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Rapid Clinical Updates: End-of-Life Care in the Hospital

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Disclosures

All speakers and planners have no relevant financial or advisory relationships with corporate organizations related to this activity, apart from those already disclosed, none of which could be perceived as a real or apparent conflict of interest.

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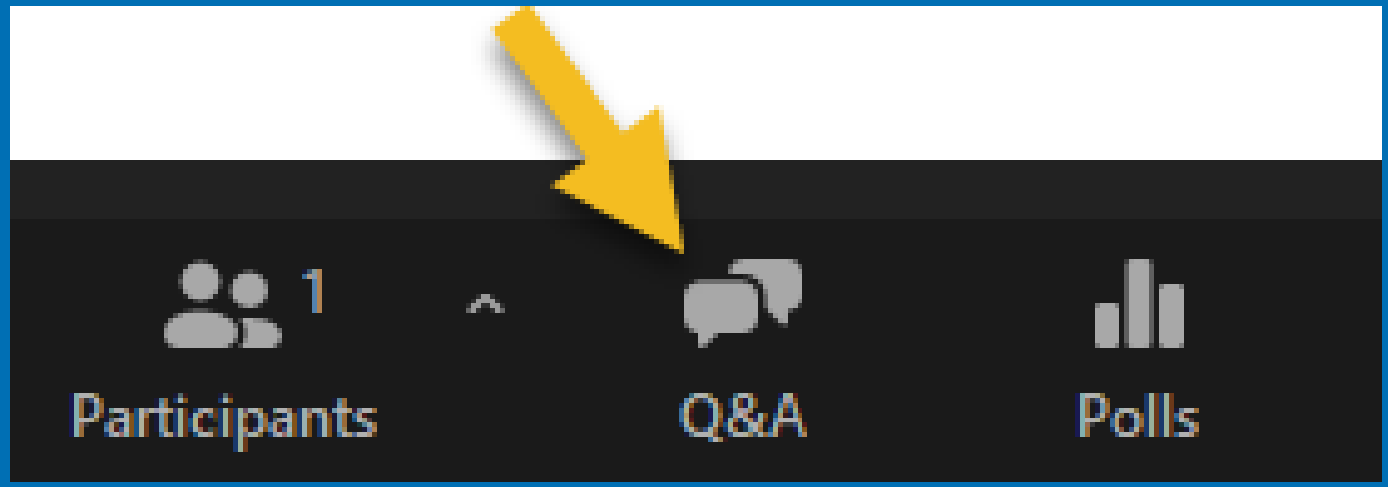
Please submit questions using Q&A feature

We will have Q&A time after



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POLL QUESTIONS

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Question 1

1. **The single most important prognostic indicator in cancer is:**

A. Symptom burden
B. Presence or absence of depression
C. Enhanced left ventricular ejection fraction
D. Readmissions

Question 2

2. **According to the studies cited, the most appropriate time to start a continuous opiate infusion for an actively dying, symptomatic patient is:**

A. Observed dyspnea
B. Once the patient is requiring more than 50 OME per day for a few days
C. Once the patient has received 2 PRN IV boluses as needed without relief of symptoms
D. Immediately after weaning non-invasive positive pressure ventilation

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Rapid Clinical Updates: End-of-Life Care in the Hospital

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We have no disclosures.

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1. Identify patients & clinical scenarios where a serious illness discussion is appropriate
2. Formulate strategies for approaching a serious illness discussion
3. Recognize symptoms at the end of life
4. Manage symptoms at the end of life

Reframe!

End-of-Life Care

↓

Serious Illness Care

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Case

You are the hospitalist seeing Ms. S, a 74 year old woman who was admitted two days ago with HFrEF (heart failure with reduced ejection fraction)(EF = 40%). She is responding well to goal-directed medical therapy and you anticipate discharge in the next couple of days.

Ms. S lives independently with her husband at home and this is her first hospitalization. She is relieved to be feeling better but worried about what the future holds for her.

