Palliative Care, Inpatient Psych Urged to Consult

BY BRUCE K. DIXON Chicago Bureau

SALT LAKE CITY — Collaboration between palliative care and the psychiatric inpatient unit can greatly improve mental health care for nursing home residents with behavioral and psychological symptoms of dementia, according to presenters at the annual meeting of the American Academy of Hospice and Palliative Medicine and the Hospice and Palliative Nurses Association. "Dementia is the most frequent reason for nursing home admissions, and nationally 80% of nursing home residents who are in need of psychiatric services fail to receive them," said Dr. Janet Bull, vice president of medical services for Four Seasons Hospice and Palliative Care in Flat Rock, N.C.

Four Seasons has a contractual relationship with every nursing home in Henderson County.

Nationwide, half of nursing homes do

not have access to adequate psychiatric consultation, said Dr. Bull, who is board certified in both hospice and palliative care and ob.gyn.

In addition, mental health funding is being cut and the Deficit Reduction Omnibus Reconciliation Act guidelines limit pharmacologic treatment for psychotic conditions, she explained.

Untreated psychiatric disorders result in decreased functioning, poor quality of life, and increased mortality, and this leads to high use of psychiatric units by nursing homes. "Very often, we don't see these patients until they end up in the ICU in a state of crisis," Dr. Bull said.

So she and her colleagues forged a collaboration with the medical psychiatric unit of Park Ridge Hospital, in nearby Hendersonville, N.C., to create an interdisciplinary team consisting of the psychiatrist, a psychiatric nurse practitioner, a nurse, a social worker, a music therapist, an activities therapist, and the hospital chaplain.

SEROQUEL® (quetiapine fumarate) Tablets BRIEF SUMMARY of Prescribing Information—Before prescribing, please consult complete Prescribing

acased Mortality in Elderly Patients with Dementia-Related Psychosis erased Mortality in Elderly Patients with Dementia-Related Psychosis treated with atypical antipsychotic drugs are at an increased risk eath compared to placebo. Analyses of seventeen placebo-controlled trials (modal duration of 10 weeks) in these ents revealed a risk of death in the drug-treated patients of between 1.6 to 1.7 times that seen in placebo-treated ents. Over the course of a typical 10 week controlled trial, the rate of death in drug-treated patients was about 6, compared to a rate of about 2.6% in the placebo group. Although the causes of death were varied, most of the this appeared to be either cardiovascular (eg, heart failure, sudden death) or infectious (eg, pneumonia) in nature. OUDEL (quetlapine) is not approved for the treatment of patients with Dementia-Related Psychosis.

Suicidality in Children and Adolescents — Antidepressants increased the risk of suicidal inhiking and behavior (suicidality) in short-term studies in children and adolescents with major depressive disorder (MDD) and other psychiatri disorders. Anyone considering the use of SERQUEL or any other antidepressant in a child or adolescent must balanch this risk with the clinical need. Patients who are started on therapy should be observed closely for clinical worsening suicidality, or unusual changes in behavior. Families and caregivers should be advised of the need for close observation and communication with the prescriber. SERQUEL is not approved for use in pediatric patients. [See WARNING and PRECAUTIONS, Pediatric Use].

and PRECAUTIONS, Pediatric Use].

Pooled analyses of short term (4 to 16 weeks) placebo controlled trials of 9 antidepressant drugs (SSRIs and others) in children and adolescents with major depressive disorder (MDD), obsessive compulsive disorder (OCD), or other psychiatric disorders (a total of 24 trials involving over 4400 patients) have revealed a greater risk of adverse events representing suicidal thinking or behavior (suicidality) during the first few months of treatment in those receiving antidepressants. The average risk of such events in patients receiving antidepressants was 4%, twice the placeborisk of 2%. No suicides occurred in these trials. [See WARNINGS and PRECAUTIONS].

INDICATIONS AND USAGE
Bipolar Disorder - SEROQUEL is indicated for the treatment of both:

Depression - The efficacy of SEROQUEL was established in two identical 8-week randomized, placebe-controlled double-blind clinical studies that included either bipolar I or II patients. Effectiveness has not been systematically evaluated in clinical trials for more than eveks.

Mania - The efficacy of SEROQUEL in acute bipolar mania was established in two 12-week monotherapy trials and one 3-week adjunct therapy trial of bipolar I patients initially hospitalized for up to 7 days for acute mania. Effectiveness has not been systematically evaluated in clinical trials for more than 12 weeks in monotherapy 3 weeks in adjunct therapy. The physician who elects to use SEROQUEL for extended periods in bipolar disorder should periodically re-evaluate the long-term risks and benefits of the drug for this individual periodical.

