REDUCING POLYPHARMACY IN THE ELDERLY-ROUND AND ROUND WE GO

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LEARNING OBJECTIVE 1:
Discuss the challenge of managing polypharmacy in the elderly.

LEARNING OBJECTIVE 2:
Highlight physician barriers to reducing polypharmacy in the elderly and the need for greater evidence-based strategies to reduce polypharmacy

CASE:
A 69-year-old man with multiple medical problems presented to his primary care physician (PCP) for medication review after expressing confusion about his regimen. He also sees four subspecialty physicians who manage his chronic diseases. Review of his medication list via the electronic medical record revealed twenty total medications; all five of his physicians had prescribed medications. As requested, the patient presented to clinic with his home medications in two large duffel bags containing a total of 45 medication bottles. In addition to his currently prescribed regimen, the patient had two expired antibiotics, three duplicate medications, and medications for blood pressure and muscle pain that had been previously discontinued. After review, 25 medication bottles were given to pharmacy for destruction. A complete medication list, including essential and as-needed medications, was reviewed with patient. The electronic medical record was reconciled accordingly, with all extraneous medications eliminated. The patient returned to primary care clinic one month later after seeing several specialists. Four new medications had been added to his list. Again, the medication list was reviewed and edited with the patient as it had been the month prior.

DISCUSSION:
Polypharmacy is a well-known topic to most internists, and an important consideration in caring for any elderly patient. One in six hospital admissions (one in three for age >75) for older adults can be attributed to an adverse drug effect. Older patients often have multiple chronic diseases, and long medication lists consisting of both essential and as-needed prescriptions. The clinical picture is complicated further by multiple prescribers. Medication lists can easily grow or change when patients have new complaints or are involved in care transitions. Even with electronic medical records, keeping medication lists current and appropriate can be a daunting task. The PCP often feels a responsibility to reduce polypharmacy, as he or she is the main coordinator of a patient's care. While studies have reported that the number of prescribing physicians is an independent risk factor for adverse drug reactions in the elderly, physicians report awkwardness and reluctance to discontinue a medication prescribed by another physician. Additional barriers include difficulty in convincing patients to discontinue long-term medications, and problems distinguishing between new complaints and medication side effects. While there is great interest in improving appropriate medication use in the elderly, how to best accomplish this goal is still unclear. A recent Cochrane review found that while the Beers criteria and Medication Appropriateness Index (MAI) appeared beneficial in reducing medication-related problems and inappropriate prescribing, it was not clear that these interventions translated into clinically significant improvements. More evidence-based strategies are needed to implement meaningful change in the area of polypharmacy to improve safety for older patients.
TUBULOINTERSTITIAL NEPHRITIS AND UVEITIS (TINU) SYNDROME IN AN ELDERLY ADULT

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LEARNING OBJECTIVE 1:

Tubulointerstitial nephritis and uveitis (TINU) syndrome is a rare autoimmune disorder that mainly affects young women and adolescents with a median age of 15 years. No identifiable risk factors have been found in most of cases although prior infection or the use of antibiotics and nonsteroidal anti-inflammatory drugs have been implicated in some instances. First described in 1975, most cases have since been documented in ophthalmology and pediatric medical literature and very rarely has it been reported in the older population.

CASE: We report a 60-year-old female patient who was referred to the Renal Clinic by her primary care physician for elevated serum creatinine together with uncontrolled hypertension. She had fever and fatigue with red and painful eyes. However, she did not have any recent history of infection or newly prescribed analgesic medications. The patient’s initial blood work revealed a Creatinine of 2.3 (baseline of 1.0) and subnephrotic range proteinuria and hematuria. The work up of the proteinuria and hematuria revealed normal complement levels, negative antinuclear antibody, myeloperoxidase, proteinase-3, hepatitis panel, and glomerular basement membrane antibodies. Ophthalmology referral for eye pain revealed uveitis for which she was treated with systemic and topical steroids for her eye symptoms. A kidney biopsy was done and showed an interstitial inflammatory process associated with tubulitis, which was consistent with active tubulointerstitial nephritis. Given the kidney biopsy results and the uveitis, she was diagnosed with TINU syndrome. This patient was treated with prednisone 1 mg/kg daily for three months followed by a tapering dose. Her renal function recovered without recurrence and she followed up with her ophthalmologist regarding the uveitis.

DISCUSSION: This case illustrates one of the few older patients who developed TINU syndrome, and whose kidney function successfully recovered after a course of steroid treatment. Noticeably, we did rule out certain autoimmune diseases relatively commonly seen before the diagnosis of TINU syndrome owing to some overlapping manifestations. Thus, this case delineates the importance of extensive system review in renal disease as well as the importance of appropriate referral and collaboration between specialties to obtain the correct diagnosis that dictates the appropriate management.
LEARNING OBJECTIVE 1:
To help guide treatment decisions for patients with DNR tattoos who may not be able to communicate their wishes.