70% of Americans would prefer to die at home

30% die in
acute care hospitals

12% die in other places

20% die in nursing homes

8% die in a hospice facility

30% die at home

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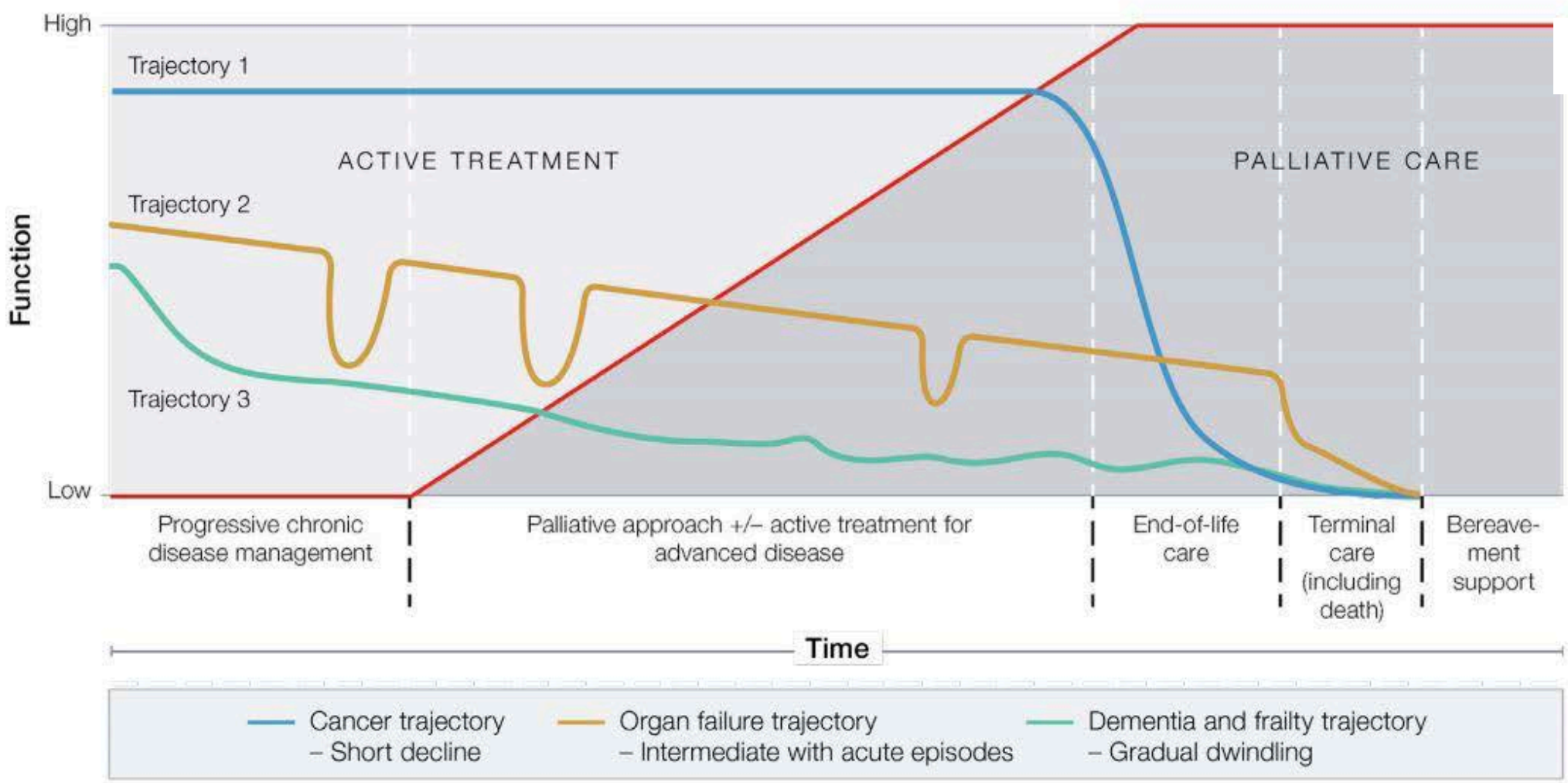
CDC data: values are approximate and based on all ages, 2016

Trajectories of Serious Illness



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Timing of Serious Illness Conversations

Early vs Later

- Early in the disease process
- During stable phases
- When the prognosis is < 1 year
  - “Surprise” question
  - Eprognosis.org
- When there is a change in the patient’s condition
- When the patient expresses concerns or uncertainty, or when values and goals of care are not clear
- Spidey sense

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Indicators of Poor Prognosis

- Comorbidities
- Readmissions
- Pressure ulcers
- Infections
- Malnutrition
- Weight loss
- Continence
- Declining functional status
  …*the less you do,*
  the worse you do

Functional status is the most important prognostic indicator in patients with cancer!