Schrüdert for warmen person and the properties of the treatment of schizophrenia. The efficacy of SEROQUEL in schizophrenia was established in short-term (Sewelx) controlled trials of schizophrenic inpatients. The effectiveness of SEROQUEL in long-term use, that is, for more than 6 weeks, has not been systematically evaluated in controlled trials. Therefore, the physician who elects to use SEROQUEL for extended periods should periodically re-evaluate the long-term usefulness of the drug for the individual patient.

than 6 weeks, has not been systematically evaluated in controlled trials. Therefore, the physician who elects to use SEROULEL for cetended periods should periodically re-evaluate the long-term sustluness of the drug for the individual patient.

CONTRAINIOGATIONS: SEROULEL is contraindicated in individuals with a known hypersensitivity to this medication or any of its ingredients.

WARNINGS: Increased Mortality in Elderly Patients with Dementia-Related Psychosis in Elderly patients with dementia-related psychosis heated with adjuical antipsychotic drugs are at an increased risk of death compared to judenous. SEROULEL (velocitagine) is not approved for the treatment of patients with dementia-related psychosis (see Board Warning). Clinical Worsening and Suicide Risk - Patients with repor depressive disorder (MIDD), both adult and pediatric, may experience violation. Clinical Worsening and Suicide Risk - Patients with repor depressive disorder (MIDD), both adult and pediatric, may experience in the patients of of the syntrorine appears to be nightes and anilong the eleuter, spectagly eutery worten, it is impossited to rely upon prevalence estimates to predict, at the inception of antipsychotic tratament, which patients are likely to develop the syndrome. Whether antipsychotic drug products differ in their potential to cause tardive dyskinesia is unknown. The risk of developing tardive dyskinesia and the likelihood that it will become inverses the inverses as the duration of treatment and the total cumulative dose of antipsychotic drugs administered to the patient increase. However, the syndrome can develop, although much less commonly, after relatively brief treatment periods at low doses. There is no known treatment for established cases of tardive dyskinesia, although the syndrome may remine parally or completely, if antipsychotic treatment is withdrawn. Antipsychotic treatment, itself, however, may suppress (or partially suppress) the signs and symptoms of the syndrome and thereby may possibly mask the underlying process. The effect this symptomatic suppression has upon the long-term course of the syndrome is unknown. Given these considerations, SERDOUEL should be prescribed in a manner that is most likely to minimize the occurrence of tardive dyskinesia. Chronic antipsychotic treatment should generally be reserved for patients who appear to suffer from a chronic illness that (1) is known to respond to antipsychotic drugs, and continued treatment should be reassessed periodically. If signs and symptoms of tardive dyskinesia appear in a patient on SEROQUEL, drug discontinuation should be considered. However, some patients may require treatment with SEROQUEL despite the presence of the syndrome. Hyperdylvemia and Diabetes Melitius-Hyperdylvemia, in some cases extreme and associations. SEROQUEL Assessment of the relationship between alpical antipsychotic use and glucose abnormalities is complicated by the possibility of an increased background risk of diabetes melitus in patients with schizophrenia and the increasing

mellitus in the general population. Given these confounders, the relationship between atypical antipsychotic use and hyperglycemiarelated adverse events is not completely understood. However, epidemiological studies suggest an increased risk of treatment-emergent
hyperglycemia-related adverse events in patients treated with the atypical antipsychotics. Precise risk estimates for hyperglycemiarelated adverse events in patients treated with atypical antipsychotics are not available. Patients with nate setablished diagnost of diabetes
mellitus who are started on atypical antipsychotics should be monitored regularly for worsening of glucose control. Patients with risk
actors for diabetes mellitus (eg, obesity, family history of diabetes) who are starting treatment with atypical antipsychotics should undergo fasting blood glucose testing at the beginning of treatment and periodically during treatment. Any patient treated with atypical
antipsychotics should be monitored for symptoms of hyperglycemia lincluding polydipsia, polyuria, polypriagia, and weakness. Patients
who develop symptoms of hyperglycemia during treatment with atypical antipsychotics should undergo fasting blood goes testing,
In some cases, hyperglycemia has resolved when the atypical antipsychotic was discontinued; however, some patients required
continuation of anti-diabetic treatment despite discontinuation of the suspect drug.

