/dt [Drug Therapy]; methylprednisolone; omeprazole; phenytoin; prednisone; zopiclone.

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25.
Barriers to accurate diagnosis and effective management of heart failure have not changed in the past 10 years: A qualitative study and national survey.
Hancock H.C., Close H., Fuat A., Murphy J.J., Hungin A.P.S., Mason J.M.
AN: 2014238306

Objectives: To explore changes in healthcare professionals' views about the diagnosis and management of heart failure since a study in 2003. Design: Focus groups and a national online cross-sectional survey. Setting and participants: Focus groups (n=8 with a total of 56 participants) were conducted in the North East of England using a phenomenological framework and purposive sampling, informing a UK online survey (n=514). Results: 4 categories were identified as contributing to variations in the diagnosis and management of heart failure. Three previously known categories included: uncertainty about clinical practice, the value of clinical guidelines and tensions between individual and organisational practice. A new category concerned uncertainty about end-of-life care. Survey responses found that confidence varied among professional groups in diagnosing left ventricular systolic dysfunction (LVSD): 95% of cardiologists, 93% of general physicians, 66% of general practitioners (GPs) and 32% of heart failure nurses. For heart failure with preserved ejection fraction (HFpEF), confidence levels were much lower: 58% of cardiologists, 43% of general physicians, 7% of GPs and 6% of heart failure nurses. Only 5-35% of respondents used natriuretic peptides for LVSD or HFpEF. Confidence in interpreting test findings was fundamental to the use of all diagnostic tests. Clinical guidelines were reported to be helpful when diagnosing LVSD by 33% of nurses and 50-56% of other groups, but fell to 5-28% for HFpEF. Some GPs did not routinely initiate diuretics (23%), ACE-inhibitors (22%) or beta-blockers (38%) for LVSD for reasons including historical teaching, perceived side effects and
burden of monitoring. For end-of-life care, there was no consensus about responsibility for heart failure management. Conclusions: Reported differences in the way heart failure is diagnosed and managed have changed little in the past decade. Variable access to diagnostic tests, modes of care delivery and non-uniform management approaches persist. The current National Health Service (NHS) context may not be conducive to addressing these issues.

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(Fuat, Murphy) County Durham and Darlington NHS Foundation Trust (CDDFT), Darlington Memorial Hospital, Darlington, County Durham, United Kingdom

Publisher
BMJ Publishing Group

Emtree Heading
adult; article; cardiologist; clinical practice; diagnostic test; female; general practitioner; health survey; *heart failure/di [Diagnosis]; *heart failure/dm [Disease Management]; heart failure with preserved ejection fraction; human; left ventricular systolic dysfunction; major clinical study; male; middle aged; nurse; practice guideline; qualitative research; terminal care; United Kingdom; young adult; beta adrenergic receptor blocking agent; dipeptidyl carboxypeptidase inhibitor; diuretic agent; natriuretic factor.

26. The effect and process evaluations of the national quality improvement programme for palliative care: The study protocol.
AN: 2014159913
Background: The nationwide integration of palliative care best practices into general care settings is challenging but important in improving the quality of palliative care. This is why the Dutch National Quality Improvement Programme for Palliative Care has recently been launched. This four-year programme consists of about 70 implementation trajectories of best practices. A large evaluation study has been set up to evaluate this national programme and separate implementation trajectories. Methods/Design. This paper presents the protocol of the evaluation study consisting of a quantitative effect evaluation and a qualitative process evaluation. The effect evaluation has a pre-test post-test design, with measurements before implementation (month 0) and after implementation (month 9) of a best practice. Patients are eligible if they have a life expectancy of less than six months and/or if they are undergoing palliative treatment and provided they are physically and mentally capable of responding to questionnaires. Bereaved relatives are eligible if they have been involved in the care of a deceased patient who died after a sickbed between six weeks and six months ago. Three types of measurement instruments are used: (1) numerical rating scales for six symptoms (pain, fatigue, breathlessness, obstipation, sadness and anxiety), (2) the Consumer Quality Index Palliative Care - patient version and (3) the
version for bereaved relatives. The process evaluation consists of analysing implementation plans and reports of the implementation, and individual and group interviews with healthcare professionals. This will be done nine to eleven months after the start of the implementation of a best practice. Discussion. This mixed-method evaluation study gives more insight into the effects of the total programme and the separate implementation trajectories. However, evaluation of large quality improvement programmes is complicated due to changing, non-controlled environments. Therefore, it is important that an effect evaluation is combined with a process evaluation. Trial registration. NTR-4085. 2014 Raijmakers et al.; licensee BioMed Central Ltd.

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Emtree Heading
anxiety; article; clinical practice; clinical protocol; constipation; dyspnea; emotion; evaluation study; fatigue; health care personnel; health care planning; *health care quality; *health program; human; life expectancy; pain; *palliative therapy; qualitative research; quantitative analysis; questionnaire; rating scale; terminal care; time of death; *total quality management.

27.
External Beam Radiotherapy and Bone Metastases.
Johnstone C., Lutz S.T.
AN: 201414755
While the management of bone metastases requires multidisciplinary care, external beam radiotherapy (EBRT) remains an effective and efficient method by which to palliate pain and prevent pathologic fracture. Dose fractionation schemes ranging from 8 Gy in a single fraction to 30 Gy in ten fractions can provide equivalent relief with a minimal risk of side effects. Highly conformal or stereotactic body radiation therapy shows promise in the treatment of these patients, with its most appropriate niches to be determined through continued accrual to ongoing clinical trials. Treatment guidelines and quality measures have been developed to better define the use of EBRT in the setting of painful bone metastases. Springer Science+Business Media Dordrecht 2014.

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28. Could a revision of the current guidelines for cancer drug use improve the quality of cancer treatment?

Lippert T.H., Ruoff H.-J., Volm M.


AN: 2014098906

Clinical practice guidelines are indispensable for such a variable disease as malignant solid tumors, with the complex possibilities of drug treatment. The current guidelines may be criticized on several points, however. First, there is a lack of information on the outcome of treatment, such as the expected success and failure rates. Treating not only drug responders but also nonresponders, that is, patients with drug resistance, must result in failures. There is no mention of the possibility of excluding the drug nonresponders, identifiable by special laboratory tests and no consideration is given to the different side effects of the recommended drug regimens. Nor are there any instructions concerning tumor cases for which anticancer drug treatment is futile. In such cases, early palliative care may lead to significant improvements in both life quality and life expectancy. Not least, there is no transparency concerning the preparation of the guidelines: persons cannot be identified who could give a statement of conflicts of interest, and responsibility is assumed only by anonymous medical associations. A revision of the current guidelines could considerably improve cancer treatment. 2014 Lippert et al.

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(Lippert, Ruoff) University of Tubingen, Tubingen, Germany  (Volm) University of Heidelberg, Heidelberg, Germany

Publisher
Dove Medical Press Ltd. (PO Box 300-008, Albany, Auckland, New Zealand)
29.
Therapeutic interventions for heart failure with preserved ejection fraction: A summary of current evidence.
uL Haq M.A., Wong C., Mutha V., Anavekar N., Lim K., Barlis P., Hare D.L.
World Journal of Cardiology. 6 (2) (pp 67-76), 2014. Date of Publication: February 2014.
AN: 2014140158
Heart failure with preserved ejection fraction (HFPEF) is common and represents a major challenge in cardiovascular medicine. Most of the current treatment of HFPEF is based on morbidity benefits and symptom reduction. Various pharmacological interventions available for heart failure with reduced ejection fraction have not been supported by clinical studies for HFPEF. Addressing the specific aetiology and aggressive risk factor modification remain the mainstay in the treatment of HFPEF. We present a brief overview of the currently recommended therapeutic options with available evidence. 2014 Baishideng Publishing Group Co.
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Publisher
Baishideng Publishing Group Co (Room 1701, 17/F, Henan Bulding, No.90 Jaffe Road, Wanchai,Hong Kong, China, China)
Emtree Heading
antihypertensive therapy; article; blood pressure regulation; cardiovascular mortality; diastolic dysfunction; diuretic therapy; elevated blood pressure; exercise; exercise tolerance; gene therapy; heart failure with preserved ejection fraction; heart function; heart muscle ischemia; heart rate; heart ventricle enddiastolic pressure; human; hypertension; palliative therapy; physical activity; practice guideline; systolic dysfunction; tachycardia; venous congestion; venous pressure; alagebrium; amlodipine; antihypertensive agent; beta adrenergic receptor blocking agent; candesartan; digoxin; dipeptidyl carboxypeptidase inhibitor; diuretic agent; endothelin; growth differentiation factor; growth differentiation factor 11; ivabradine; losartan; nebivolol; perindopril; phosphodiesterase V; propranolol; ranolazine; unclassified drug; valsartan.

30.
Applying the new statin guidelines to the long-term care population.
Aronow W.S.
Annals of Long-Term Care. 22 (1) (pp 34-36), 2014. Date of Publication: January 2014.
AN: 2014122283
Publisher
HMP Communications LLP (4365 U.S. Highway 1 Suite 250, Princeton NJ 08540, United States)
Emtree Heading
Pinto S., Carvalho M.D.
Neurodegenerative Disease Management. 4 (1) (pp 83-102), 2014. Date of Publication: February 2014.
AN: 2014111005
SUMMARY
In the last three decades, improvements in respiratory management are responsible for increasing survival and improving quality of life for amyotrophic lateral sclerosis (ALS) patients. Nowadays, ALS patients with respiratory involvement are offered a support treatment other than the traditional respiratory palliative care. Knowledge about available respiratory support potentialities is essential for appropriate, customized and effective treatment of ALS, which should probably be started sooner than the conventional approach. There is evidence supporting that respiratory support has a larger impact than riluzole on survival. Noninvasive ventilation is essential in the treatment of ALS patients with respiratory involvement. In this article methods to determine respiratory failure in ALS, mechanical invasive and noninvasive ventilation, telemetry, diaphragm pacing, cough aids and respiratory exercise are reviewed, after a brief overlook of respiratory insufficiency in ALS. 2014 Future Medicine Ltd.
Institution
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Publisher
Future Medicine Ltd. (2nd Albert Place, Finchley Central, London N3 1QB, United Kingdom)
Emtree Heading
*amyotrophic lateral sclerosis/dm [Disease Management]; assisted ventilation; *breathing exercise; breathing muscle; caregiver; coughing; diaphragm; exercise; headache; heart pacing; home monitoring; human; hypoxemia; muscle training; *noninvasive ventilation; practice
32. Should intensive care medics be palliative specialists?.
Dehnel T.
The Lancet Respiratory Medicine. 2 (2) (pp 96-97), 2014. Date of Publication: February 2014.
AN: 2014087182
Publisher
Lancet Publishing Group (Langford Lane, Kidlington, Oxford OX5 1GB, United Kingdom)
Emtree Heading
clinical protocol; cooperation; curriculum development; *health care personnel; health care planning; hospice care; human; human dignity; *intensive care unit; interpersonal communication; medical education; medical practice; *medical specialist; note; *palliative therapy; patient comfort; patient preference; practice guideline; priority journal; staff training.

33. Beyond the bridge.
Johnson S., Kautz D.D.
Nursing Critical Care. 8 (6) (pp 33-37), 2013. Date of Publication: 2013.
AN: 2014053932
Institution
(Johnson, Kautz) University of North Carolina, Greensboro, NC, United States
Publisher
Lippincott Williams and Wilkins (530 Walnut Street,P O Box 327, Philadelphia PA 19106-3621, United States)
Emtree Heading
article; artificial ventilation; cardiogenic shock/th [Therapy]; cause of death; congestive heart failure/th [Therapy]; destination therapy; empowerment; *evidence based medicine; healing; heart failure/th [Therapy]; human; informed consent; intensive care; *left ventricular assist device; life sustaining treatment; long term care; medical decision making; medical device complication/co [Complication]; medical ethics; morbidity; nurse patient relationship; nursing care; *palliative therapy; patient autonomy; patient selection; *practice guideline; priority journal; quality of life; religion; risk benefit analysis; risk reduction; survival rate; terminal care; treatment failure; treatment indication; treatment outcome; treatment planning; treatment refusal; treatment withdrawal.
A randomised controlled trial on the efficacy of advance care planning on the quality of end-of-life care and communication in patients with COPD: The research protocol.

Houben C.H.M., Spruit M.A., Wouters E.F.M., Janssen D.J.A.


AN: 2014061401

Introduction: Recent research shows that advance care planning (ACP) for patients with chronic obstructive pulmonary disease (COPD) is uncommon and poorly carried out. The aim of the present study was to explore whether and to what extent structured ACP by a trained nurse, in collaboration with the chest physician, can improve outcomes in Dutch patients with COPD and their family.

Methods and analysis: A multicentre cluster randomised controlled trial in patients with COPD who are recently discharged after an exacerbation has been designed. Patients will be recruited from three Dutch hospitals and will be assigned to an intervention or control group, depending on the randomisation of their chest physician. Patients will be assessed at baseline and after 6 and 12 months. The intervention group will receive a structured ACP session by a trained nurse. The primary outcomes are quality of communication about end-of-life care, symptoms of anxiety and depression, quality of end-of-life care and quality of dying. Secondary outcomes include concordance between patient's preferences for end-of-life care and received end-of-life care, and psychological distress in bereaved family members of deceased patients.

Intervention and control groups will be compared using univariate analyses and clustered regression analysis. Ethics and dissemination: Ethical approval was received from the Medical Ethical Committee of the Catharina Hospital Eindhoven, the Netherlands (NL42437.060.12). The current project provides recommendations for guidelines on palliative care in COPD and supports implementation of ACP in the regular clinical care.

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Emtree Heading
anxiety disorder; article; bereavement; *chronic obstructive lung disease/dm [Disease Management]; clinical effectiveness; clinical protocol; *communication skill; controlled study; depression; distress syndrome; dying; hospital discharge; hospital physician; human; intervention study; multicenter study; nurse training; outcome assessment; patient assessment; *patient care; patient preference; quality of life; randomized controlled trial; teamwork; *terminal care.

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HIV and ageing: What the geriatrician needs to know.
Levett T., Wright J., Fisher M.
AN: 2014013073

Summary The transformation of human immunodeficiency virus (HIV) from a rapidly fatal disease to a chronic manageable illness has resulted in annual increases in the numbers of people living with HIV. The HIV cohort is therefore ageing, with numbers of older adults with HIV climbing, through both prolonged survival and late acquisition of the disease. Associated with ageing is an accumulation of HIV-associated non-AIDS related co-morbidities, creating a complex patient group affected by multi-morbidity along with polypharmacy, functional decline and complex social issues. With this in mind, this review seeks to explore areas where HIV (diagnosed or undetected) may impact on the work of clinical geriatricians. 2013 Cambridge University Press.

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Emtree Heading
*aging; article; bone density; brain hemorrhage; CD4 lymphocyte count; cerebrovascular accident; cognition; comorbidity; drug efficacy; drug safety; dual energy X ray absorptiometry; fragility fracture; *geriatrician; HIV associated dementia; human; Human immunodeficiency virus; *Human immunodeficiency virus infection; medication error; osteopenia; osteoporosis; palliative therapy; polypharmacy; practice guideline; social network; social status; social support; alendronic acid; antiretrovirus agent; antithrombocytic agent; nonnucleoside reverse transcriptase inhibitor; proteinase inhibitor; RNA directed DNA polymerase inhibitor; tenofovir.

36.
Advances in the outpatient management of chronic obstructive pulmonary disease.
Possick J.D., Most J., Rochester C.L.
AN: 2013797787

Chronic obstructive pulmonary disease (COPD) remains highly prevalent, underdiagnosed, and a major cause of morbidity and mortality. Disease rates and cost of care continue to rise annually in the United States and worldwide. Recent years have seen advances in our understanding of COPD as a heterogenous disease with distinct phenotypes. It is increasingly recognized that COPD severity and impact is complex and is inadequately described by airflow obstruction alone. The revised 2011 GOLD guidelines now incorporate multidimensional measures of symptom burden, functional limitations, and exacerbation frequency in patient assessment. Moreover, COPD is commonly associated with multiple medical co-morbidities that also have an impact on the symptom burden, disease severity, and mortality for individual patients. This conceptual frame-shift to recognition of COPD as a heterogenous and multifaceted disease with varying impact on the patient has begun to revolutionize the way COPD care is approached in the
outpatient setting. Current management guidelines now emphasize broader-based patient assessment including characterization of patients' phenotypes, symptom burden, functional limitations, exacerbation risk, and co-morbidities to guide therapeutic interventions. Although some forms of therapy continue to be applicable to all patients with COPD, others seem to only benefit patients with selected disease phenotypes. Here we explore some of the recent advances in outpatient COPD management. We consider the varying manifestations of COPD, treatment approaches that remain broadly applicable, as well as selected phenotype-specific treatments, interventions targeted at reducing exacerbations, and management of intractable symptoms. We also suggest areas for future exploration. Copyright 2013 by Lippincott Williams & Wilkins. Institution
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Emtree Heading
airway obstruction; article; asthma; atopy; bronchiectasis; bronchoconstriction; bronchodilatation; chronic bronchitis; *chronic obstructive lung disease/rh [Rehabilitation]; *chronic obstructive lung disease/su [Surgery]; *chronic obstructive lung disease/th [Therapy]; chronic respiratory failure; comorbidity; corticosteroid therapy; coughing; cystic fibrosis; disease association; disease exacerbation/pc [Prevention]; disease severity; drug delivery system; dyspnea; emphysema; exercise tolerance; forced expiratory volume; functional status; high risk patient; hospital patient; human; hypoxemia; inflammation; influenza vaccination; lifestyle modification; lung fibrosis; lung function; lung resection; multicenter study (topic); muscle hypertrophy; *outpatient care; oxygen therapy; palliative therapy; patient counseling; phenotype; pneumonia; positive end expiratory pressure; practice guideline; pulmonary rehabilitation; randomized controlled trial (topic); risk assessment; sleep disordered breathing; smoking; smoking cessation; sputum; symptom assessment; vaccination; aclidinium bromide; antibiotic agent; azithromycin; beta adrenergic receptor stimulating agent; bronchodilating agent; corticosteroid; erythromycin; fluticasone; formoterol; furosemide; indacaterol; influenza vaccine; macrolide; morphine; muscarinic receptor blocking agent; opiate; phosphodiesterase IV inhibitor; placebo; Pneumococcus polysaccharide; Pneumococcus vaccine; roflumilast; salmeterol; theophylline; tiotropium bromide.
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37.
Management of depression and anxiety in COPD.
Cafarella P.A., Effing T.W., Barton C., Ahmed D., Frith P.A.
European Respiratory Monograph. 59 (pp 144-163), 2013. Date of Publication: 2013.
AN: 2013162061
Depression and anxiety are prevalent comorbidities in COPD and often appear together. Numerous theoretical models have been proposed to explain this relationship, with most suggesting bidirectional and complex pathways. Mental health assessment in COPD remains too infrequent and should be integrated into standard practice. Appropriate use of mental health
screening tools, diagnostic resources and referral pathways should be implemented for optimal management. There is evidence that depression and anxiety in COPD negatively impacts on important health outcomes, such as COPD symptom burden, physical function, health-related quality of life, adherence with recommended treatments and mortality whilst increasing disability, exacerbation rates, hospitalisations and length of stay. Treatment options for managing depression and anxiety in COPD are less frequently documented. Whilst some evidence exists supporting the efficacy of pulmonary rehabilitation, pharmacological therapy, cognitive behavioural therapy, self-management programmes, relaxation and palliative care interventions in managing depression and anxiety in COPD, there remains a paucity of high-quality studies in the field consequently limiting integration into evidence-based clinical guidelines. ERS 2013.