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Ask: How do you spend your time? How much time do you spend in a chair or lying down?

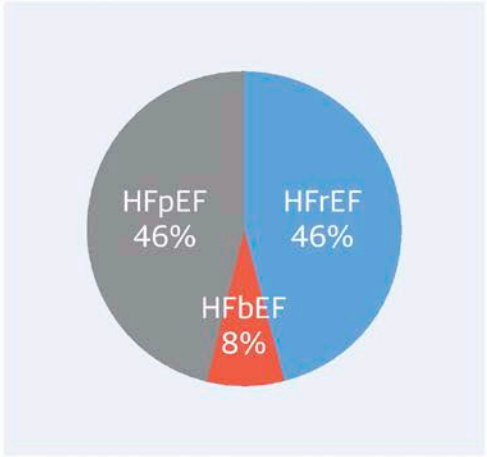
If the response is >50% of the time, and is increasing…

Then prognosis may be roughly estimated at 3 months or less.

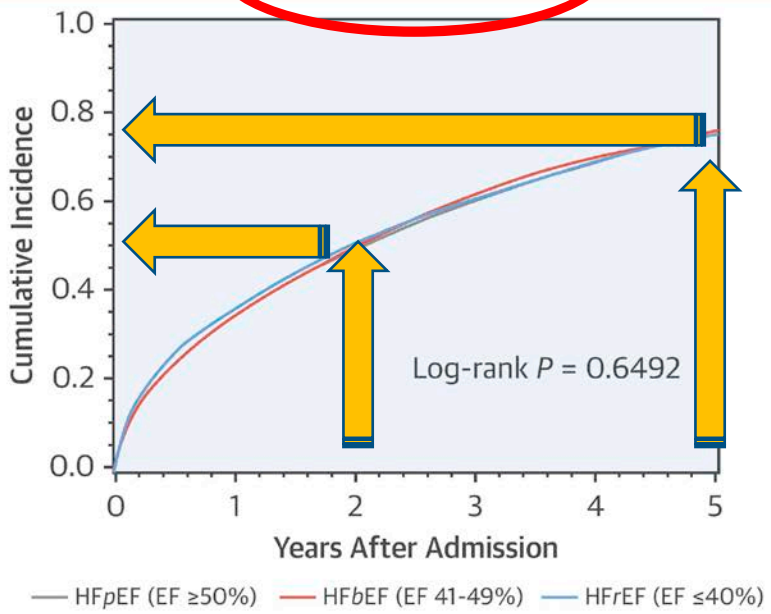
Palliative Care Fast Fact #13

CENTRAL ILLUSTRATION: 5-Year Outcomes in Patients Hospitalized With HF With Preserved, Borderline, and Reduced EF

Heart Failure



5-Year Mortality



Outcomes - 5-Year Event Rates (%)					
	Mortality	Readmission	CV Readmission	HF Readmission	Mortality/Readmission
HFrEF	75.3	82.2	63.9	48.5	96.4
HFbEF	75.7	85.7	63.3	45.2	97.2
HFpEF	75.7	84.0	58.9	40.5	97.3

Shah, K.S. et al. J Am Coll Cardiol. 2017;70(20):2476-86.

Chronic Kidney Disease: 2 Studies

- 28 patients >65 yo with CKD (3b+) were interviewed in Mayo Clinic nephrology clinic
- Most were interested in prognostic information but felt they were in an information vacuum
- More were interested in their progression to ESRD (dialysis) rather than life expectancy
- “Obviously…it’s a choice of going on dialysis or dying, right?...”

