



Letter to Editor

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Greetings:

I am a retired family nurse practitioner and a priest. At the suggestion of a fellow alumna from the Emory University School of Nursing, (MSN – MPH, 1996) I read with interest the Academy's Palliative and End of Life Care Consensus Document released at the beginning of this year. I applaud the Academy for recognizing that palliative care should be utilized across all areas of healthcare. I am concerned this document risks blurring palliative care with hospice and end of life care. We agree that palliative care isn't just for the dying anymore.

I suggest that more investigation needs to occur regarding the utilization of midazolam ((trade name – Versed) combined with an opioid in palliative care. I suggest that patients living with symptomatic heart failure (HF), chronic obstructive pulmonary disease (COPD), chronic kidney disease (CKD), and other conditions with a prognosis longer than 6 months are unlikely to tolerate this drug combination for any length of time. Midazolam is an intravenous medication used for sedation, producing rapid tolerance requiring escalating doses. I refer the reader to the package insert for Midazolam, cautions use in patients with HF, COPD, or CKD (U.S. FDA, 2022).

The Food and Drug Administration (U.S. FDA, 2016), has issued a black box warning for combined opioids and benzodiazepines. For many prescribers who have registered with the state prescribing monitoring system - will be flagged whenever these 2 medications are prescribed in combination. This combination which is promoted in the consensus document is not appropriate in patients living with chronic illness. The average length of life once diagnosed with HF for example is between five and 10 years.

Palliative care and hospice care were developed around the cancer patient. Non-cancer patients require maintenance of their routine medications in the palliative setting to reduce escalating symptoms (Kuebler, 2017). For example, the COPD patient should remain on a maintenance bronchodilator, rescue inhaler, possible inhaled corticosteroid and routine medications required for underlying comorbidities (Kuebler, 2019) The goal in palliative care is to reduce symptoms. In these patients, dyspnea is relieved with an inhaled beta agonist, anticholinergic

and/or corticosteroid - not an opioid or benzodiazepine (Kuebler, 2019)

I am concerned about the recommendation of aggressive combination medications that can sedate, reduce respiration and actively euthanize patients that may live for 2, 3, or 5 more years from diagnosis of an incurable illness. There is no mention in the consensus document on what clinical guideline is used to support the decision making on prescribing and administering opioid and benzodiazepines. The National Palliative Care Clinical Practice Guidelines are void of any clinical content (symptom management).

There is mention about the "box" of medications provided to the patient - this comes from hospice and is used at the end of life and not as appropriate in patients living with symptomatic chronic illness. Titrating diuretics, beta blockers, ACE inhibitors, anti-coagulants and others are more appropriate to reduce symptoms for the HF patient (Kuebler, 2017). Combinations of opioids and benzodiazepines are more appropriate as the patient approaches end-of-life and other treatments fail.

Palliative care should occur in patients who seek a cure and aggressive intervention. The trajectory of disease is longer in the non-cancer patient and we should be careful not to make the assumption that one medication fits all (e.g., opioid, benzodiazepine). Attention should be given on patient goals of care and diagnostic criteria. Palliative care should not be prognostic oriented - but rather initiated at the time of diagnosis. (For example, ejection fraction < 40% in a HF patient, FEV1 < 70% in a COPD and GFR less than 60 mL per minute per 1.73 m² for at least 3 months in the CKD patient.) (Kuebler, 2017)

The Academy's consensus on palliative care is focused on end stage illness and not specified between cancer and non-cancer patients that require different medications with caution on metabolism, excretion and oxygen sensitivity. Such a focus risks early death in many patients who would benefit from advanced disease management in collaboration with primary care, cardiology, pulmonary, and renal providers with a focus on the specific underlying condition and use of medications that will not hasten a patient's death. We need to avoid confusing palliative care with terminal care and avoid unnecessary use of

dangerous medications to shorten a life and not allow for patient and family closure.

Once again, I applaud the Academy for its work and recommendations.

REFERENCES

- U.S. Food and Drug Administration [FDA] (2016). FDA requires strong warnings for opioid analgesics, prescription opioid cough products, and benzodiazepine labeling related to serious risks and death from combined use. <https://www.fda.gov/news-events/press-announcements/fda-requires-strong-warnings-opioid-analgesics-prescription-opioid-cough-products-and-benzodiazepine>.
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