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Publisher
European Respiratory Society (442 Glossop Road, Sheffield S10 2PX, United Kingdom)
Heart failure readmissions.
Shah K.B., Rahim S., Boxer R.S.
Current Treatment Options in Cardiovascular Medicine. 15 (4) (pp 437-449), 2013. Date of Publication: August 2013.
AN: 2013487767
Opinion statement: Heart failure readmissions (HFR) represent a personal burden for patients and a large financial burden for the healthcare system. As such, strategies to decrease HFR are avidly sought and studied. There are many reasons for HFR that challenge programs aimed to reduce the frequency of HFR. Large pharmacological and device trials often incorporate hospital admission as an endpoint, and many programs have been developed in varied settings to address HFR. Some of the most successful programs use a multidisciplinary team approach, intensive patient education and system commitment. Many risk factors for HFR have been identified although prediction tools are limited. The reduction of HFR should incorporate a multidisciplinary approach with 1) evidenced-based physician-guided medical and device therapy; 2) institutional programs for effective care transitions; 3) strategies aimed to improve disease management; and 4) engage patients in self-care. 2013 Springer Science+Business Media New York.
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Current Science Ltd
Emtree Heading
acute heart failure/dt [Drug Therapy]; article; cardiac resynchronization therapy; device therapy; drug efficacy; drug mechanism; health care cost; health care planning; health program; *heart failure/dt [Drug Therapy]; *heart failure/th [Therapy]; *hospital readmission; human; invasive procedure; lifestyle modification; medical ethics; practice guideline; prediction; risk assessment; sodium restriction; systolic heart failure; telemonitoring; terminal care; ultrafiltration; water deprivation; aldosterone antagonist/ct [Clinical Trial]; aldosterone antagonist/dt [Drug Therapy]; angiotensin receptor antagonist/dt [Drug Therapy]; brain natriuretic peptide/ec [Endogenous Compound]; digoxin/dt [Drug Therapy]; dipeptidyl carboxypeptidase inhibitor/dt [Drug Therapy]; loop diuretic agent/dt [Drug Therapy]; loop diuretic agent/pd [Pharmacology]; nesiritide/ct [Clinical Trial]; nesiritide/dt [Drug Therapy]; placebo.
39.
Comparison of clinical guidelines for the diagnosis and treatment of chronic heart failure of CKS and ESC 2012.
Cor et Vasa. 55 (4) (pp E301-E308), 2013. Date of Publication: August 2013.
AN: 2013748930
In 2012, the Czech and European clinical guidelines for diagnosis and treatment of heart failure have been issued. The main difference between them is that the European guidelines include both acute and chronic heart failure while our national guidelines contain only chronic heart failure. They differ even in the definition of heart failure; the European guidelines do not include natriuretic peptides among the diagnostic criteria and response to treatment as an auxiliary criterion in cases of unclear diagnosis. Regarding signs and symptoms of heart failure, both guidelines are similar in this part, they only differ in their categorization. In diagnosis section, the guidelines vary in certain echocardiographic parameters, particularly of diastolic dysfunction. Cut-off points for natriuretic peptides in chronic heart failure are entirely new in the European guidelines. For patients presenting in a non-acute way, the optimum cut-off point is 125 pg/mL for NT-proBNP and 35 pg/mL for BNP. Drug groups for treatment of heart failure are similar in both documents. The European guidelines do not contain perindopril among ACE inhibitors and recommend 5 mg twice daily as the target dose of ramipril while 10 mg once daily is recommended in the Czech guidelines. The target dose of losartan is 100 mg once daily in the Czech guidelines and 150 mg in the European guidelines. Triamteren and amilorid are among recommended diuretics in the European guidelines, but not in the Czech ones. 2013 The Czech Society of Cardiology. Published by Elsevier Urban & Partner Sp. z o.o. All rights reserved.
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(Taborsky) 1st Department of Internal Medicine - Cardiology, Faculty of Medicine, Palacky University, Olomouc, Czech Republic
Publisher
Elsevier Science B.V. (P.O. Box 1527, Amsterdam 1000 BM, Netherlands)
Emtree Heading
alcohol consumption; aorta valve replacement; assisted circulation; cardiac resynchronization therapy; cardiomegaly; central venous pressure; clinical feature; comparative study; continuous hemofiltration; crackle; Czech Republic; diagnostic value; diastolic dysfunction/di [Diagnosis]; disease classification; disease duration; dyspnea; echocardiography; electrocardiogram; Europe;
fatigue; fluid intake; heart aneurysmectomy; heart arrhythmia; heart disease; *heart failure/di [Diagnosis]; *heart failure/dt [Drug Therapy]; *heart failure/pc [Prevention]; *heart failure/su [Surgery]; *heart failure/th [Therapy]; heart murmur; heart muscle revascularization; heart sound; heart transplantation; hepatomegaly; human; lung disease; mitral valve repair; palliative therapy; peripheral edema; pleura effusion; practice guideline; primary prevention; recommended drug dose; review; secondary prevention; smoking cessation; sodium restriction; symptomatology; systemic disease; tachycardia; tachypnea; thorax radiography; treatment indication; amiloride/dt [Drug Therapy]; amino terminal pro brain natriuretic peptide/ec [Endogenous Compound]; amiodarone; anticoagulant agent; antilipemic agent; antithrombocytic agent; bisoprolol/do [Drug Dose]; bisoprolol/dt [Drug Therapy]; brain natriuretic peptide/ec [Endogenous Compound]; bucindolol; candesartan/do [Drug Dose]; candesartan/dt [Drug Therapy]; captopril/do [Drug Dose]; captopril/dt [Drug Therapy]; carvedilol/do [Drug Dose]; carvedilol/dt [Drug Therapy]; digoxin/dt [Drug Therapy]; enalapril/do [Drug Dose]; enalapril/dt [Drug Therapy]; eplerenone/do [Drug Dose]; eplerenone/dt [Drug Therapy]; hydralazine; isosorbide dinitrate; ivabradine/dt [Drug Therapy]; lisinopril/do [Drug Dose]; lisinopril/dt [Drug Therapy]; losartan/do [Drug Dose]; losartan/dt [Drug Therapy]; metoprolol succinate/do [Drug Dose]; metoprolol succinate/dt [Drug Therapy]; nebivolol/do [Drug Dose]; nebivolol/dt [Drug Therapy]; omega 3 fatty acid; perindopril/dt [Drug Therapy]; ramipril/do [Drug Dose]; ramipril/dt [Drug Therapy]; spironolactone/do [Drug Dose]; spironolactone/dt [Drug Therapy]; trandolapril/do [Drug Dose]; trandolapril/dt [Drug Therapy]; triamterene/dt [Drug Therapy]; unindexed drug; valsartan/do [Drug Dose]; valsartan/dt [Drug Therapy].

40.
Do pilocarpine drops help dry mouth in palliative care patients: A protocol for an aggregated series of n-of-1 trials.
AN: 2013725291

Background: It is estimated that 39,000 Australians die from malignant disease yearly. Of these, 60% to 88% of advanced cancer patients suffer xerostomia, the subjective feeling of mouth dryness. Xerostomia has significant physical, social and psychological consequences which compromise function and quality of life. Pilocarpine is one treatment for xerostomia. Most studies have shown some variation in individual response to pilocarpine, in terms of dose used, and timing and extent of response. We will determine a population estimate of the efficacy of pilocarpine drops (6 mg) three times daily compared to placebo in relieving dry mouth in palliative care (PC) patients. A secondary aim is to assess individual patients’ response to pilocarpine and provide reports detailing individual response to patients and their treating clinician.
Methods/Design. Aggregated n-of-1 trials (3 cycle, double blind, placebo-controlled crossover trials using standardized measures of effect). Individual trials will identify which patients respond to the medication. To produce a population estimate of a treatment effect, the results of all cycles will be aggregated. Discussion. Managing dry mouth with treatment supported by the best possible evidence will improve functional status of patients, and improve quality of life for patients.
and carers. Using n-of-1 trials will accelerate the rate of accumulation of high-grade evidence to support clinical therapies used in PC. Trial registration. Australia and New Zealand Clinical Trial Registry Number: 12610000840088. 2013 Nikles et al.; licensee BioMed Central Ltd.

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Publisher
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Emtree Heading
article; *clinical protocol; controlled clinical trial (topic); drug efficacy; functional status; health care policy; human; palliative therapy; quality of life; study design; treatment response; *xerostomia/dt [Drug Therapy]; *pilocarpine/ct [Clinical Trial]; *pilocarpine/dt [Drug Therapy]; *pilocarpine/tp [Topical Drug Administration]; placebo.

41.
The ethical pain: Detection and management of pain and suffering in disorders of consciousness.
Farisco M.
Neuroethics. 6 (2) (pp 265-276), 2013. Date of Publication: August 2013.
AN: 2013711435

The intriguing issue of pain and suffering in patients with disorders of consciousness (DOCs), particularly in Unresponsive Wakefulness Syndrome/Vegetative State (UWS/VS) and Minimally Conscious State (MCS), is assessed from a theoretical point of view, through an overview of recent neuroscientific literature, in order to sketch an ethical analysis. In conclusion, from a legal and ethical point of view, formal guidelines and a situationist ethics are proposed in order to best manage the critical scientific uncertainty about pain and suffering in DOCs and ensure the best possible care for the patient. 2011 Springer Science+Business Media B.V.

Institution
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Publisher
Springer Netherlands (Van Godewijckstraat 30, Dordrecht 3311 GZ, Netherlands)

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article; behavioral pain scale; *consciousness disorder; drug efficacy; drug use; health care quality; human; living will; medical decision making; *medical ethics; medicolegal aspect; minimally conscious state; named inventories, questionnaires and rating scales; neuroscience; nociception; *pain/dt [Drug Therapy]; pain assessment; palliative therapy; patient care; patient
42.
Eastern Canadian Colorectal Cancer Consensus Conference: Standards of care for the treatment of patients with rectal, pancreatic, and gastrointestinal stromal tumours and pancreatic neuroendocrine tumours.
AN: 2013666129
The annual Eastern Canadian Colorectal Cancer Consensus Conference was held in Halifax, Nova Scotia, October 20-22, 2011. Health care professionals involved in the care of patients with colorectal cancer participated in presentation and discussion sessions for the purposes of developing the recommendations presented here. This consensus statement addresses current issues in the management of rectal cancer, including pathology reporting, neoadjuvant systemic and radiation therapy, surgical techniques, and palliative care of rectal cancer patients. Other topics discussed include multidisciplinary cancer conferences, treatment of gastrointestinal stromal tumours and pancreatic neuroendocrine tumours, the use of FOLFIRINOX in pancreatic cancer, and treatment of stage II colon cancer. 2013 Multimed Inc.
Institution
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Publisher
Multimed Inc. (66 Martin Street, Milton ONT L9T 2R2, Canada)
43.
Techniques of opioid administration.
Burwaiss M., Comerford D.
Opioids continue to be the main pharmacological treatment for severe acute pain. Traditional methods of opioid administration (oral, intramuscular, subcutaneous and intravenous) are more effective in managing pain if their treatment regimens are individualized and dosages are titrated to effect. Transdermal delivery of highly lipid-soluble opioids is an alternative route of treatment when managing severe pain in chronic conditions and palliative care scenarios. 2013 Elsevier Ltd. All rights reserved.

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adult disease/dt [Drug Therapy]; analgesic activity; article; bolus injection; breakthrough pain/dt [Drug Therapy]; burning sensation/si [Side Effect]; childhood disease/dt [Drug Therapy]; chronic pain/dt [Drug Therapy]; continuous infusion; drug absorption; *drug administration route; drug bioavailability; drug blood level; drug dose titration; drug effect; drug elimination; drug half life; drug self administration; drug solubility; epidural anaesthesia; first pass effect; human; intravenous anaesthesia; lipid solubility; lozenge; maximum plasma concentration; mucosal administration; nasal pruritus/si [Side Effect]; neuropathic pain/dt [Drug Therapy]; pain/dt [Drug Therapy]; palliative therapy; patient controlled analgesia; postoperative pain/dt [Drug Therapy]; practice guideline; priority journal; respiration depression/si [Side Effect]; single drug dose; suppository; tablet; transdermal patch; buprenorphine/ad [Drug Administration]; buprenorphine/pr [Pharmaceutics]; buprenorphine/pk [Pharmacokinetics]; buprenorphine/li [Sublingual Drug Administration]; buprenorphine/td [Transdermal Drug Administration]; codeine/ad [Drug Administration]; codeine/do [Drug Dose]; codeine/im [Intramuscular Drug Administration]; codeine/iv [Intravenous Drug Administration]; codeine/po [Oral Drug Administration]; codeine/pr [Pharmaceutics]; codeine/pk [Pharmacokinetics]; dexamphetamine/ae [Adverse Drug Reaction]; dexamphetamine/ad [Drug Administration]; dexamphetamine/na [Intranasal Drug Administration]; fentanyl/na [Intranasal Drug Administration]; fentanyl/iv [Intravenous Drug Administration]; fentanyl/pr [Pharmaceutics]; fentanyl/pk [Pharmacokinetics]; fentanyl/td [Transdermal Drug Administration]; codeine/ad [Drug Administration]; buprenorphine/ad [Drug Administration]; buprenorphine/pr [Pharmaceutics]; buprenorphine/pk [Pharmacokinetics]; buprenorphine/td [Transdermal Drug Administration]; codeine/ad [Drug Administration]; codeine/do [Drug Dose]; codeine/im [Intramuscular Drug Administration]; codeine/iv [Intravenous Drug Administration]; codeine/po [Oral Drug Administration]; codeine/pr [Pharmaceutics]; codeine/pk [Pharmacokinetics]; dexamphetamine/ae [Adverse Drug Reaction]; dexamphetamine/ad [Drug Administration]; dexamphetamine/na [Intranasal Drug Administration]; fentanyl/na [Intranasal Drug Administration]; fentanyl/iv [Intravenous Drug Administration]; fentanyl/pr [Pharmaceutics]; fentanyl/pk [Pharmacokinetics]; fentanyl/td [Transdermal Drug Administration]; hydromorphone/ad [Drug Administration]; hydromorphone/do [Drug Dose]; hydromorphone/im [Intramuscular Drug Administration]; hydromorphone/iv [Intravenous Drug Administration]; hydromorphone/po [Oral Drug Administration]; hydromorphone/pk [Pharmacokinetics]; hydromorphone/rd [Rectal Drug Administration]; methadone/ad [Drug Administration]; methadone/do [Drug Dose]; methadone/pk [Pharmacokinetics]; morphine/ad [Drug Administration]; morphine/pk [Pharmacokinetics]; morphine/ad [Drug Administration]; morphine/cm [Drug Comparison]; morphine/td [Drug Therapy]; morphine/ae [Epidural Drug Administration]; morphine/ar [Intrathecal Drug Administration]; morphine/im [Intramuscular Drug Administration]; morphine/iv [Intravenous Drug Administration]; morphine/po [Oral Drug Administration]; morphine/pr [Pharmaceutics]; morphine/pk [Pharmacokinetics]; morphine/rd [Rectal Drug Administration]; morphine/sc [Subcutaneous Drug Administration]; morphine/td [Transdermal Drug Administration]; morphine sulfate/pk [Pharmaceutics]; naloxone plus oxycodone/po [Oral Drug Administration]; naloxone plus oxycodone/pk [Pharmacokinetics]; naloxone plus oxycodone/pd [Pharmacology]; *opiate/ae
Darbepoetin in cancer related anemia.

Shah B.

AN: 71223494

Anemia is prevalent in 30-90 % of cancer patients. Correction of anemia can be achieved by either treating the underlying etiology or providing supportive care by transfusion of red blood cells or administration of erythropoiesis-stimulating agents with or without iron supplement. Cancer related anemia are multifactorial, such as blood loss, hemolysis, nutritional deficiencies, renal insufficiency, anemia of chronic disease, myelosuppressive chemotherapy or radiotherapy induced or a combination of these. If the likely cause of anemia is cancer-related inflammation or myelosuppressive chemotherapy, a risk assessment of the anemia is necessary to determine the initial intervention plan-whether the patient requires an immediate boost in hemoglobin (Hb) levels by red blood cell (RBC) transfusion or erythropoiesis stimulating agent (ESA). The RBC transfusion should be considered for symptomatic patients and asymptomatic patient with comorbidities or high risk. But RBC transfusion is related to certain risks like transfusion related hemolytic and non-hemolytic reactions, congestive cardiac failure, bacterial contamination or viral infection and iron overload. To avoid all these side effects, ESAs is an option. RBC production is normally controlled by erythropoietin, a cytokine produced in the kidneys. First introduced in
ESAs are synthetic, recombinant human erythropoietin that can stimulate erythropoiesis in patients with low RBC levels. At present, two ESAs are available: Epoetin alfa and Darbepoetin alfa. Darbepoetin has longer half-life, so we can reduce the number of injection pricks with similar efficacy. Unlike transfusion that immediately boosts the Hb level, ESAs can take weeks to elicit an Hb response, but they are effective at maintaining a target Hb level with repeated administration. In a study of 2,192 cancer patients treated with ESA therapy, an Hb increase of ≥1 g/dL was attained in 65% patients. Benefits of Darbepoetin Therapy

Avoidance of transfusion is the main benefit of Darbepoetin. A double blind, placebo-controlled, randomized phase III study enrolled 320 patients (Hb<11 g/dl) receiving Darbepoetin alfa at 2.25 mcg/kg/week versus placebo showed fewer transfusions (27 vs. 52%; 95% CI, 14-36%, P<0.001). Risks of Darbepoetin Therapy

Possible Increased Mortality and Tumor Progression Worsened health outcomes like decrease in overall survival and/or decreased locoregional disease control associated with the use of ESAs have been confirmed in 5 meta-analyses when targeting Hb levels above 12 g/dL. These analyses reported increased mortality in patients receiving ESAs with statistically significant relative risks/hazard ratios. However, this association has been refuted by two other meta-analyses, reporting no statistically significant effect of ESAs on mortality or progression. In addition, several pharmacovigilance trials reported no decrease in survival with ESA use in patients with chemotherapy related anemia when an Hb target range of 13 g/dL was utilized. Risk of Thromboembolism Darbepoetin increase the risk of venous thromboembolism. The cause of VTE is complex; it can be due to malignancy itself as well as due to certain chemotherapy. Other risk factors include prior history of VTE, heritable mutation, hypercoagulability, elevated prechemotherapy platelet counts, recent surgery, hormonal agents, prolonged immobilization, steroids, and comorbidities like hypertension. A combined analysis of six trials on Darbepoetin alfa found an increased trend of thromboembolism for patients with Hb over 12 g/dL (RR, 1.66; 95% CI, 0.9-3.04) or patients achieving over a 1 g/dL increased risk in 14 days (RR, 1.67; 95% CI, 0.96-2.88). Risk of Hypertension An increased risk for hypertension with ESA usage was reported by a Cochrane review (RR, 1.30; 95% CI, 1.08-1.56). Risk of Pure Red Cell Aplasia Any cancer patient who develops a sudden loss of response to Darbepoetin, accompanied by severe anemia and low reticulocyte count, should be evaluated for the etiology of loss effect. The plasma should be evaluated for binding and neutralizing antibodies to erythropoietin. ESAs should be permanently discontinued in patients with antibody-mediated anemia. Patients should not be switched to other ESA products as antibodies may cross react. ASh/ASCO Clinical Practice Guidelines 1. Darbepoetin should only be used to treat chemotherapy induced anemia and should be discontinued once the chemotherapy course is complete. Hence, it should not be prescribed to the patients not receiving concomitant myelosuppressive chemotherapy. Use of Darbepoetin in patients with lower risk myelodysplastic syndrome to avoid transfusions is an exception to this recommendation. 2. Darbepoetin should not be used when the anticipated treatment outcome is cure. This includes primary and adjuvant chemotherapy for malignancies such as early stage breast cancer and nonsmall cell lung cancer, lymphomas and testicular cancer, among others. Patient undergoing palliative treatment may consider ESAs therapy or transfusion for anemia. 3. Darbepoetin should be initiated at Hb between 10 and 12 g/dL. ESA treatment should be determined by clinical judgment, consideration of risks and benefits of ESAs and patient preferences. RBC transfusion is an option when warranted by clinical conditions. 4. FDA approved starting dose of Darbepoetin is 2.25 mcg/kg weekly or 500 mcg every 3 weeks subcutaneously. The dose can increase to 4.5 mcg/kg weekly if there is a<1 g/dL increase in Hb after 6 weeks of therapy. Once Hb reaches a level needed to avoid transfusion or Hb increases>1 g/dL in 2 weeks, the dose can be reduce to 40% of previous dose. The dose should be withheld if Hb exceeds a level needed to avoid transfusion; restart.
dose at 40% below previous dose when Hb approaches a level where transfusion may be required. Darbepoetin should be discontinued after completion of chemotherapy or if no response after 8 weeks of therapy. 5. Baseline and periodic monitoring of Iron, TIBC, transferrin saturation, or Ferritin levels and instituting iron repletion when indicated may help to reduce the need for Darbepoetin, maximize symptomatic improvement and determine the reason for failure to respond adequately to ESA therapy. 6. Patients with multiple myeloma, on-Hodgkin's lymphoma, or chronic lymphocytic leukemia are advised to begin treatment with chemotherapy and/or corticosteroids and observe the hematologic outcomes achieved solely through tumor reduction before considering Darbepoetin.