Older Patients with CKD and Their Perspectives on Prognosis, JGIM 2022

- VA observational study (2010-2018) of 20,440 patients (median age 77.9) looking at survival and “home time” (GFR < 12)
- Medical management group:
  - Median time to dialysis 3 years
  - Survival over 3 years: 761 days
- Dialysis group:
  - Median time to dialysis 8 days
  - ~2 weeks less time at home overall
  - Survival over 3 years: 770 days
- No dialysis subgroup: dialysis patients gained 11 weeks overall survival but spent 2 fewer weeks at home

Montez-Rath ME, et al. Effect of Starting Dialysis Versus Continuing Medical Management on Survival and Home Time in Older Adults With Kidney Failure : A Target Trial Emulation Study. Ann Intern Med. 2024 Sep;177(9):1233-1243.

Shared Decision Making:

Hemodialysis is not appropriate for everyone

These patients	Patients with limited survival (with or without dialysis): • Comorbidities (CHF, cirrhosis, advanced cancer, dementia) • Functional dependence • Advanced age
are unlikely to meet	
these goals	Goals other than living as long as possible: • Maximizing time at home with family • Avoiding hospitals/medical facilities, procedures, surgeries • Optimizing comfort and control at end of life
by initiating in-center hemodialysis	

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Adapted from Samantha Gelfand, MD

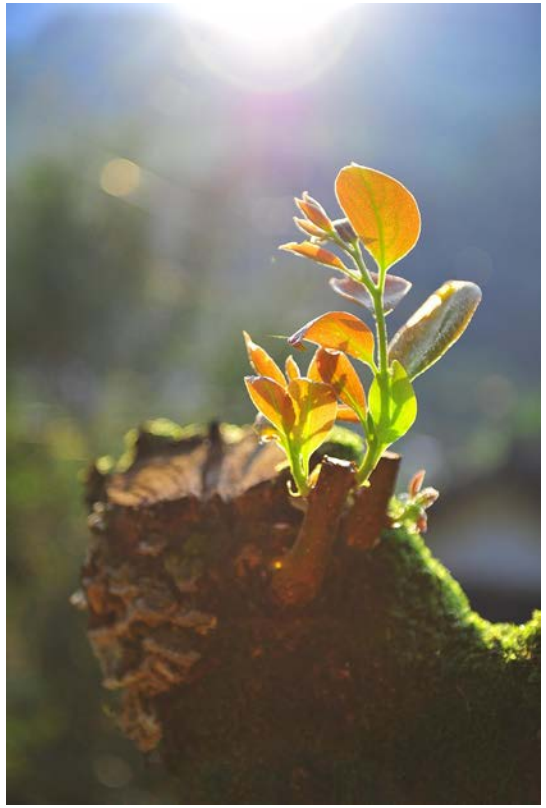
Case

You are the hospitalist caring for Mr. H, a 44 year old man with a history of rhabdomyosarcoma metastatic to his spine. He has had a complicated course at an outside hospital and has now been transferred from her/his local hospital to your hospital, the biggest academic center in the area, for specialized sarcoma care and chemotherapy initiation. Mr. H and his wife have repeatedly said how grateful they are to be under your care and how hopeful they are for a cure.

You have spoken to Mr. H's oncologist who says she can't offer additional chemotherapy or other cancer-directed treatments .You and the oncologist agree that Mr. H likely has weeks to live.

You feel like you should share Mr. H's prognosis with him but worry about taking away his hope.

Hope and Prognosis: the CONNECT trial



- 672 patients with cancer
- Hope measured by “Herth Hope Index”
- Patients’ understanding of their treatment goals, life expectancy, and terminal illness acknowledgement was assessed
- No statistical difference in patients’ hope based on more realistic vs less realistic expectations of prognosis

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Loučka M, Althouse AD, Arnold RM, Smith TJ, Smith KJ, White DB, Rosenzweig MQ, Schenker Y. Hope and illness expectations: A cross-sectional study in patients with advanced cancer. Palliat Med. 2024 Jan;38(1):131-139.

Serious Illness Conversation Guide

PATIENT-TESTED LANGUAGE

SET UP

"I would like to **talk together** about what's happening with your health and **what matters to you. Would this be ok?"**

ASSESS

"To make sure I share information that's helpful to you, can you tell me **your understanding** of what's happening with your health now?"

"How much **information about what might be ahead** with your health would be helpful to discuss today?"