PRECAUTIONS: General: Chriosatic Hypotension: SEROOUEL may induce orthostatic hypotension associated with dizziness, tachy-

antispychotics should be monitored for symptoms of hypergyleomia clind predigions including policips, and visaleness. Patients with of sevides symptoms of hypergyleomia during retained with applied antispychotics should undergh eating blood glucose besting, in some cases, hyperglycemia has resolved when the atypical antispychotic was discontinued, however, some patients required contributed or darti-dabets bratterine despite discontinuation of the suspect drug.

PRECAUTIONS. General: Orbitostatic Hypotension SENDOULE, may induce or orbitostatic hypotension associated with disciness, tachy-cardia and, in some patients, syncope, especially during the initial dose-titration period, proteins or associated with disciness, tachy-cardia and, in some patients, syncope, especially during the initial dose-titration period, proteins or advantage with a standard orbitostatic hypotension or section in the advantage of my recordial intervience of my recordial intervience of my recordial interviencian or sessions and syncope my be minimized by himting the initial dose to 25 mg bit. If hypotension occurs during titration to the teary drose, a return to the previous dose in the titration schedule is appropriate. Catarasts: The development of catarasts was observed in association with questional returned in the titration is schedule in patients during impalement and returned with a schedule protein occurs and active and the least by methods advantage to the catarast was observed in association with questional returned in the catarast was observed in association with questional returned in the catarast in the patients of the patients and the least by methods advantage to the patients and the least by methods advantage to the patients and the least by methods advantage to the patients and the least by methods advantage to the patients and the least by methods advantage to the schedule patients and the least by methods advantage to the patients and the least by methods advantage to the patients and the least by methods advantaged t

that SEHOULEL therapy does not affect them adversely. Priagram: One case of praipsim in a patient receiving SEHOULEL has been reported from market introduction. While a causal relationship to use of SEHOULEL has not been established, other drugs with alpha-adrenergic blocking effects have been reported to induce priapsim, and it is possible that SEHOULEL in supplied on the body's ability to reduce core body temperature has been attributed to antipsychotic agents. Appropriate care is advised when prescribing praips many requires using a little propriate and the propriate of the propriate of the propriate of the propriation of the body's ability to reduce core body temperature ago, exercising strenurusly, exosure to extreme heat, receiving concombant medication with anticholinergic activity, or being subject to delivoration. *Disphagine:* Esosphagid sempland dymnolity and aspiration have been associated with antipsychotic drug use. Aspiration preumonia is a common cause of morbidity and mortality in elderly patients, in particular those with advanced Alzheimer's dementia. SEROOULEL and other antipsychotic drugs schould be used califocusly in patients at risk for aspiration preumonia. *Societies* the possibility of a suicide attempt is inherent in biplant discorder and schoologenieral, case supervision of high risk patients should accompany drug therapy. Prescriptions for SEROOULEL should be written for the mainlies of the previous of the previous the risk of overdose. In 2 eight-week clinical studies in patients with biplant deprevision (14) the incidence of treatment emergent suicidal ideation or suicide attempt was low and smillar to placebo, (SEROOUEL 300 mg, 6350, 1.7%, SEROOUEL 600 mg 3948, 2.8%; Peabob, 7347, 2.9%). *Iss in Patients with Concentinal Illnesses* Clinical experience with SEROOUEL in patients with certain concomitant systemic linesses is intelled. SEROOUEL has not been evaluated or used to any appreciable extent in patients with certain concomitant systemic linesses is mitted. SEROOUEL has not

Four Seasons team members included a palliative care physician (Dr. Bull), a palliative care nurse practitioner, and administrative support.

Last year, there were 308 admissions to the hospital medical psychiatric unit, of which two-thirds were related to behavioral and psychological symptoms of dementia (BPSD), Dr. Bull explained. "On the palliative care end, we received 242 referrals in 2006 and about two-thirds of those were related to BPSD."

Symptoms of BPSD-seen in 83% of dementia patients and undoubtedly the most common cause of nursing home placement—include aggression, screaming, restlessness, agitation, wandering, sexual disinhibition, hoarding, cursing, and shadowing, she said.

Unfortunately, there are several barriers to quality end-of-life care in the typical psychiatric setting, said Judith A. Adams, the palliative care nurse at Four Sea-

"Psychiatrists often don't recognize endof-life symptoms because they're focused on psychological symptoms, and there's a

lack of knowledge of pain medications," Ms. Adams explained, adding that psychi-

Two-thirds of the referrals to palliative care received in 2006 were related to BPSD.