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Publisher
Springer India

Emtree Heading
*neoplasm; *anemia; *Indian; *society; *hematology; *blood transfusion; human; patient; transfusion; risk; chemotherapy; therapy; erythrocyte; cancer patient; hypertension; mortality; etiology; meta analysis; thromboembolism; lymphoma; adjuvant chemotherapy; chronic disease; treatment outcome; breast cancer; myelodysplastic syndrome; practice guideline; kidney failure; plasma; kidney; nutritional deficiency; hemolysis; surgery; thrombocyte count; hypercoagulability; mutation; iron therapy; venous thromboembolism; side effect; chronic lymphatic leukemia; virus infection; bleeding; immobilization; iron overload; survival; pure red cell anemia; reticulocyte count; bacterium contamination; drug surveillance program; chemotherapy induced anemia; monitoring; patient preference; congestive heart failure; lung cancer; risk factor; disease control; radiotherapy; overall survival; testis cancer; health; tumor growth; palliative therapy; decision making; repeated drug dose; risk assessment; injection; multiple myeloma; half life time; erythropoiesis; inflammation; food and drug administration; Hodgkin disease; erythrocyte transfusion; hemoglobin blood level; *novel erythropoiesis stimulating protein; antianemic agent; recombinant erythropoietin; erythropoietin; placebo; iron; antibody; neutralizing antibody; cytokine; steroid; ferritin; transferrin; corticosteroid.

45.
Painful reality check.
Chong S.
Australian Journal of Pharmacy. 94 (1119) (pp 46-51), 2013. Date of Publication: August 2013. AN: 2013682673

Publisher
Australian Pharmaceutical Publishing Company Ltd (40 Burwood Road, Hawthorn VIC 3122, Australia)

Emtree Heading
adverse outcome; analgesia; article; backache/dt [Drug Therapy]; career; drug dose reduction; drug safety; drug use; general practice; health care delivery; health care personnel; health care survey; *health education; health service; home care; human; injury; medical education; opiate addiction/si [Side Effect]; *pain; *palliative therapy; patient assessment; pharmacist; practice
Huang H., Peng X., Zhong C.
Intractable and Rare Diseases Research. 2 (3) (pp 88-93), 2013. Date of Publication: 2013.
AN: 2013658011
Idiopathic pulmonary fibrosis (IPF) is a type of intractable and rare disease, and its epidemiology in China is still unclear. The diagnosis and treatment of IPF has received considerable attention and two editions of guidelines on IPF diagnosis and treatment have been published by the Chinese Society of Respiratory Diseases. Treatment of IPF with Traditional Chinese Medicine (TCM) has been widely investigated in China and several types of TCM extracts are reported to be effective in animal models. One effective treatment is lung transplantation; this treatment has been successfully performed in China, yielding satisfactory long-term survival.
Institution
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Publisher
International Advancement Center for Medicine and Health Res (2-4-5 Kasuga, Bunkyo-ku, Tokyo 112-0003, Japan)
Emtree Heading
Adenophora stricta; Angelica dahurica; article; Astragalus membranaceus; China; Chinese medicine; clinical effectiveness; clinical feature; Curcuma longa; disease association; disease model; drug efficacy; *fibrosing alveolitis/di [Diagnosis]; *fibrosing alveolitis/dt [Drug Therapy]; *fibrosing alveolitis/ep [Epidemiology]; *fibrosing alveolitis/su [Surgery]; *fibrosing alveolitis/th [Therapy]; Ginkgo biloba; high resolution computer tomography; human; long term survival; lung biopsy; lung transplantation; medicinal plant; nonhuman; Ophiocordyceps; oxygen therapy; palliative therapy; Panax notoginseng; practice guideline; Salvia miltiorrhiza; smoking; Stephania tetrandra; survival rate; survival time; Tripterygium wilfordii; antifibrotic agent/dt [Drug Therapy]; corticosteroid/dt [Drug Therapy]; cytotoxic agent/dt [Drug Therapy]; herbaceous agent/dt [Drug Therapy]; immunosuppressive agent/dt [Drug Therapy]; tetramethylpyrazine/dt [Drug Therapy].

47. End-of-life ethical dilemmas in intensive care unit. <Eticne dileme ob koncu zivljenja v intenzivni medicini.>
Groselj U., Orazem M., Trontelj J., Grosek S.
Sustaining vital functions in critically ill in the ICU frequently allows prolongation of patient's life even in circumstances where the treatment has lost its medical rationale and/or there is no hope for the patient's condition to improve. Decision-making about termination of such treatment - usually referred to as futile, useless or inappropriate -, frequently presents a difficult ethical dilemma not only for the intensivists and other health-care workers but also for the patients and their relatives. The principles of biomedical ethics present a useful framework for decision-making in ethical dilemmas but cannot offer sufficiently explicit guidelines. Besides, the concepts of futility or futile treatment in the ICU are also not unequivocally defined. Thus, the decision regarding continuing or stopping treatment should be based on careful evaluation of the balance between its expected efficiency and benefits on the one hand and the burden imposed upon the patient on the other. If the burden clearly exceeds the expected benefits, the ethically sound decision is to terminate such treatment.

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(Grosek) Katedra za pediatrijo, Univerza v Ljubljani, Ljubljana, Slovenia
Publisher
Slovene Medical Society (Dalmatinova 10, Ljubljana 1001, Slovenia)

Guidelines for end-of-life and palliative care in Indian intensive care to units: Isccm consensus ethical position statement.
AN: 2013649320
Institution
(Mani, Amin, Chawla, Divatia, Kapadia, Khilnani, Myatra, Prayag, Rajagopalan, Todi, Uttam)
Saket City Hospital, Mandir Marg, Press Enclave Road, Saket, New Delhi 110017, India
49. Goals-of-care Discussions for Seriously Ill Hospitalized Patients.
   King K., Song S.-I.L., Quill T.
   Hospital Medicine Clinics. 2 (4) (pp 574-586), 2013. Date of Publication: October 2013.
   AN: 2013629831
   Goals-of-care discussions are important in helping patients understand their care plans and allowing them to participate in their own medical care. These discussions are a shared partnership between the clinician, patient, and family in which each partner works collaboratively to develop a care plan based on the patient's identity, values, clinical circumstances, and treatment options. Goals-of-care discussions are especially important as the patient becomes more seriously ill and potentially nears the end of life, because this is a time of uncertainty and emotional upheaval for the patient when priorities and goals frequently change. 

50. Assessing and treating depression in palliative care patients.
    Marks S., Heinrich T.
    AN: 2013588434

51.
New palliative care guidelines stress certification, diversity.

Wendling P.
Oncology Report. (JUN) (pp 16-17), 2013. Date of Publication: June 2013.
AN: 2013593360
Publisher
Elsevier Oncology (46 Green Street, 2nd Floor, Huntington NY 11743, United States)

<table>
<thead>
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<th>Emtree Heading</th>
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<tr>
<td>accreditation; *certification; clinical protocol; community hospital; conference paper; death; family; health care organization; health care personnel; health care quality; health program; hospice care; human; medical documentation; medical ethics; medical society; *palliative therapy; parent; patient care; *practice guideline; professional standard; public health service; scientist; social worker.</td>
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</table>
Palliative care in acute geriatric care units across Europe: Some reflections about the experience of geriatricians.


AN: 2013574427

Purpose Little is known about geriatricians' knowledge, training and attitudes towards end-of-life issues as well as about how their experience concerning end-of-life decisions in the older patient. The aim of this survey was to explore the experience and the attitudes of geriatricians across Europe towards end-of-life care of patients dying in acute geriatric care units. Subjects/Materials and methods A quantitative online survey was sent to the 21 members of the full board of the European Union Geriatric Medicine Society (EUGMS). These representatives had the possibility to forward it to colleagues from their countries, if they were not working in a geriatric acute care unit. Results Thirty-five geriatricians representing nine countries of Europe responded to the survey. The results highlighted a mortality rate in these units (between 10 and 30%). More than half of the geriatricians described few resources to help them deal with issues of end-of-life care (guidelines, ethics committee, and palliative care consultation). Twenty-four geriatricians had to take a decision to withhold or withdraw life-prolonging treatment in their patient. They reported a high level of burden associated with this decision-making and also the need of more training in palliative care. Discussion and conclusion These results highlight a number of needs of geriatricians working in acute geriatric care units that should encourage an action plan on palliative care and geriatric medicine to improve the quality of life of older patients with chronic diseases and to avoid moral distress in caregivers. 2013 Elsevier Masson SAS and European Union Geriatric Medicine Society.

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Publisher
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Emtree Heading
article; chronic disease; distress syndrome; emergency care; Europe; *geriatric care; geriatrician; geriatrics; human; life sustaining treatment; medical decision making; medical education; medical ethics; medical society; mortality; *palliative therapy; physician; physician attitude; practice guideline; priority journal; quality of life; quantitative analysis; terminal care.
Advising caregivers.
Wittenberg D.F.
AN: 2013560779
Publisher
Health and Medical Publishing Group (Private Bag X1, Pinelands 7430, South Africa)
Emtree Heading
behavior change; cerebral palsy; childhood obesity; diarrhea; editorial; health care policy; *health care practice; health education; health personnel attitude; lifestyle modification; mortality; oral rehydration therapy; palliative therapy; *patient information; practice guideline; public health.
55. Palliative care of pressure ulcers in long-term care.
Burt T.
Annals of Long-Term Care. 21 (3) (pp 20-28), 2013. Date of Publication: March 2013.
AN: 2013520529
Pressure ulcers are highly prevalent among older adults and elders receiving palliative care in numerous care settings. A palliative care approach to wounds involves a comprehensive assessment of existing wounds and prevention of new wounds. Treatment of wounds and their associated complications is typically driven by symptom management to improve patient comfort and quality of life. While much is known about palliative wound care in general, evidence to guide palliative care of pressure ulcers, specifically in older adults residing in long-term care (LTC) settings, is severely lacking. Many LTC facilities may follow the evidence-based guidelines developed by the National Pressure Ulcer Advisory Panel and the European Pressure Ulcer Advisory Panel. Although these organizations make specific recommendations to palliative care providers, scientific evidence should be strengthened and expanded upon. This article reviews the current body of medical literature on the palliative care of pressure ulcers in older adults, particularly those in LTC settings; examines how the medical literature compares with clinical practice guidelines; and identifies gaps where further research is needed.
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HMP Communications LLP (4365 U.S. Highway 1 Suite 250, Princeton NJ 08540, United States)
Emtree Heading
Aloe vera; Braden Scale; clinical assessment; clinical assessment tool; debridement; *decubitus/su [Surgery]; human; hydration; immobilization; *long term care; medical literature; medical research; moisture; nutrition; odor; pain/co [Complication]; pain/dt [Drug Therapy]; pain assessment; palliative performance scale; *palliative therapy; patient positioning; practice guideline; quality of life; review; risk assessment; shame; sleep disorder; social isolation; social psychology; wound assessment; wound care; wound fluid; wound infection/co [Complication]; diamorphine/dt [Drug Therapy]; glucoside; lidocaine/dt [Drug Therapy]; prilocaine/dt [Drug Therapy]; silver chloride.
56. Resuscitation of the patient with the functionally univentricular heart.
Marino B.S., Tibby S.M., Hoffman G.M.
AN: 2013509051
Neonates and infants with functional single ventricle anatomy face nearly certain early mortality without cardiac transplantation or successive palliation through a pathway of staged interventions. Patients with single ventricle variants typically have multiple hospitalizations and high incidence of cardiac arrest. Few studies have directly addressed the physiology, pharmacology, techniques or outcomes of resuscitation of this high-risk group. The unique challenge posed by resuscitation of this patient group was recently recognized within the 2010 International Liaison Committee on Resuscitation consensus statement, where, for the first time, two worksheets were devoted exclusively to the resuscitation of the single ventricle patient before and after S1P and those patients with bidirectional Glenn/hemi-Fontan and Fontan physiology. This article will review the consensus on science, treatment recommendations, and areas of uncertainty in the resuscitation of the infants and children with single ventricle physiology during each stage of surgical repair.
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(Marino, Tibby, Hoffman) Department of Pediatrics, Division of Cardiology, Cincinnati Children's Hospital Medical Center, 3333 Burnet Avenue, MLC 5050, Cincinnati, OH 45229, United States
Publisher
Bentham Science Publishers B.V. (P.O. Box 294, Bussum 1400 AG, Netherlands)
Emtree Heading
bidirectional glenn surgery; consensus development; Fontan procedure; heart arrest; *heart single ventricle/th [Therapy]; heart surgery; hemi Fontan surgery; high risk population; hospitalization; human; incidence; newborn mortality; palliative therapy; pharmacology; physiology; priority journal; resuscitation; review; surgical technique.

57. Current guidelines for the management of idiopathic pulmonary fibrosis.
Antoniou K.M., Daniil Z., Polychronopoulos V., Papiris S., Bouros D.
Pneumon. 25 (SUPPL.1) (pp 110-112), 2012. Date of Publication: 2012.
AN: 2013488129
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(Antoniou) Department of Thoracic Medicine, Medical School, University of Crete, Greece
(Daniil) Department of Thoracic Medicine, Medical School, University of Thessaly, Greece
(Polychronopoulos) Ygeia Hospital, Athens, Greece
58. Are we using oxycodone appropriately? A utilisation review in a UK tertiary care centre.
Todd A., Husband A., Richardson R., Jassal N., Robson P., Andrew I.
European Journal of Hospital Pharmacy: Science and Practice. 20 (2) (pp 125-128), 2013. Date of Publication: April 2013.
AN: 2013214634
Objectives To evaluate the utilisation of oxycodone in a tertiary care centre based in the North of England serving a population of 330 000. Methods A prospective study which gathered data from October 2011 to March 2012. Medical notes were screened to determine the prevalence of oxycodone use during the study period. The medication histories were determined; once the reason for oxycodone initiation was established, it was interpreted and classified as either appropriate or inappropriate. Results During the study period, a total of 51 patients were taking oxycodone; one patient was lost to followup. General practitioners were found to be the most common group responsible for initiating oxycodone (22 patients, 44%), followed by specialist palliative care nurses (11 patients, 22%). Other prescribers included palliative care consultants (nine patients, 18%); hospital doctors (seven patients, 14%) and a site-specific specialist nurse (one patient, 2%). Of the 50 patients, 17 (34%) were considered to be using oxycodone inappropriately. The most frequent reason for inappropriate use was initiating oxycodone without initially trying morphine. Conclusions Oxycodone is initiated inappropriately in a significant
The changing face of cancer care: Evolution to a collaborative model.
Kolodziej M.
American Health and Drug Benefits. 6 (5), 2013. Date of Publication: July 2013.
AN: 2013465489
Publisher
Engage Healthcare Communications, Inc. (241 Forsgate Drive, Suite 205, Jamesburt, NJ 08831, United States)

59.

60.
Herrmann N., Lanctot K.L., Hogan D.B.
AN: 2013441682

Background: While there have been no new medications approved for the treatment of Alzheimer's disease (AD) or other dementias in Canada since 2004, the Canadian Consensus Conference on the Diagnosis and Treatment of Dementia (CCCDTD) reviewed and updated the clinical practice guidelines on the pharmacological management of dementia that were published previously. Methods. This review focused on the literature for the pharmacological treatment of dementia based on studies published since the third CCCDTD in 2006. A literature search of English-language medical databases was performed for studies pertaining to the pharmacological treatment of AD and other dementias that examined the management of cognitive and functional impairment, as well as neuropsychiatric symptoms. All previous recommendations were reviewed, and only those that required updating based on new published studies were revised. Several new recommendations were also added. Recommendations were rated for quality of evidence and were approved by consensus. Results: There were 15 revised or new recommendations approved by consensus. The revised recommendations included acknowledging that cholinesterase inhibitors (ChEIs) possess a class effect and any of the agents can be used for AD across the spectrum of severity and with co-existing cerebrovascular disease. There was insufficient evidence to recommend for or against the use of ChEIs in combination with memantine for the primary indication of treating neuropsychiatric symptoms, or for the treatment of vascular dementia. Recommendations for the discontinuation of cognitive enhancers were revised and clarified, as well as the risks associated with discontinuing these drugs. ChEIs were recommended as a treatment option for dementia with Parkinson's disease. Risks associated with use of antipsychotics for neuropsychiatric symptoms were strengthened, and guidelines regarding the use of antidepressants for affective disturbances in dementia were weakened, and are now considered an option but not a firm recommendation. Valproate was recommended not to be used, and there was insufficient evidence to recommend for or against the use of selective serotonin reuptake inhibitors or trazodone for the treatment of agitation and aggression.