SHARE

"Can I share my understanding of what may be ahead with your health?"

Uncertain: "It can be difficult to predict what will happen. **I hope you will feel as well as possible** for a long time, and we will work toward that goal. **It's also possible that you could get sick quickly**, and I think it is important that **we prepare** for that."

OR

Time: "I **wish** this was not the case. I am **worried** that time may be as short as *(express a range, e.g. days to weeks, weeks to months, months to a year).*"

OR

Function: "It can be difficult to predict what will happen. **I hope you will feel as well as possible** for a long time, and we will work toward that goal. **It's also possible that it may get harder to do things** because of your illness, and I think it is important that we prepare for that."

Pause: Allow silence. Validate and explore emotions.

EXPLORE

"If your health was to get worse, what are your **most important goals**?"

"What are your biggest **worries**?"

"What **gives you strength** as you think about the future?"

"What **activities** bring joy and meaning to your life?"

"If your illness was to get worse, **how much would you be willing to go through** for the possibility of more time?"

"How much do the **people closest to you know** about your priorities and wishes for your care?"

"Having talked about all of this, **what are your hopes** for your health?

CLOSE

"I'm hearing you say that ___ **is really important to you** and that you are **hoping for** ___. Keeping that in mind, and what we know about your illness, I **recommend** that we ___. This will help us make sure that your **care reflects what's important to you. How does this plan seem to you?"**

"I will do everything I can to support you through this and to make sure you get the **best care possible."**

SI-CG 2023-05-18

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Keychain

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https://www.ariadnelabs.org/wp-content/uploads/2023/05/Serious-Illness-Conversation-Guide.2023-05-18.pdf

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Nathan Gray @inkvessel
Inkvessel.com

Case

You are the hospitalist taking care of Ms. M, an 81 year old woman admitted with respiratory insufficiency. She has a history of end stage COPD and diabetes. After some initial improvement with medical management, her work of breathing increases and you are concerned that she is progressing towards respiratory failure. She has no advance directives.

You call her daughter and tell her you have a serious update to share.

“If her breathing gets worse, we’re going to need to intubate her,” you say. “Has your mom ever talked about what she want in this situation?”

Her daughter says, “She would want to get better. Please do everything possible to help her.”
You pause, feeling uneasy. You want to honor the daughter’s wishes but don’t feel like her mother will be able to come off the ventilator once she’s intubated. Doesn’t she realize how sick her mother is?

Words Matter: High Yield Tips

Never-Words	Alternative
There's nothing else we can do	Therapy X has been ineffective in controlling the cancer, but we still have the chance to focus on treatments that will improve your symptoms and, hopefully, your quality of life.
She will not get better	I'm worried she won't get better.
Withdrawing care	We can shift our focus to his comfort rather than persisting with the current treatment, which isn't working."
Do you want us to do everything?	Let's discuss the available options if the situation gets worse.
What would he want?	If he could hear all of this, what might he think?

Never-Words: What Not to Say to Patients With Serious Illness. Mayo Clin Proc. October 2024;99(10):1553-1557. doi.org/10.1016/j.mayocp.2024.05.011

Words Matter: High Yield Tips

What would you do if he were your dad? Making a recommendation.

Summarize	What I heard is that your [father] considered ___ most important, and that [he] would consider treatments that result in ___ unacceptable. **Did I get that right?**
Recommendation	Based on what you've shared with me, **we would recommend:** • Intensive treatment focused on comfort; or • Intensive treatment focus on recovering from illness We will use all available medical treatments that we think will help [his] recover from this illness. For [his], this means: • Supporting [his] body in recovering from this illness without treatments that could make [his] more uncomfortable, while do everything we can to assure that [he] is comfortable and peaceful; or • Supporting [his] body in recovering from this illness with intensive treatments, including ventilators, while also doing everything we can to assure that [he] is as comfortable as possible. I worry that even with maximum care, [his] body may still tire out. The admitting teams will support you over the coming days with upcoming decisions. Does this sound ok?
Document the conversation	

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Ouchi K, Lawton AJ, Bowman J, Bernacki R, George N. Managing Code Status Conversations for Seriously Ill Older Adults in Respiratory Failure. Ann Emerg Med. 2020 Dec;76(6):751-756. doi: 10.1016/j.annemergmed.2020.05.039.