CASE:
Tattooing as a form of artistic expression remains as popular as ever, and some people are now choosing their ink based upon their attitudes towards health care. A 69-year-old widowed man with "Do Not Resuscitate" tattooed on his left forearm and past medical history of lung cancer presented to our emergency room with shortness of breath and fever. He was found to be in acute respiratory failure from pneumonia. Though he had difficulty speaking, he was able to communicate that he wished full resuscitation efforts to be made, including intubation, if needed. Mechanical ventilation as well as appropriate treatment was initiated, which led to a complete recovery. He explained that the tattoo represented his frustration with the health care system after losing his wife to cancer several years prior, but his attitude about health care changed after establishing a rewarding doctor-patient relationship with a new primary care physician. He was healthy when the tattoo was inked, and he never intended for it to be taken as an advance directive.

DISCUSSION:
To help guide treatment decisions for future patients who may not be able to communicate their wishes, we searched Pubmed and Google scholar for articles containing the phrase "do not resuscitate" and the word "tattoo." Review of these articles revealed four previously published case reports, which formed a series of five cases when added to our own. Based on these reports, we identified three reasons why a DNR tattoo should not be actionable in clinical practice. 1) A tattoo inked years ago may not be an accurate reflection of a patient's current wishes. 2) DNR tattoos are ambiguous and are often intended to make a public statement unrelated to decisions about resuscitation. 3) DNR tattoos are not legally binding. While the third reason reflects a technical concern, the first two give insight into the true feelings of patients who get this type of tattoo. In our case series, patients with tattoos had a change in preference regarding resuscitation status in 2/5 cases. The meaning behind the tattoo did not coincide with specific decisions about resuscitation in 3/5 cases. In total, we found that tattoos did not accurately reflect patient resuscitation preferences in 4/5 cases. From this first known case series of patients with DNR tattoos, we conclude that clinicians should strongly consider resuscitating patients unless they have appropriate documentation. Tattoos, however, should be used as a starting point for conversations regarding preferences for care. In our case, this discussion led to a narrative that enriched the relationship between the patient and his healthcare providers.
LOSING A BATTLE BUT NOT THE WAR: INSIGHTS INTO A VETERAN'S PREFERENCE FOR AGGRESSIVE MEASURES IN ADVANCED ILLNESS
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LEARNING OBJECTIVE 1:
Appreciate the potential complexity surrounding goals of care discussions for patients with terminal illness.

LEARNING OBJECTIVE 2:
Recognize that a decline in health status may prompt a change in goals of care for such patients.

CASE:
A 96-year-old World War II veteran with prostate and bladder cancer with metastases to bone and brain presented to the hospital after an unwitnessed fall at home. Chart review revealed numerous cancer treatments over a span of several years, including a series of radiation treatments and transurethral resection of bladder tumor procedures. The patient's son reported that his father had been living at home independently until a few weeks prior to admission, when his growing forgetfulness and loss of energy prompted the hiring of a home health aid. He had no focal neurologic deficits on exam. CT scan showed subarachnoid hematoma of the right frontal lobe. A chest x-ray showed a large right-sided pleural effusion, and CT of the abdomen and pelvis showed a new bladder wall mass, metastatic lesions in his lung, and bilateral hydronephrosis and hydroureter. Urinalysis was consistent with urinary tract infection. Due to intracranial hemorrhage, he was admitted to the intensive care unit for close monitoring. Goals of care discussions initially centered on the patient and family's insistence upon aggressive measures, including full code status, despite the patient's overall poor prognosis. The patient's son confirmed that his father was always a "fighter," and despite multiple prior hospitalizations, he was always able to return to living at home independently and without significant symptom burden, even in the face of metastatic cancer. Within hours of arrival to the hospital, a chest tube and bilateral nephrostomy tubes were placed. The patient tolerated these procedures well and was transferred out of the intensive care unit the next day. While on the medicine floor, he took a turn for the worse, developing delirium and a steady cognitive decline, eventually responding only to voice. In light of this, his family decided to focus on making him comfortable and enrolled him in an inpatient hospice program. He died the next day.

DISCUSSION:
Within only a few days, the patient in this case had a dramatic shift in care preferences spanning opposite ends of the treatment spectrum. Such decision making would at first glance make little sense to a medical team fully cognizant of his overall prognosis. However, certain aspects of the patient and family's perspective in initially insisting on aggressive treatment were compelling. The patient proudly identified as a veteran and maintained his "fighting" spirit in approaching chronic illness, not without prior successes, and his quality of life prior to this hospitalization was excellent. In his understanding, he was perhaps "winning the war," but facing a new setback of unclear significance. From the perspective of the medical team, they had inherited a "losing battle" in terms of the seeming futility of aggressive treatment at such a late stage in the patient's illness. Initial discussions about goals of care were awkward, as the team had just met the patient and family and were trying to gingerly reveal bleak prognostic information that perhaps had not been fully discussed previously. Ultimately, the patient's poor prognosis declared itself fully, and with the aid of continued conversations between the medical team and family, a smooth transition to hospice care was made. This case illustrates the vital role of communication in providing compassionate, patient-centered care at the end of life. Preferences for patients with advanced illness have been shown to be highly dynamic, thus necessitating careful, ongoing discussions involving the patient and a family member who can serve as health care proxy when needed. It is unclear whether advance care planning in the outpatient setting for this patient would have altered his care trajectory while hospitalized, but in the least it may have more clearly established his values and better prepared both him and his family for in-the-moment decision making.