Conclusion: In spite of the lack of new therapeutic agents for the treatment of dementia, recent studies have helped to clarify and strengthen recommendations to optimize the pharmacological management of these illnesses. 2013 BioMed Central Ltd.

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Emtree Heading
aggression; agitation; Alzheimer disease; anxiety; apathy; appetite; brain infarction; cerebrovascular disease; clinical practice; cognition; cognitive defect; *consensus; daily life activity; *dementia/dt [Drug Therapy]; depression/dt [Drug Therapy]; disease severity; drug safety; drug tolerability; dysthymia; functional disease; hallucination; human; major affective disorder;
61.
Treat advanced cancer patient with care, strengthen multi-disciplinary cooperation: The 8th Conference of Chinese Cancer Rehabilitation and Palliative Care was held in Qingdao.
Cheng Y.,
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Publisher
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Emtree Heading
*advanced cancer/th [Therapy]; cancer palliative therapy; cancer rehabilitation; cancer survival; Chinese; Chinese medicine; clinical research; conference paper; cooperation; human; *malignant neoplastic disease/th [Therapy]; outcome assessment; *patient care; practice guideline; publication; quality of life; social support; traditional medicine; opiate; oxycodone.
<td colspan=""/>

62.
Managing juvenile Huntington’s disease.
Neurodegenerative Disease Management. 3 (3) (pp 267-276), 2013. Date of Publication: June 2013.
AN: 2013348919
Huntington's disease (HD) is a well-recognized progressive neurodegenerative disorder that follows an autosomal dominant pattern of inheritance. Onset is insidious and can occur at almost any age, but most commonly the diagnosis is made between the ages of 35 and 55 years. Onset <20 years of age is classified as juvenile HD (JHD). This age-based definition is arbitrary but remains convenient. There is overlap between the clinical pathological and genetic features seen in JHD and more traditional adult-onset HD. Nonetheless, the frequent predominance of bradykinesia and dystonia early in the course of the illness, more frequent occurrence of epilepsy and myoclonus, more widespread pathology, and larger genetic lesion means that the distinction is still relevant. In addition, the relative rarity of JHD means that the clinician managing the patient is often doing so for the first time. Management is, at best, symptomatic and supportive with few or no evidence-based guidelines. In this article, the authors will review what is known of the condition and present some suggestions based on their experience. 2013 Future Medicine Ltd.
COPD is a progressive illness that requires a multidisciplinary approach to management. Our Drug review discusses its diagnosis and the available treatment options. 2013 Wiley Interface Ltd.

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airway obstruction/di [Diagnosis]; ambulatory care; anxiety disorder/di [Diagnosis]; anxiety disorder/dm [Disease Management]; article; assisted ventilation; asthma/di [Diagnosis]; asthma/dt [Drug Therapy]; bronchodilatation; bronchospirography; cardiovascular risk; chronic lung disease/pc [Prevention]; *chronic obstructive lung disease/di [Diagnosis]; *chronic obstructive lung disease/dm [Disease Management]; *chronic obstructive lung disease/dt [Drug Therapy]; *chronic obstructive lung disease/rh [Rehabilitation]; *chronic obstructive lung disease/su [Surgery]; *chronic obstructive lung disease/th [Therapy]; clinical assessment; clinical examination; clinical feature; cost effectiveness analysis; coughing/dt [Drug Therapy]; daily life activity; depression/di [Diagnosis]; depression/dm [Disease Management]; differential diagnosis; disease exacerbation; drug blood level; drug delivery device; drug mechanism; dry powder inhaler; flow measurement; forced expiratory volume; forced vital capacity; gastrointestinal symptom/si [Side Effect]; high risk patient; home care; human; immunization; influenza/pc [Prevention]; influenza vaccination; laboratory test; long term care; lung function; lung resection; maintenance therapy; medical history; metered dose inhaler; muscle atrophy; nebulizer; nicotine replacement therapy; noninvasive ventilation; occupational therapy; oxygen therapy; palliative therapy; paresthesia/si [Side Effect]; patient attitude; patient care; patient compliance; peripheral edema/si [Side Effect]; physical examination; practice guideline; pulmonary rehabilitation; quality of life; respiratory failure/rh [Rehabilitation]; risk factor; scoring system; secondary health care; self care; side effect/si [Side Effect]; smoking cessation; social isolation; treatment response; xerostomia/si [Side Effect]; aclidinium bromide/dt [Drug Therapy]; beta 2 adrenergic receptor stimulating agent/dt [Drug Therapy]; beta 2 adrenergic receptor stimulating agent/ih [Inhalational Drug Administration]; beta 2 adrenergic receptor stimulating agent/pd [Pharmacology]; bronchodilating agent/ae [Adverse Drug Reaction]; bronchodilating agent/cr [Drug Concentration]; bronchodilating agent/dt [Drug Therapy]; bronchodilating agent/ih [Inhalational Drug Administration]; bronchodilating agent/pd [Pharmacology]; budesonide plus formoterol/dt [Drug Therapy]; carbocisteine/dt [Drug Therapy]; cholinergic receptor blocking agent/dt [Drug Therapy]; cholinergic receptor blocking agent/ih [Inhalational Drug Administration]; cholinergic receptor blocking agent/pd [Pharmacology]; corticosteroid/dt [Drug Therapy]; corticosteroid/ih [Inhalational Drug Administration]; fluticasone propionate plus salmeterol/dt [Drug Therapy]; fluticasone propionate plus salmeterol xinafoate; glycopyrronium bromide/dt [Drug Therapy]; indacaterol/ae [Adverse Drug Reaction];
Pain relief and the end of life.
Tai V., Lovell M.R.
AN: 2013308566

Good pain control is possible in most patients in the months, weeks and days preceding death. This leads not only to better patient care but also to a better bereavement experience for families.

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*analgesia; bereavement; breakthrough pain/dt [Drug Therapy]; dose response; human; neuropathic pain/dt [Drug Therapy]; pain/dt [Drug Therapy]; palliative therapy; patient care; practice guideline; review; *terminal care; amitriptyline/dt [Drug Therapy]; *analgesic agent/dt [Drug Therapy]; anticonvulsive agent/dt [Drug Therapy]; buprenorphine/dt [Drug Therapy]; buprenorphine/td [Transdermal Drug Administration]; codeine/dt [Drug Therapy]; fentanyl/td [Drug Therapy]; fentanyl/td [Transdermal Drug Administration]; gabapentin/td [Drug Therapy]; hydromorphone/dt [Drug Therapy]; hydromorphone/po [Oral Drug Administration]; hydromorphone/sc [Subcutaneous Drug Administration]; methadone/dt [Drug Therapy]; methadone/po [Oral Drug Administration]; morphine/dt [Drug Therapy]; morphine/po [Oral Drug Administration]; morphine/sc [Subcutaneous Drug Administration]; naloxone/dt [Drug Therapy]; narcotic analgesic agent/do [Drug Dose]; narcotic analgesic agent/dt [Drug Therapy]; nonsteroid antiinflammatory agent/dt [Drug Therapy]; oxycodone/dt [Drug Therapy]; oxycodone/po [Oral Drug Administration]; oxycodone/sc [Subcutaneous Drug Administration]; paracetamol/dt [Drug Therapy]; pregabalin/dt [Drug Therapy]; tramadol/dt [Drug Therapy].
65.
Using aggregated single patient (N-of-1) trials to determine the effectiveness of psychostimulants to reduce fatigue in advanced cancer patients: A rationale and protocol.
AN: 2013304577
Background: It is estimated that 29% of deaths in Australia are caused by malignant disease each year and can be expected to increase with population ageing. In advanced cancer, the prevalence of fatigue is high at 70-90%, and can be related to the disease and/or the treatment. The negative impact of fatigue on function (physical, mental, social and spiritual) and quality of life is substantial for many palliative patients as well as their families/carers. Method/design. This paper describes the design of single patient trials (n-of-1 s or SPTs) of a psychostimulant, methylphenidate hydrochloride (MPH) (5 mg bd), compared to placebo as a treatment for fatigue, with a population estimate of the benefit by the aggregation of multiple SPTs. Forty patients who have advanced cancer will be enrolled through specialist palliative care services in Australia. Patients will complete up to 3 cycles of treatment. Each cycle is 6 days long and has 3 days treatment and 3 days placebo. The order of treatment and placebo is randomly allocated for each cycle. The primary outcome is a reduction in fatigue severity as measured by the Functional Assessment of Cancer Therapy-fatigue subscale (FACIT-F). Secondary outcomes include adverse events, quality of life, additional fatigue assessments, depression and Australian Karnovsky Performance Scale. Discussion. This study will provide high-level evidence using a novel methodological approach about the effectiveness of psychostimulants for cancer-related fatigue. If effective, the findings will guide clinical practice in reducing this prevalent condition to improve function and quality of life. Trial registration. Australian New Zealand Clinical Trials Registry ACTRN12609000794202. 2013 Senior et al.; licensee BioMed Central Ltd.
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Emtree Heading
*advanced cancer; article; Australia; cancer patient; clinical article; *clinical protocol; controlled study; double blind procedure; ethics; *fatigue/dt [Drug Therapy]; functional assessment; health service; human; palliative therapy; quality of life; randomized controlled trial; *methylphenidate/ct [Clinical Trial]; *methylphenidate/dt [Drug Therapy]; placebo.
Rare clinical types of breast cancer. <Szczegolne postacie kliniczne nowotworow zlos liwych piersi.>
Piekarski J.H.
Current Gynecologic Oncology. 10 (4) (pp 326-336), 2012. Date of Publication: 2012.
AN: 2013275052

Paget's disease of the nipple may exist as an isolated condition or may be associated with breast cancer. Paget's disease-associated breast cancer may be intraductal or invasive; depending on location, it may be retromamillary or peripheral. Surgical treatment consists in sparing procedure or breast amputation. Patients with Paget's disease coexisting with an infiltrating breast cancer, should undergo sentinel node biopsy or axillary lymphadenectomy. Bilateral breast cancer is diagnosed in women diagnosed with primary cancer in both breasts. This definition does not include metastases of unilateral breast cancer to contralateral breast. Recommended type of surgical treatment is bilateral mastectomy and bilateral biopsy of sentinel node or axillary lymphadenectomy. Sparing treatment is a therapeutic option applicable in reference centers only. Isolated metastases of other tumors to the breasts are very rare. The usual origin of breast metastases is contralateral breast cancer. Less frequent are secondary foci of lymphoma and melanoma. Management strategy depends on what type of malignant tumor was the source of metastases. The cornerstone of treatment is usually systemic treatment, if available. Surgical treatment is limited to surgical biopsy or palliative treatment (e.g. mastectomy due to bleeding from the tumor). Occult breast cancer is diagnosed in women with metastases of adenomatous cancer, non-differentiated or non-classified to axillary lymph nodes, when neither physical nor radiological examination reveal a primary breast cancer. The most probable origin of axillary metastases is breast cancer. Surgical treatment consists in axillary lymphadenectomy and mastectomy. One may withhold from mastectomy if spared breast will undergo total radiotherapy. Breast cancer in the elderly, i.e. persons over 70, accounts for over 30% of all breast cancer cases. Surgical treatment of elderly women with breast cancer should be based on standard protocols (mastectomy or sparing treatment; biopsy of sentinel node and/or axillary lymphadenectomy). Standard treatment protocol can and should be modified when treatment-associated risk exceeds expected benefits thereof. Curr. Gynecol. Oncol. 2012.

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Publisher
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Emtree Heading
article; axillary lymph node; bilateral cancer; *breast cancer/dt [Drug Therapy]; *breast cancer/rt [Radiotherapy]; *breast cancer/su [Surgery]; breast metastasis; cancer chemotherapy; cancer patient; cancer radiotherapy; cancer surgery; clinical protocol; human; lymph node dissection; lymphoma; mastectomy; melanoma; multimodality cancer therapy; occult cancer; Paget nipple disease; palliative therapy; rare disease; senescence; sentinel lymph node biopsy; systemic therapy; antineoplastic agent/dt [Drug Therapy]; cytokeratin 20/ec [Endogenous Compound];
cytokeratin 7/ec [Endogenous Compound]; epidermal growth factor receptor 2/ec [Endogenous Compound]; estrogen receptor/ec [Endogenous Compound]; progesterone receptor/ec [Endogenous Compound].

67.
Improving health care benefits by reducing costs.
Grouse L.
AN: 2013271169
Institution
(Grouse) University of Washington School of Medicine, Seattle, WA, United States
Publisher
Pioneer Bioscience Publishing Company (8/F,Cnt Comm Bldg, 302 Queen's Rd Central, Hong Kong)
Emtree Heading
article; cost benefit analysis; *cost control; disability; health care availability; health care management; *health care quality; health status; human; life expectancy; longevity; outcome assessment; patient satisfaction; practice guideline; primary medical care; public health; quality adjusted life year; reimbursement; terminal care.

68.
News from the american heart association scientific sessions 2012.
Hlatky M.
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Institution
(Hlatky) Stanford University, School of Medicine, California, United States
Publisher
MediNews (Cardiology) Ltd (3 Duchess Place, Edgbaston, Birmingham B16 8NH, United Kingdom)
Emtree Heading
acute heart failure; arrhythmogenesis; calcium signaling; catheter ablation; chronic kidney disease; conference paper; *consensus; heart atrium fibrillation; heart ejection fraction; *heart failure; heart infarction; human; implantable cardioverter defibrillator; *medical society; percutaneous coronary intervention; practice guideline; randomized controlled trial (topic); risk factor; secondary prevention; ST segment elevation myocardial infarction; stem cell transplantation; systolic dysfunction; terminal care; ventricular assist device; apixaban; brain natriuretic peptide; dabigatran; eplerenone; rivaroxaban.
69. The Development of Supportive Care for Cancer Patients in India: A UK Perspective. Cullen J., Rew D. Indian Journal of Surgical Oncology. 4 (1) (pp 30-34), 2013. Date of Publication: 2013. AN: 2013130834

This article discusses the development of supportive care for cancer patients in India from a UK professional nursing perspective. 2012 Indian Association of Surgical Oncology.

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(Rew) University Hospitals of Southampton, Southampton, United Kingdom

Publisher
Springer India (Barakhamba Road 110001, New Delhi 110 001, India)

Emtree Heading
article; *cancer palliative therapy; *cancer patient; clinical decision making; clinical nurse specialist; clinical practice; communication skill; empowerment; health care delivery; health care policy; health care quality; health education; human; India; medical education; mental health care personnel; morbidity; nurse practitioner; *nursing care; nursing care plan; nursing career; nursing practice; patient advocacy; *patient care; priority journal; smoking; social care; social isolation; terminal care; United Kingdom; working time; workplace.

70. Terminating the ventilatory support: An ethical dilemma. Kojikj L.

Anaesthesia, Pain and Intensive Care. 16 (3) (pp 223-225), 2012. Date of Publication: September-December 2012.

AN: 2013212334

Intensive care physicians in modern set ups frequently have to face a dilemma in which they have to vote for a choice to sustain or to withdraw ventilatory treatment in terminally sick patients. The rapidly developing science of organ transplantation has given birth to many new questions, some of which still remain unanswered. Although most of the main religions have somehow endorsed organ harvesting from these patients to sustain the life of some other sick persons, and although many countries have clear guidelines authenticated by the legislation, clinicians in many countries still have to answer these questions based upon their experience and other factors. Many of them refuse to accept the option of terminating life supporting treatment including ventilatory therapy. In this editorial the later viewpoint has been discussed by the esteemed author.