Words Matter: High Yield Tips

How sick is sick?

- Every hospitalized patient is sick
- Try saying “sick enough to die”

BMJ 2019;367:l5917 doi: 10.1136/bmj.l5917

Using the word “need”

- “We’re going to need to…”

“If her breathing gets any worse, she will need to be intubated.”

- Instead, make space

“Your mother’s breathing is getting worse. Can we talk about what this means and what to do next?”

Kruser JM, Clapp JT, Arnold RM. Reconsidering the Language of Serious Illness. *JAMA.* 2023;330(7):587–588. doi:10.1001/jama.2023.11409

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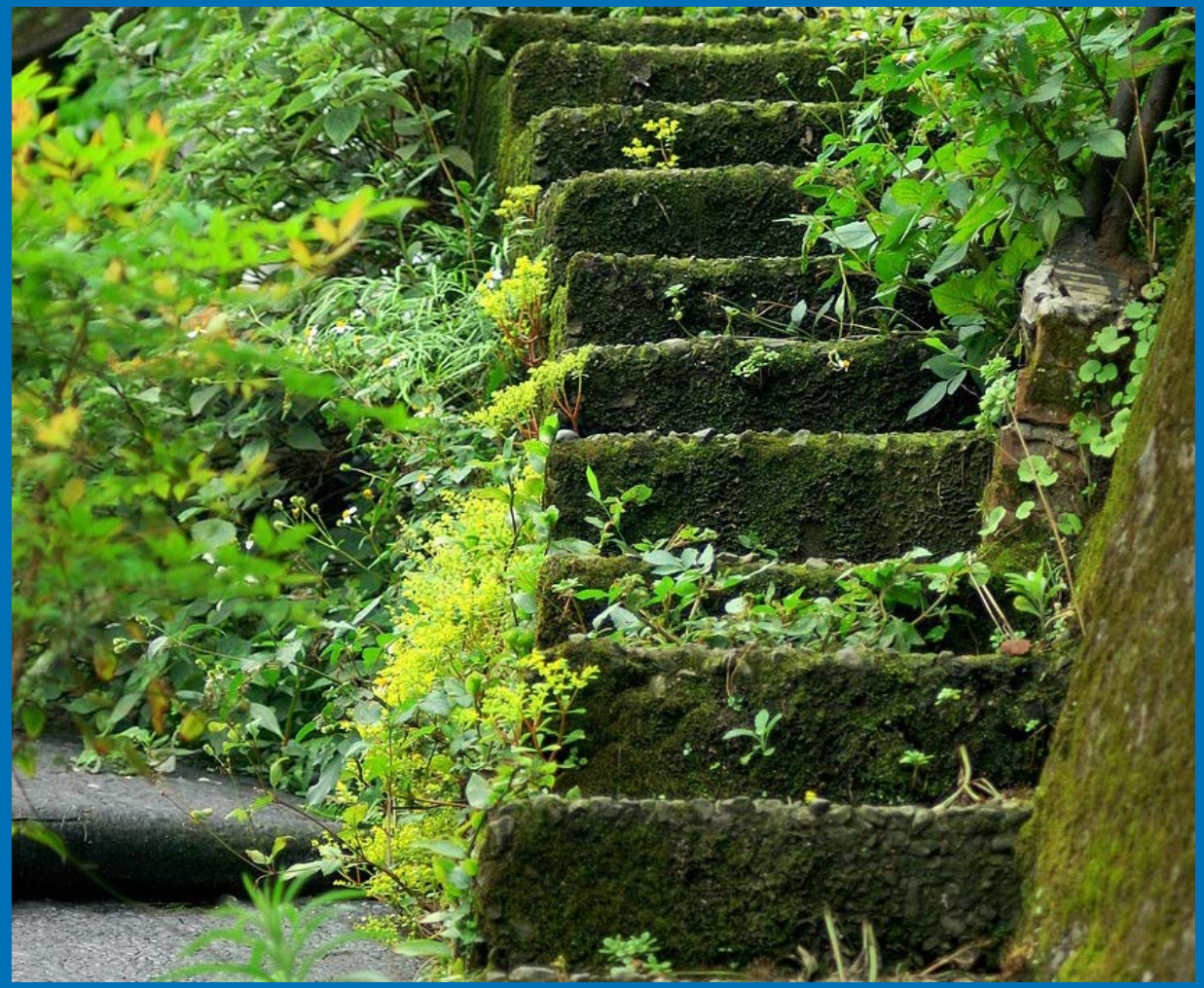
What is one strategy you can bring forward?