DR. BULL

atric patients face many stressors, such as physical restraints and noisy, busy environments.

Although psychiatry profession is taking strides to improve end-of-life care, the psychiatry-palliative

care partnership approach offers an excellent alternative, she said.

"However, roles have to be clearly de-

fined. In the psychiatry department, the psychiatrist is the attending physician. Our role is strictly one of consultation, and this is a crucial point. We are assessing and treating pain and nonpain symptoms, and we're not going to treat unless the psychiatrist asks us to," Ms. Adams cautioned.

A second pitfall is not having clear communications on the expectations of the palliative care consult.

The partnership has resulted in improved patient quality of care; avoidance of suffering and futile care in future medical admissions related to clear goals; and overall enhancement of the hospital's palliative care service, Ms. Adams said.

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state were decreased by 10 to 12% when divalgrove (500 mg bid) was administered with questiapine (150 mg bid). The mean oral lociance of total valpropic and (administered as divalgroves 500 mg bid) was administered with questiapine (150 mg bid). The changes were not significant. Lithium: Concomitant administration of questiapine (250 mg bid) with lithium had no effect on a yor of the steady state pharmaconicine parameters of lithium. Analymprine. Administration of multiple aidy doses up to 750 mg/dsy (on a lof schedule) of questiapine to subjects with selected psychotic disorders had no clinically relevant effect on the detarrace of antipyrine or univary recovery of antipyrine remobilists. These results incidea that questigue doses not significantly incube height environments. Place and the properties of the properties. Place and the properties of the properties of the properties of the properties. Place and the properties of the properties. Place and the properties of the properties. Place and the properties of the pr

DIVERSE REACTIONS. The information below is ferred from a clinical rial database for SENOULE. Consisting of over 3700 patients. Of these approximately 3700 subjects, approximately 3400 (2300 in schizophrenia, 406 in acute bipolar mania, and 688 in bipolar degression) were patients who participated in multiple dose effectiveness this, and their experience corresponded to approximately 382.6 patient-years. (Refer to the Hersching) information for details of adverse event take culection.) Adverse Findings Observed in Sturt-Term, Controlled Trials. Adverse Events Associated with Discontinuation of Treatment in Short-Term, Patient-Controlled Trials. Bipolar Biosedire: Depression. Overall, isocontinuations due to adverse events were 12% for SENOULE. 300 mg vs. 1970 for SENOULE. 300 mg vs. 1970

EPS. In six additional placebo-controlled clinical trials (3 in audite menia and 3 in schizophrenial using variable doses of SEPOQUEL. the placebo report of the placebo property of the investories of SEPS and SEPS and the use of concomitant anticholineage medications to treat (FPS, in the placebo property) and clinical trials of the retentient of bipolar depression using 300 may and 600 may of SEPOQUEL. The incidence of adverse events potentially related to EPS was 12% in both dose groups and 6% in the placebo group. In these studies, the incidence of adverse events potentially related to EPS was 12% in both dose groups and 6% in the placebo group. In these studies, the incidence of the individual adverse events (age individual, extranymatid disorder, terror, depoties, dispolar, estissens, muscle contradions involuntary, psychomotor hyperactivity and muscle rigidity) were generally low and did not exceed 4% in any treatment group. The 3 class of the second state of the contradions involuntary properties with a significant change in School table of second and Sep 50 data. Assessment core of the end of treatment. The use of concomitant anticholineagic relations with a significant product of the second state o

ambulurets commone secretion (sIAUH), and Stevens-Jonnson syndrome (sUs).

BRIG ABUSE AND DEPENDENCE: Controlled Substance Class: SEROQUEL is not a controlled substance. Physical and Psychologis dependence: SEROQUEL has not been systematically studied, in animals or humans, for its potential for abuse, tolerance or physical dependence. While the clinical trials did not reveal any tendency for any drug-seeking behavior, these observations were not systematic and it is not possible to predict on the basis of this limited experience the extent to which a CNS-active drug will be misused, diverted, and/or abused once marketed. Consequently, patients should be evaluated carefully for a history of drug abuse, and such patients should be observed closely for signs of misuse or abuse of SEROQUEL, e.g., development of tolerance, increases in dose, drug-seeking behavior.