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AN: 2013195001
Ongoing supportive follow-up for patients with malignant glioma lacks good evidence to define and guide practice, and certain approaches have previously been criticized. In the UK, it commonly involves routine hospital visits with imaging to monitor treatment effects and detect disease progression. Aims: Through use of an observational study evaluate and compare oncologist-led follow-up with a multidisciplinary group follow-up method from the perspective of patients and caregivers. Materials & methods: A total of 40 patients, and 32 of their caregivers, were recruited 3 months after completing radical radiotherapy treatment. Face-to-face interviews conducted at home with patients gathered information about access to and experiences of follow-up services. Standardized questionnaires measured patients' quality of life and unmet care needs, and caregivers' psychological wellbeing. Assessment was repeated three times over a 6-month period. Results: Inevitable attrition left 26/40 patients and 19/32 caregivers with complete data. Most (65%) patients' quality of life improved or was maintained over the study period. However, psychological support for patients and caregivers was suboptimal, notably 56% of caregivers had probable psychiatric morbidity. Though few significant differences were found between the two follow-up methods, multidisciplinary follow-up provided better continuity of care and more efficient test result provision. Conclusion: Innovative interventions are required to ameliorate psychological distress in patients and caregivers. 2012 Future Medicine Ltd.
Institution (Catt, Fallowfield) Sussex Health Outcomes, Research and Education in Cancer (SHORE-C), Brighton and Sussex Medical School, University of Sussex, Brighton BN1 9QG, United Kingdom (Chalmers) Institute of Cancer Sciences, University of Glasgow, G12 8QQ, United Kingdom (Critchley) Hurstwood Park Neurological Centre, Haywards Heath, RH16 4EX, United Kingdom Publisher Future Medicine Ltd. (2nd Albert Place, Finchley Central, London N3 1QB, United Kingdom)
Pain perception in disorders of consciousness: Neuroscience, clinical care, and ethics in dialogue.
Neuroethics. 6 (1) (pp 37-50), 2013. Date of Publication: April 2013.
AN: 2013183183
Pain, suffering and positive emotions in patients in vegetative state/unresponsive wakefulness syndrome (VS/UWS) and minimally conscious states (MCS) pose clinical and ethical challenges. Clinically, we evaluate behavioural responses after painful stimulation and also emotionally-contingent behaviours (e.g., smiling). Using stimuli with emotional valence, neuroimaging and electrophysiology technologies can detect subclinical remnants of preserved capacities for pain which might influence decisions about treatment limitation. To date, no data exist as to how healthcare providers think about end-of-life options (e.g., withdrawal of artificial nutrition and hydration) in the presence or absence of pain in non-communicative patients. Here, we aimed to better clarify this issue by re-analyzing previously published data on pain perception (Prog Brain Res 2009 177, 329-38) and end-of-life decisions (J Neurol 2010 258, 1058-65) in patients with disorders of consciousness. In a sample of 2259 European healthcare professionals we found that, for VS/UWS more respondents agreed with treatment withdrawal when they considered that VS/UWS patients did not feel pain (77%) as compared to those who thought VS/UWS did feel pain (59%). This interaction was influenced by religiosity and professional background. For MCS, end-of-life attitudes were not influenced by opinions on pain perception. Within a contemporary ethical context we discuss (1) the evolving scientific understandings of pain perception and their relationship to existing clinical and ethical guidelines; (2) the discrepancies of attitudes within (and between) healthcare providers and their consequences for treatment approaches, and (3) the implicit but complex relationship between pain perception and attitudes toward life-sustaining treatments. 2012 Springer Science+Business Media B.V.
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Publisher
73.
Summary of the ESC Guidelines for the diagnosis and treatment of acute and chronic heart failure 2012. Prepared by the Czech Society of Cardiology.
Hradec J., Vitouec J., Spinar J.
AN: 2013197133
Institution
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*acute heart failure/di [Diagnosis]; *acute heart failure/dt [Drug Therapy]; *acute heart failure/ep [Epidemiology]; *acute heart failure/et [Etiology]; *acute heart failure/su [Surgery]; angina pectoris; angiocardiology; article; cachexia; cardiac resynchronization therapy; cardiovascular magnetic resonance; cardiovascular mortality; chronic obstructive lung disease; coronary artery bypass graft; depression; diabetes mellitus; diastolic dysfunction; diastolic heart failure/dt [Drug Therapy]; diastolic heart failure/su [Surgery]; diastolic heart failure/th [Therapy]; dyspnea; echocardiology; endocardium; erectile dysfunction; exercise tolerance; fatigue; gout; headache/si [Side Effect]; heart afterload; heart atrium fibrillation; heart catheterization; heart conduction; *heart failure/di [Diagnosis]; *heart failure/ep [Epidemiology]; *heart failure/et [Etiology]; *heart failure/su [Surgery]; heart muscle revascularization; heart preload; heart rhythm; heart transplantation; human; hyperlipidemia; hypertension; hypotension/si [Side Effect]; iron deficiency; kidney dysfunction; meta analysis (topic); noninvasive ventilation; obesity; palliative therapy; pathophysiology; pericardium; peripheral edema; positron emission tomography; *practice guideline; prostate hypertrophy; quality of life; randomized controlled trial (topic); sleep disorder; sodium restriction; systematic review; systolic heart failure/dt [Drug Therapy]; systolic heart failure/su [Surgery]; systolic heart failure/th [Therapy]; thorax radiography; treatment response; valvular heart disease/su [Surgery]; adrenalin/dt [Drug Therapy]; adrenalin/iv
74.
Verhagen A.A.E.
AN: 2013162321
A substantial number of reports and studies in the last 10-15 years have described the physician's attitude towards neonatal EoL decisions and medical practice in the Netherlands. Legal developments have supported the concept that the decision to withholding and withdrawing life-sustaining treatment in newborns can be regarded normal medical practice. Deliberate ending of life, however, is labeled as an extraordinary category of medical actions, both medically and legally, that requires reporting and review as described in the Groningen Protocol. A recent study has indicated that reports have become increasingly rare. This might be because deliberate life-ending has become virtually non-existent, or it might still occur unreported because it's unclear to the physicians where the demarcation between 'good' palliative care and deliberate life-ending lies. The medical profession should and could work together to get this issue cleared up. 2013 Bentham Science Publishers.
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Management of periviable newborns in the Nordic Countries.
Hansen T.W.R., Saugstad O.D.
AN: 2013162317
Perinatal and neonatal health care is quite uniform in the Nordic countries in spite of large
differences in population densities and transport distances. For the present study data was
collected with a questionnaire sent to neonatologists in the five Nordic countries Denmark,
Finland, Iceland, Norway, and Sweden. In these countries there are totally approximately 80 level
II and 25 level I NICUs. Care of periviable immature infants is strongly centralized with a few
exceptions in Norway due to long transport distances. Iceland with one level III NICU only is the
only country with national guidelines for management of prematurity, and only Norway has
national guidelines for follow-up. In all countries the lower margin of viability is considered as < 23
weeks, although practical handling of these smallest children may vary between countries and
within each country. In parts of Sweden proactive management is recommended while other
units, for instance in Denmark, practice palliative care at 23 weeks and life support at 24 weeks.
Following a consensus conference organized in Norway in 1998 it became common practice to
treat babies with gestational age down to 23 weeks, however parental choice and autonomy
should be respected. This seems to be in accordance with recent international guidelines. In
summary, ELBWIs are offered intensive care treatment in all Nordic countries but with some
variation between countries concerning rate of referral and degree of centralization of care.
Survival rates for these babies are quite high in all the Nordic countries. 2013 Bentham Science
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Rates of population growth, total fertility and birth among the Saudi population are increasing, resulting in more than half a million newborns delivered every year. Despite this significant number of deliveries, there is still an existing shortage in NICU (neonatal intensive care unit) beds in tertiary level hospitals. The percentage of pre-viable newborns in Saudi Arabia is similar to most countries worldwide. We agree that the definition of pre-viability is vague rather than distinct. Recently, a religious opinion regarding resuscitation of pre-viable newborns was issued from Saudi Arabia. It states that for infants born at less than 6 lunar months (252/7 weeks), two specialist physicians could assess the infant’s clinical condition at birth and based on their opinion the infant could be offered full resuscitation if it is beneficial to the infant or he or she can be left without intervention to die but should not be deprived of nutrition or fluids. In this review, we compared the outcome of infants less than 1500 grams in three tertiary hospitals in Saudi Arabia with outcome of infants recently published by NICHD. We found that outcomes of these infants born in our tertiary level hospitals are comparable with the outcome of similar groups from NICHD. We strongly believe that clear guidelines are highly needed to support shared decision making to avoid inconsistency in managing ELBW infants at all Saudi hospitals. 2013 Bentham Science Publishers.

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(Alallah) Neonatology Section, Department of Pediatrics, King Abdulaziz Medical City, WR Affiliated to King Saud Bin Abdulaziz University for Health Sciences, Jeddah, Saudi Arabia  (AlFaleh) Neonatal Section, Department of Pediatrics, College of Medicine and King Khalid University Hospital, Saudi Arabia

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Bentham Science Publishers B.V. (P.O. Box 294, Bussum 1400 AG, Netherlands)

Emtree Heading
child health; decision making; delivery; *fetal well being; fetus weight; fluid intake; gestational age; human; intensive care unit; newborn morbidity; newborn mortality; nutrition; palliative therapy; physician; practice guideline; pregnancy outcome; *prematurity/dt [Drug Therapy]; *prematurity/ep [Epidemiology]; *preivable newborn/ep [Epidemiology]; priority journal; publication; resuscitation; review; Saudi Arabia; small for date infant/ep [Epidemiology]; survival rate; terminal care; tertiary health care; corticosteroid/dt [Drug Therapy].

76.
Pre-viable newborns in Saudi Arabia: Where are we now and what the future may hold?.
Al-Alaiyan S., Al-Abdi S., Alallah J., Al-Hazzani F., AlFaleh K.
Current Pediatric Reviews. 9 (1) (pp 4-8), 2013. Date of Publication: 2013.
AN: 2013162314
End of life issues in the intensive care units.
Datta R., Chaturvedi R., Rudra A., Jaideep C.N.
Medical Journal Armed Forces India. 69 (1) (pp 48-53), 2013. Date of Publication: 2013.
AN: 2013106970
A structured discussion of End-of-Life (EOL) issues is a relatively new phenomenon in India. Personal beliefs, cultural and religious influences, peer, family and societal pressures affect EOL decisions. Indian law does not provide sanction to contentious issues such as do-not-resuscitate (DNR) orders, living wills, and euthanasia. Finally, published data on EOL decisions in Indian ICUs is lacking. What is needed is a prospective determination of which patients will benefit from aggressive management and life-support. A consensus regarding the concept of Medical Futility is necessary to give impetus to further discussion on more advanced policies including ideas such as Managed Care to restrict unnecessary health care costs, euthanasia, the principle of withhold and/or withdraw, ethical and moral guidelines that would govern decisions regarding futile treatment, informed consent to EOL decisions and do-not-resuscitate orders. This review examines the above concepts as practiced worldwide and looks at some landmark judgments that have shaped current Indian policy, as well as raising talking points for possible legislative intervention in the field. 2012, Armed Forces Medical Services (AFMS). All rights reserved.
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(Datta) Anaesthesiology, Army Hospital (R and R), New Delhi, India (Chaturvedi) CH (AF), Bangalore 560 007, India
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Publisher
Medical Journal Armed Forces India (Pune411040India)
Emtree Heading
attitude to illness; beneficence; euthanasia; family decision making; health belief; health care cost; health care policy; human; India; *intensive care unit; life sustaining treatment; living will; long term care; medical decision making; medical ethics; medicolegal aspect; organ transplantation; palliative therapy; patient autonomy; physician attitude; practice guideline; quality of life; religion; resuscitation; review; right to life; survival rate; *terminal care; terminally ill patient; treatment outcome; treatment withdrawal.

78.
The perspectives of educators, regulators and funders of massage therapy on the state of the profession in British Columbia, Canada.
Shroff F.M., Sahota I.S.
AN: 2013093630
Background: Registered Massage Therapists (RMTs) are valuable members of the healthcare team who assist in health promotion, disease prevention, treatment, rehabilitation and palliation.
RMT visits have increased across Canada over the past decade with the highest increase in British Columbia (BC). Currently, RMTs are private practitioners of healthcare operating within a largely publicly funded system, positioning them outside of the dominant system of healthcare and making them an important case study in private healthcare. In another paper we examined the perspectives of RMTs themselves. Here, we offer perspectives of regulators, educators and funders of Massage Therapy (MT) on advancement of the profession.

Methods: We interviewed 28 stakeholders of MT in BC - including members of the MT regulatory board, representatives from MT colleges in BC and public and private health insurers. Results: All three groups identified research, particularly on efficacy of MT, as playing a vital role in enhancing the professional credibility of MT. However, participants noted that presently research is not a large feature of the current MT curricula and we analyze why this may be and how it can improve. Finally, conferral of baccalaureate degree status could assist RMTs in gaining recognition with the general public and other healthcare professionals. Conclusion: RMTs have potential to ameliorate population health in a cost-effective manner. Their role in British Columbia's healthcare landscape could be expanded if they produce more research and earn degree status.

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Publisher
BioMed Central Ltd. (Floor 6, 236 Gray's Inn Road, London WC1X 8HB, United Kingdom)

Emtree Heading
article; Canada; clinical protocol; health care personnel; health care system; health insurance; health promotion; human; interview; massage; *massage therapy; medical education; palliative therapy; *physiotherapy; preventive medicine; priority journal; questionnaire; registered massage therapist.

79.
CoMPASs: IOn programme (Care of Memory Problems in Advanced Stages of dementia: Improving Our Knowledge): Protocol for a mixed methods study.
Jones L., Harrington J., Scott S., Davis S., Lord K., Vickerstaff V., Round J., Candy B., Sampson E.L.
AN: 2013077634
Introduction: Approximately 700 000 people in the UK have dementia, rising to 1.2 million by 2050; one-third of people aged over 65 will die with dementia. Good end-of-life care is often neglected, and detailed UK-based research on symptom burden and needs is lacking. Our project examines these issues from multiple perspectives using a rigorous and innovative design, collecting data which will inform the development of pragmatic interventions to improve care.

Methods and analysis: To define in detail symptom burden, service provision and factors affecting care pathways we shall use mixed methods: prospective cohort studies of people with advanced
dementia and their carers; workshops and interactive interviews with health professionals and carers, and a workshop with people with early stage dementia. Interim analyses of cohort data will inform new scenarios for workshops and interviews. Final analysis will include cohort demographics, the symptom burden and health service use over the follow-up period. We shall explore the level and nature of unmet needs, describing how comfort and quality of life change over time and differences between those living in care homes and those remaining in their own homes. Data from workshops and interviews will be analysed for thematic content assisted by textual grouping software. Findings will inform the development of a complex intervention in the next phase of the research programme. Ethics and dissemination: Ethical approval was granted by National Health Service ethical committees for studies involving people with dementia and carers (REC refs. 12/EE/0003; 12/LO/0346), and by university ethics committee for work with healthcare professionals (REC ref. 3578/001). We shall present our findings at conferences, and in peer-reviewed journals, prepare detailed reports for organisations involved with end-of-life care and dementia, publicising results on the Marie Curie website. A summary of the research will be provided to participants if requested.

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Publisher
BMJ Publishing Group (Tavistock Square, London WC1H 9JR, United Kingdom)

Emtree Heading
article; clinical protocol; cohort analysis; computer program; *dementia; demography; DSM-IV; follow up; health care organization; health care personnel; *health program; health service; home care; human; interview; national health service; patient care; *professional knowledge; prospective study; quality of life; terminal care; United Kingdom; workshop.

80.
Outstanding ethico-legal-fiqhi issues.
Kasule O.H.K.
Journal of Taibah University Medical Sciences. 7 (1) (pp 5-12), 2012. Date of Publication: August 2012.
AN: 2013085610
Objective: To examine the practical issues arising in implementation of DNR from the perspectives of maqasid al shari‘at and qawa‘id al shari‘at. Methods: The purposes and principles of the Law provided a conceptual framework for analyzing practical issues related to DNR orders. The issues were identified from a Pubmed literature search with the key word ‘DNR’ covering about 30 years and were analyzed as they related to the principles of intention, certainty and preventing harm and also to the purposes of preserving life and resources. Results: It is proposed that DNR orders be written for patients in an established death process, i.e. cardiorespiratory failure beyond Young’s point ‘z’. Patients with terminal incurable conditions who develop acute, reversible cardiorespiratory arrest should be resuscitated if the net benefit will last for a reasonable time. Five components of DNR (cardiopulmonary resuscitation involving chest
compression and oxygenation, endotracheal intubation, mechanical ventilation, defibrillation and vasoactive or ionotropic medication) could be provided on a case-by-case basis. The interventions may or may not include renal dialysis, blood transfusion, parenteral nutrition, pulmonary hygiene and normal treatment such as antibiotics. All patients, irrespective of their DNR status, deserve supportive care. Conclusion: To improve DNR processes, training should be given on end-of-life ethical issues for physicians and nurses, DNR orders should specify interventions, the autonomy of physicians who have a conscientious objection to DNR should be respected, more psychosocial support should be given to the families of DNR patients, more empirical research is required on DNR, and DNR decisions should be audited regularly. 2012 Taibah University.

Institution
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Publisher
Darussalam Publisher (P.o Box 22743, Riyadh 11416, Saudi Arabia)

Emtree Heading
artificial ventilation; blood transfusion; cardiopulmonary insufficiency; compression therapy; conceptual framework; death; defibrillation; *do not resuscitate; endotracheal intubation; euthanasia; family decision making; health care delivery; human; informed consent; *legal aspect; life; *medical ethics; *medical order; oxygenation; palliative therapy; parenteral nutrition; practice guideline; renal replacement therapy; resuscitation; review; *terminal care; time; antibiotic agent; vasoactive agent.

81.
Chronic idiopathic urticaria: Keys to improving quality of life.
Philip B., Katelaris C.H.
AN: 2013056161
The intense pruritus and evanescent skin lesions of urticaria are poorly tolerated by patients, and long-term disease can lead to sleep disturbances, anxiety and reduced quality of life. Nonsedating antihistamines, patient education and psychological support form the basis of management. Corbis/Visuals Unlimited.

Institution
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Publisher
Medicine Today Pty Ltd (P.O. Box 1473, Neutral Bay NSW 2089, Australia)

Emtree Heading
alcohol consumption; angioneurotic edema; antibody detection; anxiety; autoimmune thyroiditis; bacterium detection; blood cell count; chemical analysis; cholinergic urticaria; *chronic idiopathic urticaria/dt [Drug Therapy]; *chronic idiopathic urticaria/ep [Epidemiology]; *chronic idiopathic urticaria/et [Etiology]; *chronic idiopathic urticaria/th [Therapy]; *chronic urticaria/dt [Drug
Ending hand feeding of patients with advanced cognitive decline: What is “doing the right thing”?.
Smucker D.R.
Annals of Long-Term Care. 20 (6) (pp 41-42), 2012. Date of Publication: June 2012.
AN: 2013065224
Dr. Smucker comments on the issues of end-of-life palliative care raised by Drs. Singer and Clary in "Doing the Right Thing".
Institution
(Smucker) Department of Family and Community Medicine, University of Cincinnati College of Medicine, OH, United States
Publisher
HMP Communications LLP (4365 U.S. Highway 1 Suite 250, Princeton NJ 08540, United States)
Emtree Heading
article; bioethics; clinical assessment; consultation; distress syndrome; *feeding; general practitioner; *hand feeding; human; medical specialist; *mental deterioration; mental health care;
oligophrenia; palliative therapy; patient decision making; practice guideline; quality of life; terminal care.

83.
Special considerations for endoscopists on PEG indications in older patients.
Cardin F.
AN: 2012745228
Undernutrition in frail elderly people is a pathological condition that needs to be recognized and addressed early. Neurological dysphagia is among the most frequent causes of this condition in the elderly but should be considered a terminal event in Alzheimer-type dementias. Tube feeding is an important resource for facilitating metabolic recovery in cachectic patients and is particularly successful in "bridging" and stabilizing therapies prior to major treatment able to cure the patient. Clinical management of tube feeding in "incurable" conditions is complex and becomes part of the palliative care and comfort provided in the terminal stages of illness. Non-specialized physicians are often unfamiliar with the theory and practice of end-of-life interventions, and the resulting decisions are in many cases actually contrary to patient comfort. These problems deserve to be more carefully addressed when the patient is unable to cooperate or express his/her preferences and needs. The success of percutaneous endoscopic gastrostomy has led to increasingly frequent referrals for placement in critically ill elderly patients. Endoscopists therefore become a key figure in stimulating rational, correct treatment of these patients. 2012 Fabrizio Cardin.
Institution
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Publisher
International Scholarly Research Network (410 Park Avenue, 15th Floor, #287 pmb, New York NY 10022, United States)
Emtree Heading
Alzheimer disease; aspiration pneumonia; cachexia; critically ill patient; dementia; dysphagia/surgery; *elderly care; enteric feeding; feeding apparatus; frail elderly; general condition deterioration; human; malnutrition; medical decision making; medical practice; mortality; palliative therapy; patient preference; patient referral; *percutaneous endoscopic gastrostomy; physician; practice guideline; priority journal; review; survival rate; swallowing; *treatment indication.

84.
Successful aging and family resilience.
Walsh F.
This chapter examines the emerging challenges and resilience of families in later life, grounded in a developmental family systems perspective. It examines salient issues with retirement and financial security; grandparenthood; caregiving with chronic illness; and end-of-life challenges and the loss of loved ones. Core principles in a family resilience framework are presented. Clinical guidelines and case illustrations are offered to address common challenges and to encourage the potential for personal and relational well-being and growth in intimate, companionate, and intergenerational bonds. 2012 Springer Publishing Company.

Publisher
Springer Publishing Company (11 West 42nd Street, 15th Floor, New York NY 10036, United States)

Emtree Heading
*aging; article; caregiver; child rearing; chronic disease; conceptual framework; coping behavior; death; decision making; ecology; emotion; empathy; family assessment; *family coping; *family resilience; financial management; geriatric care; grandparent; human; intimacy; medical research; physician; practice guideline; psychological well being; retirement; socioeconomics; terminal care.

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Sleep hypoventilation in patients with neuromuscular diseases.
Grigg-Damberger M.M., Wagner L.K., Brown L.K.
Sleep Medicine Clinics. 7 (4) (pp 667-687), 2012. Date of Publication: December 2012.
AN: 2012722572
Sleep-disordered breathing (SDB), especially sleep-related hypercapnic hypoventilation, is common in patients with neuromuscular disorders (NMD). Whether the NMD is acute and reversible or indolent and progressive, the accompanied respiratory muscle weakness predisposes to hypoventilation. Probably the 3 most common NMD referred to sleep medicine specialists are Duchenne muscular dystrophy, myotonic dystrophy type 1, and amyotrophic lateral sclerosis. Symptoms-based and physiologic predictors of sleep hypoventilation have been described for patients with NMD. Nocturnal polysomnography remains the gold standard for diagnosis of SDB in NMD and for titration of nocturnal positive pressure ventilation. 2012 Elsevier Inc.

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Publisher
W.B. Saunders (Independence Square West, Philadelphia PA 19106-3399, United States)

Emtree Heading
abnormal respiratory sound; amyotrophic lateral sclerosis; arousal; arterial gas; article; artificial ventilation; assisted ventilation; Becker muscular dystrophy; bloating; breathing; breathing
muscle; breathing rate; bulbar paralysis; carbon dioxide tension; claustrophobia; corticosteroid therapy; coughing; cyanosis; daytime somnolence; deep sedation; drug dose reduction; Duchenne muscular dystrophy/dt [Drug Therapy]; dysphagia; dyspnea; dystrophinopathy; electrostimulation therapy; end tidal carbon dioxide tension; endurance; exercise; fatigue; headache; heart arrhythmia; human; hypercapnia; hypersalivation; *hypoventilation/th [Therapy]; hypoxia; infection; kyphoscoliosis; long term care; lung capacity; lung function; lung function test; malnutrition; motor performance; muscle weakness; myotonic dystrophy; neurologic examination; *neuromuscular disease; night sleep; nightmare; noninvasive ventilation; oximetry; oxygen therapy; palliative therapy; physical examination; polysomnography; positive end expiratory pressure; practice guideline; priority journal; prognosis; REM sleep; respiratory failure; respiratory function; respiratory tract infection; scoliosis; *sleep disordered breathing/th [Therapy]; *sleep hypoventilation; sleep quality; sleep time; spasticity; survival; tachypnea; thorax pressure; tidal volume; tracheotomy; wakefulness; weakness; weight reduction; botulinum toxin; deflazacort/dt [Drug Therapy]; diazepam; morphine; prednisone/dt [Drug Therapy]; tricyclic antidepressant agent.

86.
Palliative care in thoracic oncology.
Schonfeld N., Blum T.
Breathe. 9 (2) (pp 125-131), 2012. Date of Publication: 2012.
AN: 2012719566
Institution
(Schonfeld, Blum) Lungenklinik Heckeshorn, HELIOS Klinikum Emil von Behring, Walterhoferstr. 11, 14165 Berlin, Germany
Publisher
European Respiratory Society (4 Ave Sainte-Luce, Lausanne CH-1003, Switzerland)
Emtree Heading
airway obstruction; analgesia; article; artificial embolism; bone metastasis; cachexia; cancer chemotherapy; cancer pain/dt [Drug Therapy]; *cancer palliative therapy; chemotherapy induced nausea and vomiting/dt [Drug Therapy]; clinical assessment; clinical assessment tool; clinical protocol; coughing; disease severity; distress syndrome/di [Diagnosis]; dyspnea/dt [Drug Therapy]; dyspnea/th [Therapy]; fatigue; hemoptysis/di [Diagnosis]; hemoptysis/th [Therapy]; human; life expectancy; noninvasive ventilation; oxygen therapy; pleura effusion/su [Surgery]; psychosocial disorder; self care; social isolation; spiritual care; symptomatology; thoracocentesis; *thorax cancer/th [Therapy]; treatment planning; video assisted thoracoscopic surgery; analgesic agent/dt [Drug Therapy]; antiemetic agent/dt [Drug Therapy]; bisphosphonic acid derivative/dt [Drug Therapy]; morphine/dt [Drug Therapy]; narcotic analgesic agent/dt [Drug Therapy]; nonsteroid antiinflammatory agent/dt [Drug Therapy]; opiate derivative/dt [Drug Therapy].
Guidelines for a palliative approach for aged care in the community setting: A suite of resources.
Toye C., Blackwell S., Maher S., Currow D.C., Holloway K., Tieman J., Hegarty M.
AN: 2012719412

In Australia, many people ageing in their own homes are becoming increasingly frail and unwell, approaching the end of life. A palliative approach, which adheres to palliative care principles, is often appropriate. These principles provide a framework for proactive and holistic care in which quality of life and of dying is prioritised, as is support for families. A palliative approach can be delivered by the general practitioner working with the community aged care team, in collaboration with family carers. Support from specialist palliative care services is available if necessary. The Guidelines for a Palliative Approach for Aged Care in the Community Setting were published by the Australian Government Department of Health and Ageing to inform practice in this area. There are three resource documents. The main document provides practical evidence based guidelines, good practice points, tools, and links to resources. This document is written for general practitioners, nurses, social workers, therapists, pastoral care workers, and other health professionals and responded to needs identified during national consultation. Evidence based guidelines were underpinned by systematic reviews of the research literature. Good practice points were developed from literature reviews and expert opinion. Two ‘plain English’ booklets were developed in a process involving consumer consultation; one is for older people and their families, the other for care workers. The resources are intended to facilitate home care that acknowledges and plans for the client's deteriorating functional trajectory and inevitable death. At a time when hospitals and residential aged care facilities are under enormous pressure as the population ages, such a planned approach makes sense for the health system as a whole. The approach also makes sense for older people who wish to die in their own homes. Family needs are recognised and addressed. Unnecessary hospitalisations or residential placements and clinically futile interventions are also minimised.

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(Toye, Maher) Sir Charles Gairdner Hospital, Australia
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Publisher
Australasian Medical Journal Pty Ltd (12 Lancett Crt, Sorrento, WA 6020 WA, Australia)

Emtree Heading
article; Australia; *community care; community structure; conceptual framework; dying; *elderly care; evidence based practice; family counseling; family functioning; frail elderly; general practitioner; human; *palliative therapy; practice guideline; quality of life.
Guidelines for end-of-life and palliative care in Indian intensive care units' ISCCM consensus Ethical Position Statement.
Indian Journal of Critical Care Medicine. 16 (3) (pp 166-181), 2012. Date of Publication: July-September 2012.
AN: 2012692490
Purpose To develop an ethical framework and practical procedure for limiting inappropriate therapeutic interventions to improve the quality of care of the dying in the intensive care unit through a professional consensus process. Evidence Since the publication of the last guideline in 2005,[1] there has been an exponential increase in empirical information and discussion on the subject. The literature reviewed address key surveys, observational studies, randomized controlled and interventional studies as well as guidelines and recommendations for education and quality improvement from all over the world and India. Established and evolving bioethical and medico-legal opinions in the world and in India are also included in this review. The search terms were: End-of-life care; DNR directives; withdrawal and withholding; intensive care; terminal care; medical futility; ethical issues; palliative care; end-of-life care in India; cultural variations. Materials and Methods Proposals from the Chair were debated and recommendations were formulated through a consensus process. The members of the Committee took into account the established ethical principles and procedural practices elsewhere in the world, incorporating the sociocultural and legal perspectives unique to this country.
Institution
(Mani, Amin, Chawla, Divatia, Kapadia, Khilnani, Myatra, Prayag, Rajagopalan, Todi, Uttam)
Indian Society of Critical Care Medicine, Artemis Health Institute, Sector 51, Gurgaon, Haryana, India
Publisher
Medknow Publications and Media Pvt. Ltd (B9, Kanara Business Centre, off Link Road, Ghatkopar (E), Mumbai 400 075, India)
Emtree Heading
article; artificial ventilation; beneficence; bioethics; brain death; cancer center; cancer patient; cardiopulmonary insufficiency; coma; correlation analysis; court; decision making; dementia; disease marker; distress syndrome/dt [Drug Therapy]; distress syndrome/pc [Prevention]; endotracheal intubation; ethical decision making; *euthanasia; family counseling; health care; hospital bed; human; Indian; intensive care; intensive care unit; intervention study; law; legal aspect; long term care; mortality; newborn care; pain/dt [Drug Therapy]; pain/pc [Prevention]; palliative therapy; passive euthanasia; persistent vegetative state; personal autonomy; physician; practice guideline; prospective study; quadriplegia; resuscitation; suicide attempt; survival; systemic circulation; terminal disease; tertiary health care; treatment withdrawal; barbituric acid derivative; carbapenem; morphine; opiate/dt [Drug Therapy].

89.
Nutritional differences in neurologically impaired children.
Riley A., Vadeboncoeur C. 
Paediatrics and Child Health (Canada). 17 (9) (pp e98-e101), 2012. Date of Publication: 
November 2012. 
AN: 2012652390

Objectives: To determine whether the recommended nutritional intake of moderately to severely 
neurologically impaired children is congruent with current growth parameter expectations.

Methods: Observational cross-sectional study at a children's hospice and a tertiary care children's 
hospital. Medically stable enterally fed children followed by the palliative care team underwent 
anthropometric assessment and chart review for diagnosis, intake and medications. Intakes, 
guidelines and recommendations were compared. Results: Intakes were less than recommended. 
All children were <50th percentile weight-for-age, with many <3rd percentile. Fourteen of 15 were 
in higher percentiles for absolute and relative body fat. Conclusions: Recommended dietary 
intakes were not achieved by these children. Despite this, measures of body fat indicate 
adequate intake. Low weight values may reflect diagnosis-related growth stunting or decreased 
muscle mass and bone density from immobility. The Centers for Disease Control and Prevention 
(Georgia, USA) weight-for-age and body mass index are not suitable measures of adequate 
intake in this group of children. 2012 Pulsus Group Inc. All rights reserved.

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Published literature shows that evidence-based medical care can improve hip fracture outcomes. 
The orthogeriatrician plays a key role in providing this care, in collaboration with surgical and 
multidisciplinary professionals, managing pre-operative conditions and post-operative 
complications that may affect functional recovery, and ensuring co-ordinated effective 
management of hip fractures right from admission to discharge. Several management guidelines 
are available for this vulnerable group of elderly patients. Recent UK guidelines recommend that, 
from time of admission, hip fracture patients should be offered a formal acute orthogeriatric or
orthopaedic ward-based 'Hip Fracture Programme’, which includes orthogeriatric assessment as an essential key component. Copyright 2012 Cambridge University Press.

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Publisher
Cambridge University Press (Shaftesbury Road, Cambridge CB2 2RU, United Kingdom)

Emtree Heading
aged; analgesia; anemia/th [Therapy]; antibiotic prophylaxis; article; bladder function; blood transfusion; cerebrovascular accident/co [Complication]; comorbidity; compression stocking; constipation/dt [Drug Therapy]; constipation/si [Side Effect]; decubitus/po [Prevention]; deep vein thrombosis/co [Complication]; deep vein thrombosis/dt [Drug Therapy]; deep vein thrombosis/po [Prevention]; deep vein thrombosis/th [Therapy]; delirium/et [Etiology]; delirium/si [Side Effect]; dementia; electrolyte balance; fall risk assessment; fluid balance; gastrointestinal hemorrhage/co [Complication]; *gerontologist; heart infarction/co [Complication]; *hip fracture/dm [Disease Management]; *hip fracture/et [Etiology]; *hip fracture/rh [Rehabilitation]; *hip fracture/su [Surgery]; hip surgery; human; intestine function; low drug dose; lung embolism/co [Complication]; lung embolism/dt [Drug Therapy]; malnutrition; medical audit; *orthogeriatrician; *orthopedic specialist; osteoporosis/dt [Drug Therapy]; osteoporosis/et [Etiology]; pain/dt [Drug Therapy]; palliative therapy; postoperative care; postoperative complication/co [Complication]; postoperative complication/et [Etiology]; practice guideline; surgical infection/co [Complication]; surgical infection/dt [Drug Therapy]; surgical infection/po [Prevention]; thrombocytopenia/si [Side Effect]; thrombosis prevention; United Kingdom; urinary tract infection/co [Complication]; urine retention/co [Complication]; urine retention/th [Therapy]; venous thromboembolism/dt [Drug Therapy]; acetylsalicylic acid/cb [Drug Combination]; acetylsalicylic acid/dt [Drug Therapy]; antiinflammatory agent/dt [Drug Therapy]; cephalosporin derivative/dt [Drug Therapy]; clindamycin/dt [Drug Therapy]; clopidogrel/cb [Drug Combination]; clopidogrel/dt [Drug Therapy]; codeine/ae [Adverse Drug Reaction]; codeine/dt [Drug Therapy]; dipyridamole/cb [Drug Combination]; dipyridamole/dt [Drug Therapy]; fondaparinux/ct [Clinical Trial]; fondaparinux/dt [Drug Therapy]; heparin/dt [Drug Therapy]; laxative/dt [Drug Therapy]; low molecular weight heparin/ae [Adverse Drug Reaction]; low molecular weight heparin/dt [Drug Therapy]; paracetamol/dt [Drug Therapy]; vancomycin/dt [Drug Therapy]; vitamin K group; warfarin/ct [Clinical Trial]; warfarin/cb [Drug Combination]; warfarin/dt [Drug Therapy]; zoledronic acid/ct [Clinical Trial]; zoledronic acid/dt [Drug Therapy].

91.
Payers collaborate with providers to adopt oncology pathways, new care delivery models. Greenapple R.


AN: 2012589871

Publisher
Euthanasia and death with dignity in Japanese law.
Kai K.
Journal de Medecine Legale Droit Medical. 55 (3-4) (pp 217-223), 2012. Date of Publication: September 2012.
AN: 2012613917
In Japan, there are no acts and, specific provisions or official guidelines on euthanasia, but recently, as I will mention below, an official guideline on "death with dignity" has been made. Nevertheless in fact, this guideline provides only a few rules of process on terminal care. Therefore the problems of euthanasia and "death with dignity" are mainly left to the legal interpretation by literatures and judicial precedents of homicide (Article 199 of the Criminal Code; where there is no distinction between murder and manslaughter) and of homicide with consent (Article 202 of the Criminal Code). Furthermore, there are several cases on euthanasia or "death with dignity" as well as borderline cases in Japan. In this paper I will present the situation of the latest discussions on euthanasia and "death with dignity" in Japan from the viewpoint of medical law. Especially, "death with dignity" is seriously discussed in Japan, therefore I focus on it.
Institution
(Kai) Waseda University, Tokyo, Japan
Publisher
Editions Alexandre Lacassagne (68, Rue Montgolfier, Lyon 69006, France)
93.
The European Association for Palliative Care: Forging a vision of excellence in Palliative Care.
Radbruch L., Blumhuber H., Payne S.
Progress in Palliative Care. 20 (4) (pp 223-226), 2012. Date of Publication: September 2012.
AN: 2012609612
The European Association for Palliative Care (EAPC) represents 46 national associations from 27 European countries and more than 50 000 health care workers and volunteers working or
interested in palliative care. The area of influence includes 23 developing countries, most of them in Eastern Europe and Central Asia. Even though many countries are improving rapidly in their economy and the development of their health care systems, there still are major gaps between Western and Eastern European countries. EAPC has produced guidance on different areas of palliative care from symptom assessment to organization of care. The congresses and research congresses as well as the website (www.eapcnet.eu) are renowned platforms for dissemination and exchange of information. The research network and a number of task forces are active on a wide range of topics. Members from developing countries can benefit from these activities, and, for example, pan-European comparisons such as the Atlas of Palliative Care in Europe have been used with good effect for advocacy work in individual countries. EAPC actions such as the Budapest Commitments and the Venice Declaration also have been useful for developing countries. However, more specific support is needed for the developing countries. EAPC has set up a newsletter for Eastern European and Central Asian countries that is available in English and Russian, and more recently also a Russian website (www.eapcspeaksrussian.eu). A survey on information needs is currently under way to provide a basis for more tailored provision of information and knowledge. More specifically the ATOME project (Access to Opioid Medications in Europe) funded in the seventh Framework programme of the European Commission works at the improvement of access to opioids for medical and scientific use in 12 East and South European countries. As a first central project goal, a revised version of the World Health Organization policy guidelines on ensuring balance in access to controlled medicines has been released only recently. The European Association for Palliative Care produces high-quality expert advice, with congresses, publications, the website and various other activities. Palliative care professionals from Eastern European and Central Asian countries benefit from these activities. In addition, EAPC has initiated additional activities with a focus on developing countries, ranging from information needs assessment to specific research projects. The range of activities of EAPC is only possible with the continuing input of palliative care professionals from all over Europe. Palliative care professionals from developing countries are invited to contribute and share the successes of EAPC. W.S. Maney & Son Ltd 2012.

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Publisher
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Emtree Heading
article; clinical assessment; developing country; Eastern Europe; Europe; *European Association for Palliative Care; health care access; health care personnel; health care policy; health care system; health survey; human; information dissemination; information processing; knowledge; medical research; *medical society; *palliative therapy; patient advocacy; practice guideline; Russian Federation; Western Europe; world health organization.
Cosgrove J.F., Bari F.
AN: 2012580410
Modern intensive care fulfils advanced supportive roles in the care of patients with actual or threatened multiple organ dysfunction. Such roles prolong patients' lives and whilst intensive care mortality rates have reduced in the last two decades, death following intensive care admission remains relatively common. Dealing with death and caring for dying patients is therefore a day-to-day reality of intensive care medicine and an urgent treatment. Clinicians have a duty to recognize the progression towards death and understand the ethical and legal concepts guiding best practice. This includes understanding the concept of medical futility, the ethical and medico-legal framework of decision-making in such circumstances and what factors constitute a good death on a case by case basis. This approach can enable the provision of effective care for the patient (encompassing both physical and holistic aspects of end-of-life care) and effective guidance for the family.
Institution
(Cosgrove, Bari) Freeman Hospital, Newcastle upon Tyne, United Kingdom
Publisher
Elsevier Ltd (Langford Lane, Kidlington, Oxford OX5 1GB, United Kingdom)
Emtree Heading
article; clinical decision making; good clinical practice; hospital physician; human; human rights; *intensive care unit; legal aspect; living will; medical ethics; medicolegal aspect; mortality; multiple organ failure; palliative therapy; patient care; priority journal; *terminal care; United Kingdom.