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OVERDOSAGE: Human experience: In clinical trials, survival has been reported in acute overdoses of up to 30 grams of quetiapine. Most patients who overdosed experienced no adverse events or recovered fully from the reported events. Death has been reported in a clinical trial following an overdose of 13.6 grams of quetiapine alone. In general, reported signs and symptoms were those resulting from an exaggeration of the drug's known pharmacological effects, i.e., drowsiness and sedation, tachycardia and hypotension. Patients with pre-existing severe cardiovascular disease may be at an increased risk of the effects of overdose for PRECAUTIONS: Orthostatic Hypotension() no cases, involving an estimated overdose of 9500 mg, was associated with hypokalemia and first degree heart block. In post-marketing experience, there have been very rare reports of overdose of SEROQUEL alone resulting in death, coma, or OTc prolongation. Management of Overdosage: In case of acute overdosage, establish and maintain an airway and ensure adequate oxygenation and ventilation. Gastinc lavage dafter intubation, if patient is unconscious) and administration of activated charcoal together with a laxative should be considered. The possibility of obtundation, seziume of vertose of section of the head and neck following overdose may create a risk of aspiration with induced emess; cardiovascular monitoring should commence immediately and should include continuous electrocardiographic monitoring to detect possibility of multiple drug involvement should be to patients with acute overdosage of SEROQUEL. Similarly it is reasonable to expect that the alpha-adrenergic-blocking properties of bretylium might be additive to those of quelapine, resulting in problemating and provided reary at heroceical hazard of additive OT-prolonging effects when administered in patients with acute overdosage of SEROQUEL.

extrapyramidal symptoms, anticholinergic medication should be administered. Close medical supervision and monitoring should continue until the patient recovers.

DOSAGE AND ADMINISTRATION: Dosing in Special Populations: Consideration should be given to a slower rate of dose titration and a lower target dose in the elderly and in patients who are debilitated or who have a predisposition to hypotensive reactions. When indicated, dose escalation should be performed with caution in these patients. Patients with hepatic impairment should be started on 25 mg/day. The dose should be increased daily in increments of 25-50 mg/day to an effective dose, depending on the clinical responses and tolerability of the patient. The elimination of quetapine was enhanced in the presence of phenytoin. Higher maintenance doses of quetapine may be required when it is coadministered with phenytoin and other enzyme inducers such as carbanepine and phenocharbital (See Drug Interactions under PRECAUTIONS). Maintenance Treatment: While there is no body of evidence available to answer the question of how long the patient treated with SEROQUEL should be maintained, it is generally recommended that responding patients be continued beyond the acute response, but at the lowest dose needed to maintain enrisission. Patients should be periodically reassessed to determine the need for maintenance treatment. Reinitiation of Treatment in Patients Previously Discontinued: Although there are not data to specifically address reinitiation of treatment, it is recommended that when restarting patients who have been off SEROQUEL is not required and the maintenance dose may be reinitiated. When restarting there are not systematically collected data to specifically address reinitiated on the previous antipsychotic returned in the patients with schoolphrenia from antipsychotics. There are no systematically collected data to specifically address switching patients with schoolphrenia from antipsychotics and schoolphrenia from antipsychotics. There are no system

Dementia Care: Go **Beyond Patient**

BALTIMORE — Supportive care for patients with dementia and their caregivers is an important component of overall dementia care, Dr. Constantine G. Lyketsos said at a meeting on Alzheimer's disease and related disorders sponsored by Johns Hopkins University.

Supportive care for the patient should provide comfort and emotional support, safety, structure, activity and stimulation, planning/assistance with decision making, management of medical comorbidities, and good nursing care for advanced stages, said Dr. Lyketsos, chair of psychiatry at Johns Hopkins Bayview Medical Center in Baltimore.

In terms of safety, "many patients with dementia, in fact most of them, should stop driving," said Dr. Lyketsos. "Most of them can't live alone entirely. That doesn't mean that there needs to be someone in the house 24 hours a day, but there needs to be some support."

Providing structure means ensuring a safe, predictable place to live with support for activities of daily living. "Because of diminishing cognition, making sure that structure is available is critical. ... The more dementia advances, the more important it is to have daily structure in place that's predictable," he said.

Participation in activities can make a big difference. "One of the things we found in the Maryland Assisted Living Study was that the more participation there was in activities, the longer patients were able to stay in their assisted living facility," Dr. Lyketsos said.

Support for caregivers includes emotional support and comfort, education, instruction in the skills of caregiving, problem-solving and crisis-intervention help, respite, and attention to personal needs and wants.

'The piece that we don't have a good way to deliver yet is respite. Caregivers need breaks. They can get easily overwhelmed," he said. Caregivers tend to overlook their own health, so they need to pay attention to their personal needs and wants as well. They also need to maintain touch with social contacts, which is an important part of the support network.