95. Challenges of pain management in long-term care.
Farless L.B., Ritchie C.S.
Annals of Long-Term Care. 20 (5) (pp 32-38), 2012. Date of Publication: May 2012.
AN: 2012567182
Persistent pain is common among older long-term care (LTC) residents, yet it remains underrecognized and undertreated, partly because healthcare providers and institutions lack a standardized approach to assessing and managing pain in older persons in this setting. Currently, there is a relative dearth of data on pain management in nursing home residents, and although pain guidelines are available, including by the American Geriatrics Society and AMDA-Dedicated to Long Term Care Medicine (formerly the American Medical Directors Association), a review of the literature shows that pain assessment protocols are generally lacking in nursing homes and that care is often no delivered according to pain guidelines. The authors discuss challenges in assessing and managing pain among LTC residents and evaluate whether adherence to pain guidelines in older adults can provide sufficient pain management in the LTC setting.
Institution
96.
Home and community based care program assessment for people living with HIV/AIDS in Arba Minch, Southern Ethiopia.
Zerfu T.A., Yaya Y., Dagne S., Deribe K., Ruiseor-Escudero H., Biadgilign S.
AN: 2012542839

Background: People Living with HIV/AIDS (PLWHA) require significant care and support; however, most care needs are still unmet. To our knowledge, no studies have described the activities and challenges of care services in Ethiopia. Our objective was to assess the status, shortcomings and prospects of care and support services provided to PLWHA in the town of Arba Minch, Ethiopia, and surrounding areas. Methods: A cross-sectional quantitative study combined with qualitative methods was conducted in Southern Ethiopia among 226 randomly selected PLWHAs and 10 service providers who were purposively selected. Data was collected using a pre-tested structured interview questionnaire and in-depth interview guideline. Quantitative data was analyzed using SPSS windows based statistical software while qualitative data was analyzed manually using thematic framework analysis. Results: A total of 226 PLWHAs were interviewed. Socio-economic support (material and income generating activities) was being received by 108 (47.8%) of the respondents, counseling services (e.g. psychological support) were being received 128(56.6%), 144 (63.7%) alleviation of stigma and discrimination as human right and legal support for study participants. Inadequate external financial support, lack of proper referral systems between different care providers were among the reasons identified for the low quality and redundancy of care and support activities. Nonetheless, many opportunities and prospects, including easily accessible care receivers (PLWHA), good political and societal will were also implicated. Conclusion: Care and support services provided to PLWHAs in the study area are by far lower in terms of coverage and quantity. Strategies for improvement could be facilitated given the observed political will, social support and access to care givers. 2012 Alemu et al.; licensee BioMed Central Ltd.
Institution (Fine) Pain Research Center, School of Medicine, University of Utah, Salt Lake City, UT, United States Publisher Future Medicine Ltd. (2nd Albert Place, Finchley Central, London N3 1QB, United Kingdom) Emtree Heading *analgesia; evidence based practice; health care personnel; health care system; human; medical research; neuropathic pain; note; pain/dt [Drug Therapy]; palliative therapy; patient care; practice guideline; priority journal; opiate/dt [Drug Therapy].
<td colspan=""/>

Bone metastases are a common manifestation of malignancy, and external beam radiotherapy (EBRT) effectively and safely palliates the pain caused by this clinical circumstance. The myriad of EBRT dosing schemes and complexities involved with coordinating radiotherapy with other interventions necessitated the need for bone metastases treatment guidelines. Here we compare and contrast the bone metastases radiotherapy treatment guidelines recently published by the American Society for Radiation Oncology (ASTRO) and the American College of Radiology (ACR). These evaluations acknowledge current controversies in treatment approaches, they evaluate the nuances of ASTRO and ACR task force decisionmaking regarding standard approaches to care, and they project the upcoming research results that may clarify approaches to palliative radiotherapy for bone metastases. The results of these two dedicated radiotherapy guidelines are compared to the brief mentions of radiotherapy for bone metastases in the National Comprehensive Cancer Network (NCCN) guidelines. Finally, the paper describes how treatment guidelines may influence patterns of care and reimbursement by their use as quality measures by groups such as the National Quality Forum (NQF). 2012 Elsevier GmbH.

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Emtree Heading  
American Society for Radiation Oncology; *bone metastasis/rt [Radiotherapy]; breast cancer; cancer pain; cancer palliative therapy; clinical decision making; consensus; CyberKnife; decompression surgery; external beam radiotherapy; health care organization; human; intensity modulated radiation therapy; kidney cancer; kyphoplasty; lung non small cell cancer; lung small cell cancer; metastatic bone pain; multiple myeloma; national comprehensive cancer network; patient care; percutaneous vertebroplasty; *practice guideline; prostate cancer; proton therapy; publication; radiation dose fractionation; *radiotherapy; review; spinal cord compression/rt [Radiotherapy]; stereotactic ablative body radiotherapy; stereotactic body radiation therapy; stereotactic procedure; thyroid cancer; tomotherapy; radioisotope; radium 223; samarium 153; strontium 89; unclassified drug.

99.
Understanding integrated care pathways in palliative care using realist evaluation: A mixed methods study protocol.
Dalkin S.M., Jones D., Lhussier M., Cunningham B.
AN: 2012433803
Introduction: Policy- and evidence-based guidelines have highlighted the need for improved palliative and end-of-life care. However, there is still evidence of individuals dying undignified deaths with little pain control, therefore inflicting unnecessary suffering. New commissioning powers have enabled a 2-year pilot of an innovative integrated care pathway (ICP) designed to
improve arrangements for individuals with life-limiting illnesses requiring palliative care. A novel feature of the ICP is its focus on palliative care over the last 6 months of life, aiming to intervene early to prepare for and ensure a good death. What is not known is if this pathway works, how it works and who it works for. Methods and analysis: A realist evaluation and a complex analytical framework will investigate and discover context, mechanism and outcome conjectures and configurations of the ICP and thus facilitate exploration of how it works and who it works for. A mixed methods approach will be used with small sample sizes to capture the breadth of the ICP. Phase 1 will identify if the pathway works through analysis of NHS Morbidity Information Query and Export Syntax data, locality Death Audit data and the Quality of Dying and Death Questionnaire. Phase 2 employs soft systems methodology with data from focus groups with health professionals to identify how the pathway works. Phase 3 uses the Miller Behavioural Style Scale and interviews with palliative care patients and bereaved relatives to analyse communication in palliative care. Ethics and dissemination: Ethical approval has been granted from the NHS local ethics committee (REC reference number: 11/NE/0318). Research & Development approval has been gained from four different trusts, and relevant voluntary organisations and the local council have been informed about the research. This protocol illustrates the complexity inherent in evaluating a palliative care ICP. Identification of whether the pathway works, how it works and who it works for will be beneficial to all practices and other care providers involved as it will give objective data on the impact of the ICP. Results will be disseminated throughout the study for continuous quality improvement of the ICP. Outcomes from each data collection phase will be disseminated separately if analysis warrants it; all data collection will be utilised in the realist evaluation. The research provides a potential for the dissemination of the pathway to other localities through the transferable knowledge it will generate, from its focus on the contexts that are crucial for successful implementation, the mechanisms that facilitate implementation and the outcomes achieved.

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article; clinical pathway; clinical practice; clinical protocol; dying; human; *integrated health care system; national health service; *palliative therapy; practice guideline; *terminal care; terminally ill patient.

100.
Developing and testing a strategy to enhance a palliative approach and care continuity for people who have dementia: Study overview and protocol.
Toye C., Robinson A.L., Jiwa M., Andrews S., McInerney F., Horner B., Holloway K., Stratton B.
AN: 2012405908
Background: Typically, dementia involves progressive cognitive and functional deterioration, leading to death. A palliative approach recognizes the inevitable health decline, focusing on quality of life. The approach is holistic, proactive, supports the client and the family, and can be provided by the client's usual care team. In the last months of life, distressing symptoms, support needs, and care transitions may escalate. This project trialed a strategy intended to support a consistent, high quality, palliative approach for people with dementia drawing close to death. The strategy was to implement two communities of practice, drawn primarily from service provider organizations across care sectors, supporting them to address practice change. Communities comprised practitioners and other health professionals with a passionate commitment to dementia palliative care and the capacity to drive practice enhancement within partnering organizations. Project aims were to document: (i) changes driven by the communities of practice; (ii) changes in staff/practitioner characteristics during the study (knowledge of a palliative approach and dementia; confidence delivering palliative care; views on death and dying, palliative care, and a palliative approach for dementia); (iii) outcomes from perspectives of family carers, care providers, and community of practice members; (iv) the extent to which changes enhanced practice and care continuity; and (v) barriers to and facilitators of successful community of practice implementation. Methods/design. This action research project was implemented over 14 months in 2010/11 in metropolitan Perth, Western Australia and regional Launceston, Tasmania. Each state based community of practice worked with the researchers to scope existing practice and its outcomes. The research team compiled a report of existing practice recommendations and resources. Findings of these two steps informed community of practice action plans and development of additional resources. Change implementation was recorded and explored in interviews, comparisons being made with practice recommendations. Changes in staff/practitioner characteristics were evaluated using survey data. Findings from semi structured interviews and survey administration established outcomes from perspectives of family carers, care providers, and community of practice members. Consideration of processes and outcomes, across the two state based settings, informed identification of barriers and facilitators. Community of practice reflections also informed study recommendations. 2012Toye et al; licensee BioMed Central Ltd.

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Practical Radiation Oncology. 2 (3) (pp 210-225), 2012. Date of Publication: July 2012.
AN: 2012359122

Purpose: To systematically review the evidence for the radiotherapeutic and surgical management of patients newly diagnosed with intraparenchymal brain metastases. Methods and Materials: Key clinical questions to be addressed in this evidence-based Guideline were identified. Fully published randomized controlled trials dealing with the management of newly diagnosed intraparenchymal brain metastases were searched systematically and reviewed. The U.S. Preventative Services Task Force levels of evidence were used to classify various options of management. Results: The choice of management in patients with newly diagnosed single or multiple brain metastases depends on estimated prognosis and the aims of treatment (survival, local treated lesion control, distant brain control, neurocognitive preservation). Single brain metastasis and good prognosis (expected survival 3 months or more): For a single brain metastasis larger than 3 to 4 cm and amenable to safe complete resection, whole brain radiotherapy (WBRT) and surgery (level 1) should be considered. Another alternative is surgery and radiosurgery/radiation boost to the resection cavity (level 3). For single metastasis less than 3 to 4 cm, radiosurgery alone or WBRT and radiosurgery or WBRT and surgery (all based on level 1 evidence) should be considered. Another alternative is surgery and radiosurgery or radiation boost to the resection cavity (level 3). For single brain metastasis (less than 3 to 4 cm) that is not resectable or incompletely resected, WBRT and radiosurgery, or radiosurgery alone should be considered (level 1). For nonresectable single brain metastasis (larger than 3 to 4 cm), WBRT should be considered (level 3). Multiple brain metastases and good prognosis (expected survival 3 months or more): For selected patients with multiple brain metastases (all less than 3 to 4 cm), radiosurgery alone, WBRT and radiosurgery, or WBRT alone should be considered, based on level 1 evidence. Safe resection of a brain metastasis or metastases causing significant mass effect and postoperative WBRT may also be considered (level 3). Patients with poor prognosis (expected survival less than 3 months): Patients with either single or multiple brain metastases with poor prognosis should be considered for palliative care with or without WBRT (level 3). It should be recognized, however, that there are limitations in the ability of physicians to accurately predict patient survival. Prognostic systems such as recursive partitioning analysis, and diagnosis-specific graded prognostic assessment may be helpful. Conclusions: Radiotherapeutic intervention (WBRT or radiosurgery) is associated with improved brain control. In selected patients with single brain metastasis, radiosurgery or surgery has been found to improve survival and locally treated metastasis control (compared with WBRT alone). 2012 American Society for Radiation Oncology.
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article; *brain metastasis/dt [Drug Therapy]; *brain metastasis/rt [Radiotherapy]; *brain metastasis/su [Surgery]; brain radiation; *brain surgery; cancer chemotherapy; cancer control; cancer diagnosis; cancer prognosis; *cancer radiotherapy; cancer survival; comparative effectiveness; drug use; *evidence based medicine; human; palliative therapy; postoperative care; practice guideline; priority journal; radiation dose fractionation; radiosurgery; risk assessment; systematic review; therapy effect; tumor volume; whole body radiation; chloroethyl nitrosourea derivative/dt [Drug Therapy]; efaproxiral/dt [Drug Therapy]; fotemustine/dt [Drug Therapy]; gadolinium texaphyrin/dt [Drug Therapy]; radiosensitizing agent/dt [Drug Therapy]; temozolomide/dt [Drug Therapy]; teniposide/dt [Drug Therapy]; thalidomide/dt [Drug Therapy]; topotecan/dt [Drug Therapy].

Drug Trade Names and Manufacturers
rsr 13

<td colspan=""uellement>
Casting stones and casting aspersions: Let's not lose sight of the main issues in the euthanasia debate.
Pereira J.
Current Oncology. 19 (3) (pp 139-142), 2012. Date of Publication: 2012. 
AN: 2012351711
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Publisher
Multimed Inc. (66 Martin Street, Milton ONT L9T 2R2, Canada)
Emtree Heading
article; assisted suicide; beneficence; consultation; critically ill patient; *euthanasia; human; legal procedure; length of stay; medical decision making; medical ethics; medicolegal aspect; palliative therapy; patient right; physician attitude; practice guideline; professional competence; psychologic assessment; quality of life.

103.
Routine oxygen at end of life can add to discomfort.
Jancin B.
AN: 2012347965
Publisher
Elsevier Oncology (46 Green Street, 2nd Floor, Huntington NY 11743, United States)
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article; chronic obstructive lung disease; clinical protocol; disease exacerbation; heart failure; high risk patient; human; lung cancer; *oxygen therapy; pneumonia; randomized controlled trial (topic); respiratory distress; survival rate; *terminal care; terminally ill patient.

104.
Programmable morphine pump (an intrathecal drug delivery system) - A promising option for pain relief and palliation in cancer patients.
Singh M., Cugati G., Singh P., Singh A.K.
Indian Journal of Medical and Paediatric Oncology. 33 (1) (pp 58-59), 2012. Date of Publication: January-March 2012. 
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105.
Explicit appropriateness prescription criteria in advanced dementia. Are we there yet?.
Lertxundi U., Hernandez Palacios R., Cibrian Gutierrez F., Urrutia Losada A.
European Geriatric Medicine. 3 (3) (pp 196-197), 2012. Date of Publication: June 2012.
AN: 2012330606
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Publisher
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*appropriate prescribing; *dementia; drug classification; drug formulation; dysphagia; human; letter; life expectancy; palliative therapy; patient care; practice guideline; *prescription; priority journal; risk benefit analysis; acenocoumarol; antiandrogen; anticonvulsive agent; antithyroid agent; anxiolytic agent; appetite stimulant; benzodiazepine; cholinergic receptor stimulating agent; clonazepam; dabigatran; dutasteride; febuxostat; hormone antagonist; hypnotic agent; lidocaine; medroxyprogesterone; morphine; rivaroxaban; sex hormone.
Drug Trade Names and Manufacturers
lidoderm
The ethical challenges related to organ donation and transplantation have been widely debated. Opinions regarding donation and transplantation are diverse. This article aims to highlight current areas of debate. The pursuit for clear definition of death has resulted from the increased demand for organ transplantation. Guidance regarding the definition of death has been provided although ethical debate continues. The number of donors after circulatory death has increased over recent years. Nevertheless, ethical issues persist, especially related to patient care at the juncture of end of life care and organ donation. Adjusting the end of life pathway to facilitate donation with no direct medical benefit to the donor can result in clinicians feeling that they are not acting in the patient's best interest. There is debate about what could and should be done in order to increase the number of organs available for transplantation. It is vital that any changes to the system to secure and distribute organs for transplant are ethically sound and that society, individuals and families have faith in the system. There are varying opinions regarding who can authorize donation of organs. Consent to donation should be well informed, un-coerced and on the basis of the individual's beliefs and values. 2012 Elsevier Ltd. All rights reserved.
108.

Ethics and intensive care - Murky water.
Bennett S.
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Institution
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Publisher
Stansted News Ltd (134 South Street, Bishop's Stortford, Hertfordshire, Essex CM23 3BQ, United Kingdom)
Emtree Heading
emergency health service; hospital admission; human; *intensive care; letter; *medical ethics; palliative therapy; patient referral; practice guideline.

109.

Cancer pain management and bone metastases: An update for the clinician.
Schneider G., Voltz R., Gaertner J.
Breast Care. 7 (2) (pp 113-120), 2012. Date of Publication: April 2012.
AN: 2012296842
Breast cancer patients with bone metastases often suffer from cancer pain. In general, cancer pain treatment is far from being optimal for many patients. To date, morphine remains the gold standard as first-line therapy, but other pure mu agonists such as hydromorphone, fentanyl, or oxycodone can be considered. Transdermal opioids are an important option if the oral route is impossible. Due to its complex pharmacology, methadone should be restricted to patients with difficult pain syndromes. The availability of a fixed combination of oxycodone and naloxone is a promising development for the reduction of opioid induced constipation. Especially bone
metastases often result in breakthrough pain episodes. Thus, the provision of an on-demand opioid (e.g., immediate-release morphine or rapid-onset fentanyl) in addition to the baseline (regular) opioid therapy (e.g., sustained-release morphine tablets) is mandatory. Recently, rapid onset fentanyls (buccal or nasal) have been strongly recommended for breakthrough cancer pain due to their fast onset and their shorter duration of action. If available, metamizole is an alternative non-steroid-anti-inflammatory-drug. The indication for bisphosphonates should always be checked early in the disease. In advanced cancer stages, glucocorticoids are an important treatment option. If bone metastases lead to neuropathic pain, coanalgetics (e.g., pregabalin) should be initiated. In localized bone pain, radiotherapy is the gold standard for pain reduction in addition to pharmacologic pain management. In diffuse bone pain radionuclids (such as samarium) can be beneficial. Invasive measures (e.g., neuroaxial blockage) are rarely necessary but are an important option if patients with cancer pain syndromes are refractory to pharmacologic management and radiotherapy as described above. Clinical guidelines agree that cancer pain management in incurable cancer is best provided as part of a multiprofessional palliative care approach and all other domains of suffering (psychosocial, spiritual, and existential) need to be carefully addressed ('total pain').

110.
Advance Directives.
Breu A.
Hospital Medicine Clinics. 1 (2) (pp e254-e264), 2012. Date of Publication: April 2012.
AN: 2012277024
The primary aim of advance directives (including both proxy directives and instructional directives) is to ensure that patients' wishes are enacted even when they no longer have the capacity to voice them. However, barriers remain and gaps persist, particularly in vulnerable populations. In addition, many objections have been raised regarding the creation and
implementation of advance directives. This article aims to define advance directives, while discussing issues surrounding their creation, implementation, utility, and the legal status across states. 2012 Elsevier Inc.

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Publisher
W.B. Saunders (Independence Square West, Philadelphia PA 19106-3399, United States)

Emtree Heading
advanced cancer; Alzheimer disease; artificial ventilation; critical illness; custody; disease severity; health care quality; health care utilization; human; life sustaining treatment; "living will; medical care; medical ethics; medicolegal aspect; mild cognitive impairment; neoplasm; patient satisfaction; practice guideline; priority journal; resuscitation; review; terminal care.

111.
Endoscopic therapy of small-bowel neoplasms.
Maranki J.L., Haluszka O.
Techniques in Gastrointestinal Endoscopy. 14 (2) (pp 112-116), 2012. Date of Publication: April 2012.
AN: 2012246816
Although many patients with small-bowel tumors require surgical resection, the incorporation of device-assisted enteroscopy into clinical practice has changed the management of smaller tumors and polyps, particularly in those with Peutz-Jeghers syndrome and familial adenomatous polyposis. The endoscopic management of select patients with small-bowel tumors can reduce the incidence of polyp-related complications (intussusception, obstruction, bleeding, and malignant transformation) and may reduce the need for surgical intervention. 2012 Elsevier Inc.

Institution
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Publisher
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adenoma/su [Surgery]; adenomatous polyp/su [Surgery]; clinical effectiveness; cost effectiveness analysis; disease surveillance; duodenum tumor/su [Surgery]; endoscopic polypectomy; *endoscopic therapy; familial polyposis/su [Surgery]; genetic disorder; hamartoma/di [Diagnosis]; hamartoma/su [Surgery]; human; ileum tumor/di [Diagnosis]; ileum tumor/su [Surgery]; intestine intussusception/co [Complication]; jejunum tumor/su [Surgery]; laparoscopic surgery; malignant transformation/co [Complication]; neuroendocrine tumor/su [Surgery]; outcome assessment; palliative therapy; patient positioning; patient selection; Peutz Jeghers syndrome/su [Surgery]; practice guideline; review; small intestine hemorrhage/co [Complication]; "small intestine tumor/su [Surgery]; treatment planning; tumor volume.
Effects of a unique pediatric hematology-oncology palliative care program on medical decision-making and communication between healthcare providers and families: Results of a supportive care survey.

Kline C., Reineke A., Auger J.A., Willert J., Roberts W., Schiff D.

Progress in Palliative Care. 20 (1) (pp 13-18), 2012. Date of Publication: January 2012.

AN: 2012227928

Purpose: The purpose of this study was to evaluate family satisfaction with an embedded pediatric hematology-oncology (Hem-Onc) palliative care program and its decision-making tool (DMT). A secondary aim was to identify factors that play an important role in family medical decision-making. Methods: Families were asked to complete a self-administered questionnaire within 4 weeks of participating in a Supportive Care Team (SCT) conference and receiving a DMT. Results: Twenty parents or guardians of pediatric Hem-Onc patients participated in the study. All of the patients had approached a major treatment-related change; all of the study participants had attended a SCT medical decision-making conference and received a DMT. The most important considerations to the study participants regarding treatment decisions were their child's quality of life, their child's chance of improving, perception of their child's wishes, and the hospital staff's advice. Of the people and services that were most useful in guiding medical decision-making, 100% reported that nurses, 95% reported physicians, and 90% reported the SCT helped guide treatment decisions. Ninety percent of those surveyed remembered receiving the DMT, found it to be clear and straightforward, and thought that it improved communication between the family and healthcare providers. Conclusions: These findings suggest an embedded pediatric Hem-Onc supportive care program (SCP) and use of a DMT facilitate effective communication between families and healthcare providers, and provide families with adequate decision-making support. W.S. Maney & Son Ltd 2012.
113. ASCO urges early palliative care in metastatic cancers: Commentary. 
Loprinzi C.L. 
AN: 2012225132
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Publisher
Elsevier Oncology (46 Green Street, 2nd Floor, Huntington NY 11743, United States)
Emtree Heading
cancer chemotherapy; cancer resistance; cancer survival; health care cost; human; note; 
Palliative therapy; patient care; practice guideline; quality of life.

114. Malignant melanoma: The implications of cost for stakeholder innovation. 
Styperek A., Kimball A.B. 
AN: 2012216575
Objectives: To evaluate the 2008 cost of care for melanoma in the United States, assess the cost impact of physician decision making, and prioritize areas needing innovation. Study Design: Construction of an activity-based cost accounting model in Excel. Methods: We built a survival-adjusted cost accounting model, leveraging the clinical practice guidelines published by the National Comprehensive Cancer Network. Additional assumptions were derived from the literature and clinical experience at Massachusetts General Hospital Melanoma Center. Cost estimates were based on 2008 national average Medicare reimbursements. Our model did not include indirect costs such as lost productivity and, therefore, does not examine the full societal cost of melanoma. Results: The 2008 cost of care for malignant melanoma was estimated to be $1563 million and reflects a 2.8-fold increase in cost since 1997. Stage I and II disease comprised 10% and 17% of total costs, respectively; stage III and IV disease consumed 15% and 57% of the total cost, respectively. Eighty percent of the total annual direct cost of treating melanoma is incurred by patients diagnosed within the first year. Conclusions: The growing cost of melanoma continues to highlight the medical need to find cost-effective means of prevention and reduce the economic burden of malignant melanoma. We quantified and prioritized 3 areas-
Integrating palliative care with intensive care for critically ill patients with lung cancer.
Gay E.B., Weiss S.P., Nelson J.E.
AN: 2012220906

With newer information indicating more favorable outcomes of intensive care therapy for lung cancer patients, intensivists increasingly are willing to initiate an aggressive trial of this therapy. Concerns remain, however, that the experience of the intensive care unit for patients with lung cancer and their families often may be distressing. Regardless of prognosis, all patients with critical illness should receive high-quality palliative care, including symptom control, communication about appropriate care goals, and support for both patient and family throughout the illness trajectory. In this article, we suggest strategies for integrating palliative care with intensive care for critically ill lung cancer patients. We address assessment and management of symptoms, knowledge and skill needed for effective communication, and interdisciplinary collaboration for patient and family support. We review the role of expert consultants in providing...
palliative care in the intensive care unit, while highlighting the responsibility of all critical care clinicians to address basic palliative care needs of patients and their families. 2012 Gay et al. Institution
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Springer Verlag (Tiergartenstrasse 17, Heidelberg D-69121, Germany)
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artificial ventilation; cancer chemotherapy; cancer control; cancer diagnosis; cancer pain/dt [Drug Therapy]; *cancer palliative therapy; cancer patient; cardiopulmonary arrest/th [Therapy]; clinical assessment; clinical decision making; clinical protocol; clinical trial; consultation; *critically ill patient; disease severity; distress syndrome/dt [Drug Therapy]; drug efficacy; drug safety; drug tolerability; evidence based medicine; family; family counseling; human; *intensive care; intensive care unit; interpersonal communication; kidney failure; knowledge; *lung cancer/di [Diagnosis]; *lung cancer/dm [Disease Management]; *lung cancer/dt [Drug Therapy]; *lung cancer/ep [Epidemiology]; *lung cancer/th [Therapy]; medical expert; neurotoxicity/si [Side Effect]; overall survival; physician; prevalence; priority journal; prognosis; prospective study; psychological well being; quality of life; respiratory distress/dt [Drug Therapy]; respiratory distress/th [Therapy]; resuscitation; review; risk benefit analysis; skill; symptom; analgesic agent/dt [Drug Therapy]; antineoplastic agent/dt [Drug Therapy]; hypertensive agent/dt [Drug Therapy]; morphine/ae [Adverse Drug Reaction]; morphine/dt [Drug Therapy]; psychotropic agent/dt [Drug Therapy].

116.
Issues at the end of life.
Li J.M.W., Breu A.
Hospital Medicine Clinics. 1 (1) (pp e124-e131), 2012. Date of Publication: January 2012.
AN: 2012097791
All patients must eventually deal with their own mortality and the hospitalist is often the provider who navigates them through the process. It is increasingly important that hospitalists are fluent in the language of end-of-life issues. This article introduces and enforces key concepts when treating patients who may be near the end of life. 2012 Elsevier Inc.
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Publisher
W.B. Saunders (Independence Square West, Philadelphia PA 19106-3399, United States)
Emtree Heading
acute heart infarction; artificial ventilation; bipolar disorder; cardiopulmonary arrest; clinical assessment tool; congestive heart failure; coronary artery disease; death; depression; disease association; euthanasia; heart arrhythmia; hospital discharge; human; intensive care unit; intubation; law; living will; Medical Order for Life-Sustaining Treatment; mortality; osteoarthritis;
Surgical treatment of neuroendocrine liver metastases.

Lee S.Y., Cheow P.C., Teo J.Y., Ooi L.L.P.J.

AN: 2012186943

Management of Neuroendocrine liver metastases (NELM) is challenging. The presence of NELM worsens survival outcome and almost 10% of all liver metastases are neuroendocrine in origin. There is no firm consensus on the optimal treatment strategy for NELM. A systematic search of the PubMed database was performed from 1995-2010, to collate the current evidence and formulate a sound management algorithm. There are 22 case series with a total of 793 patients who had undergone surgery for NELM. The overall survival ranges from 46-86 at 5 years, 35-79 at 10 years, and the median survival ranges from 52-123 months. After successful cytoreductive surgery, the mean duration of symptom reduction is between 16-26 months, and the 5-year recurrence/progression rate ranges from 59-76. Five studies evaluated the efficacy of a combination cytoreductive strategy reporting survival rate of ranging from 83 at 3 years to 50 at 10 years. To date, there is no level 1 evidence comparing surgery versus other liver-directed treatment options for NELM. An aggressive surgical approach, including combination with additional liver-directed procedures is recommended as it leads to long-term survival, significant long-term palliation, and a good quality of life. A multidisciplinary approach should be established as the platform for decision making. Copyright 2012 Ser Yee Lee et al.

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Publisher
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algorithm; cancer growth; cancer recurrence/co [Complication]; cancer survival; clinical protocol; cytoreductive surgery; human; *liver metastasis/co [Complication]; *liver metastasis/dm [Disease Management]; *liver metastasis/su [Surgery]; liver resection; neuroendocrine tumor/su [Surgery]; overall survival; palliative therapy; priority journal; quality of life; review; survival time; systematic review; treatment outcome.
118.
Letters to the editor.
Cortez M.
AN: 2012168551
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Ochsner Clinic (1514 Jefferson Highway, New Orleans LA 70121, United States)
Emtree Heading
critical illness; dying; family; human; letter; medical school; newborn intensive care; *palliative therapy; practice guideline; terminal care.

119.
Avoiding deaths in hospital from anorexia nervosa: The MARSIPAN project.
Robinson P.
Psychiatrist. 36 (3) (pp 109-113), 2012. Date of Publication: March 2012.
AN: 2012166678
The MARSIPAN (MAnage ment of Really SIck Patients with Anorexia Nervosa) project was established in response to reports of patients admitted to medical wards and proving refractory to treatment, sometimes dying on the ward. Psychiatrists, physicians and other clinicians in nutrition and eating disorders were brought together to discuss key issues in the assessment and management of such patients. The resulting guidance report, which applies to adult patients over 18, addresses: assessment of risk, where to treat the patient, specialist support for medical teams, key elements of treatment, namely (a) safe refeeding to avoid refeeding syndrome and underfeeding syndrome, (b) management of problematic behaviours, (c) support for the family, and (d) transfer to a specialist eating disorder unit when appropriate and possible.
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*anorexia nervosa/dm [Disease Management]; behavior disorder; family counseling; *health care management; health service; human; malnutrition; *management of really sick patient with anorexia nervosa; medical personnel; *mortality; nutritional deficiency; palliative therapy; practice guideline; psychiatrist; refeeding syndrome; review; risk assessment.
A group of German breast cancer experts (medical oncologists and gynaecologists) reviewed and commented on the results of the first international 'Advanced Breast Cancer First Consensus Conference' (ABC1) for the diagnosis and treatment of advanced breast cancer. The ABC1 Conference is an initiative of the European School of Oncology (ESO) Metastatic Breast Cancer Task Force in cooperation with the EBCC (European Breast Cancer Conference), ESMO (European Society of Medical Oncology) and the American JNCI (Journal of the National Cancer Institute). The main focus of the ABC1 Conference was metastatic breast cancer (stage IV). The ABC1 consensus is based on the vote of 33 breast cancer experts from different countries and has been specified as a guideline for therapeutic practice by the German expert group. It is the objective of the ABC1 consensus as well as of the German comments to provide an internationally standardized and evidence-based foundation for qualified decision-making in the treatment of metastatic breast cancer.
Physiotherapy clinical guidelines for Huntington's disease.
Quinn L., Busse M.
Neurodegenerative Disease Management. 2 (1) (pp 21-31), 2012. Date of Publication: February 2012.
AN: 2012164996
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Publisher
Future Medicine Ltd. (2nd Albert Place, Finchley Central, London N3 1QB, United Kingdom)
Emtree Heading
adaptive behavior; aerobic exercise; apraxia; behavior; body equilibrium; body movement; body posture; breathing exercise; clinical decision making; cognition; consultation; daily life activity; exercise; fall risk; gait; genetic counseling; goal attainment; human; *Huntington chorea/th [Therapy]; leisure; motor activity; motor dysfunction; nutrition; occupational therapy; patient care; physical performance; physiotherapist; *physiotherapy; *practice guideline; priority journal; range of motion; resistance training; respiratory failure; review; scoring system; sensory stimulation; sitting; speech therapy; task performance; terminal care; treatment outcome; treatment planning; velocity; walking.

Development of physiotherapy guidance and treatment-based classifications for people with Huntington's disease.
Quinn L., Busse M.
Neurodegenerative Disease Management. 2 (1) (pp 12-19), 2012. Date of Publication: February 2012.
AN: 2012164984
Background: Physiotherapy may provide a means of delaying onset or progression of Huntington's disease (HD), resulting in improved daily functioning and quality of life.
Physiotherapy is being more frequently recommended for people with HD, but there have been no specific guidelines published for implementation of a structured physiotherapy program. The Physiotherapy Working Group (PWG) of the European Huntington's Disease Network (EHDN) set out to develop a comprehensive Guidance Document for physiotherapists to provide best practice guidelines. Methods: A review of the literature was conducted using a systematic approach. There was insufficient literature in support of physiotherapy interventions and approaches to be able to conduct a complete evidenced-based review, therefore, physiotherapy expert subgroups were formed to incorporate consensus as to best practice. A draft document was distributed to the entire membership of the working group, to outside physiotherapists and other healthcare professionals within EHDN to elicit feedback and comments. Results: A Guidance Document covering eight specific areas pertaining to physiotherapy management of HD was developed. In order to facilitate the document's practical usability among clinicians, a treatment-based classification system is proposed to categorize patients based on presenting signs and symptoms, and provide a foundation for development of a more standardized intervention approach. Discussion: The Physiotherapy Guidance for HD is a comprehensive, consensus- and evidence-based document that can be used by physiotherapists to implement a plan of care that is currently consistent with best practice for individuals at all stages of HD. As evidence becomes available, future systematic reviews will be required in order to inform further development. The use of treatment-based classifications, which aim to better categorize common signs and symptoms and link them to appropriate intervention plans, may be useful in relatively rare diseases, such as HD, to aid clinical reasoning and promote effective outcome evaluation. 2012 Future Medicine Ltd.

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Emtree Heading
article; bradykinesia; disease course; dystonia; exercise; functional status; health care personnel; human; *Huntington chorea/th [Therapy]; immobilization; involuntary movement; palliative therapy; patient care; physiotherapist; *physiotherapy; practice guideline; priority journal; quality of life; therapy effect; treatment outcome.

123.

The EORTC Gastrointestinal Tract Cancer Group: 50 years of research contributing to improved gastrointestinal cancer management.


AN: 2012156451

During the last decades, the evolution of treatment - including radiotherapy, chemotherapy and targeted agents - has improved the cure and survival of patients with gastrointestinal (GI) cancer.
Within the past 50 years of the EORTC's existence, significant progress has been made in the fight against cancer. During this time several cancer clinical trials were completed, and through these we are able to identify the most notable advances in GI cancer research done by the EORTC Gastrointestinal Tract Cancer Group (GI Group). Several EORTC clinical trials results have changed practice (e.g. standard of care of liver metastases of colorectal cancer has been changed by the EPOC trial) or have helped to support new treatment strategies in either early- or advanced-stage GI cancers. In addition to its clinical activities the group has started an extensive program of translational research. This changed strategy towards a translational, multidisciplinary program regarded as the basis for future developments. This review of the major achievements of the GI Group shows that it has played an important role in the scientific development of the understanding and treatment of GI cancer over the last 50 years. 2012 European Organisation for Research and Treatment of Cancer.
124. Dementia and palliative care.
Casey D.A., Northcott C., Stowell K., Shihabuddin L., Rodriguez-Suarez M.
Clinical Geriatrics. 20 (1) (pp 36-41), 2012. Date of Publication: January 2012.
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Emtree Heading
article; ataxia/si [Side Effect]; bedtime dosage; cardiotoxicity/si [Side Effect]; cognitive defect/si [Side Effect]; cognitive therapy; constipation/si [Side Effect]; delirium/co [Complication]; delirium/dt [Drug Therapy]; delirium/th [Therapy]; *dementia/th [Therapy]; depression/co [Complication]; depression/dt [Drug Therapy]; disease course; falling; feeding apparatus; gastrointestinal toxicity/si [Side Effect]; human; liver toxicity/si [Side Effect]; mental disease/si [Side Effect]; mortality; nephrotoxicity/si [Side Effect]; neuropathic pain/dt [Drug Therapy]; opiate addiction/si [Side Effect]; orthostatic hypotension/si [Side Effect]; pain/dt [Drug Therapy]; pain assessment; *palliative therapy; polypharmacy; practice guideline; psychotherapy; respiration depression/si [Side Effect]; sedation; side effect/si [Side Effect]; sleep disorder/co [Complication]; sleep disorder/dt [Drug Therapy]; terminal care; amitriptyline; anticonvulsive agent/dt [Drug Therapy]; antidepressant agent/dt [Drug Therapy]; benzodiazepine derivative; cholinergic receptor blocking agent; citalopram/dt [Drug Therapy]; clonazepam/ae [Adverse Drug Reaction]; digoxin/it [Drug Interaction]; diphenhydramine/dt [Drug Therapy]; doxepin/dt [Drug Therapy]; fluoxetine/it [Drug Interaction]; haloperidol/dt [Drug Therapy]; hydroxyzine/dt [Drug Therapy]; lorazepam/dt [Drug Therapy]; megestrol acetate/dt [Drug Therapy]; melatonin/dt [Drug Therapy]; methylphenidate/dt [Drug Therapy]; mirtazapine/dt [Drug Therapy]; neuroleptic agent; nonsteroid antiinflammatory agent/ae [Adverse Drug Reaction]; nonsteroid antiinflammatory agent/dt [Drug Therapy]; opiate derivative/ae [Adverse Drug Reaction]; opiate derivative/dt [Drug Therapy]; paracetamol/ae [Adverse Drug Reaction]; paracetamol/dt [Drug Therapy]; risperidone/dt [Drug Therapy]; serotonin uptake inhibitor; trazodone/dt [Drug Therapy]; tricyclic antidepressant agent/dt [Drug Therapy]; warfarin/it [Drug Interaction]; zolpidem/dt [Drug Therapy].
<td colspan=""/>
Dementia and palliative care.
Casey D.A., Northcott C., Stowell K., Shihabuddin L., Rodriguez-Suarez M.
Annals of Long-Term Care. 20 (1) (pp 21-26), 2012. Date of Publication: January 2012.
AN: 2012070380
Although patients with dementia are considered to have a terminal illness, they are often subjected to or continued on therapies that can lead to unnecessary suffering. Palliative care, which strives to provide patients with a peaceful and dignified final phase of life, is an important treatment approach for these patients. This article discusses several palliative care practices that can be incorporated into the care of individuals with dementia, including strategies for minimizing the medical burden on patients (eg, reducing polypharmacy), assessing for and managing pain, and managing psychiatric symptoms or syndromes (eg, delirium, depression, sleep disturbances).
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Publisher
HMP Communications LLP (4365 U.S. Highway 1 Suite 250, Princeton NJ 08540, United States)

Keeping an open mind: Achieving balance between too liberal and too restrictive prescription of opioids for chronic non-cancer pain: Using a two-edged sword.
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analgesia; *chronic pain/dt [Drug Therapy]; constipation/si [Side Effect]; dose response; drug release; drug tolerance; drug withdrawal; fatigue/si [Side Effect]; health care policy; human; libido disorder/si [Side Effect]; mood; nausea/si [Side Effect]; note; opiate addiction; palliative therapy; practice guideline; *prescription; prevalence; priority journal; quality of life; randomized controlled trial (topic); terminal care; total quality management; treatment outcome; *opiate/ae [Adverse Drug Reaction]; *opiate/do [Drug Dose]; *opiate/dt [Drug Therapy].