- Surprise question
- Functional status
  - How much time in bed/chair
- Initiating a serious illness conversation (SIC)
- Thinking about prognosis & SICs ***earlier***
- Checking out ePrognosis.org
- Words matter
  - “Sick enough to die”
  - Avoiding the word “need”
  - Never-words
  - Making a recommendation



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Case

You are the admitting hospitalist on a Friday evening, when the Emergency Department calls you to admit Mr. J. He is an 87 year old man who was brought in from his skilled facility for altered mental status.

Vitals are 36.0º C, HR 108, RR 20, BP 150/90 and 82% on RA. He is now 94% on 2L O_2 via nasal cannula.

Labs show WBC 11, Hgb 10, Hct 30, Plt 200. Na 130, K 3.4, Cl 98, HCO_3 18, BUN 54 and SCr 1.2. Glucose is 98 g/dL.

UA shows SpGr 1.016, 1+ WBC, no bacteria

CXR shows a RLL hazy opacity

EKG shows atrial fibrillation with no new ischemia.

You open the chart and find that this is his third admission this year. He was discharged to this facility 3 weeks ago after an admission for a fall with a hip fracture, and 6 months ago he was hospitalized for pneumonia.

Palliative Performance Scale

%	Ambulation	Activity Level Evidence of Disease	Self-Care	Intake	Level of Consciousness	Estimated Median Survival in Days (a)	(b)	(c)
100	Full	Normal *No Disease*	Full	Normal	Full			
90	Full	Normal *Some Disease*	Full	Normal	Full	N/A		
80	Full	Normal with Effort *Some Disease*	Full	Normal or Reduced	Full		N/A	
70	Reduced	Can't do normal job or work *Some Disease*	Full	As above	Full	145		108
60	Reduced	Can't do hobbies or housework *Significant Disease*	Occasional Assistance Needed	As above	Full or Confusion	29	4	
50	Mainly sit/lie	Can't do any work *Extensive Disease*	Considerable Assistance Needed	As above	Full or Confusion	30	11	41
40	Mainly in Bed	As above	Mainly Assistance	As above	Full or Drowsy or Confusion	18	8	
30	Bed Bound	As above	Total Care	Reduced	As above	8	5	
20	Bed Bound	As above	As above	Minimal	As above	4	2	6
10	Bed Bound	As above	As above	Mouth Care Only	Drowsy or Coma	1	1	
0	Death	-	-	-	--			

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Recognizing Symptoms at the End-of-Life

WHY:

Death-related distress is unsettling for patients, families and caregivers (read: other members of the team)

Most people want to spend their final days in the community

But there are some who cannot

Hospitalists' ability to recognize End-of-Life symptoms can help patients and families prepare

- Stop treatments and testing that are more burden than benefit
- Reduce the unexpected as much as possible
- If we can't get the patient home, can we make the hospital more home-like?

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https://doi.org/10.1177/2333721423118324

Recognizing Symptoms at the End-of-Life

WHAT: End-of-Life is defined as *the period when a person with an advanced, progressive, or incurable condition is expected to die within 12 months*

Many sources use this term to mean the final weeks, months, days, hours or moments of life

End-Of-Life Care is the support and medical care given during the time surrounding death, with a focus on providing *symptomatic relief* for the dying person by identifying, assessing, and treating pain and other distressing physical signs and symptoms, along with *emotional, social, and spiritual support* tailored to the needs and wishes of the dying individual and their loved ones

A Good Death is person-centered EOL care that controls distressing physical symptoms, provides emotional and spiritual support, and honors the dying person's ability to die in a place of their choosing where their dignity and privacy are respected, and measures that increase suffering and needlessly prolong life without an added quality are avoided

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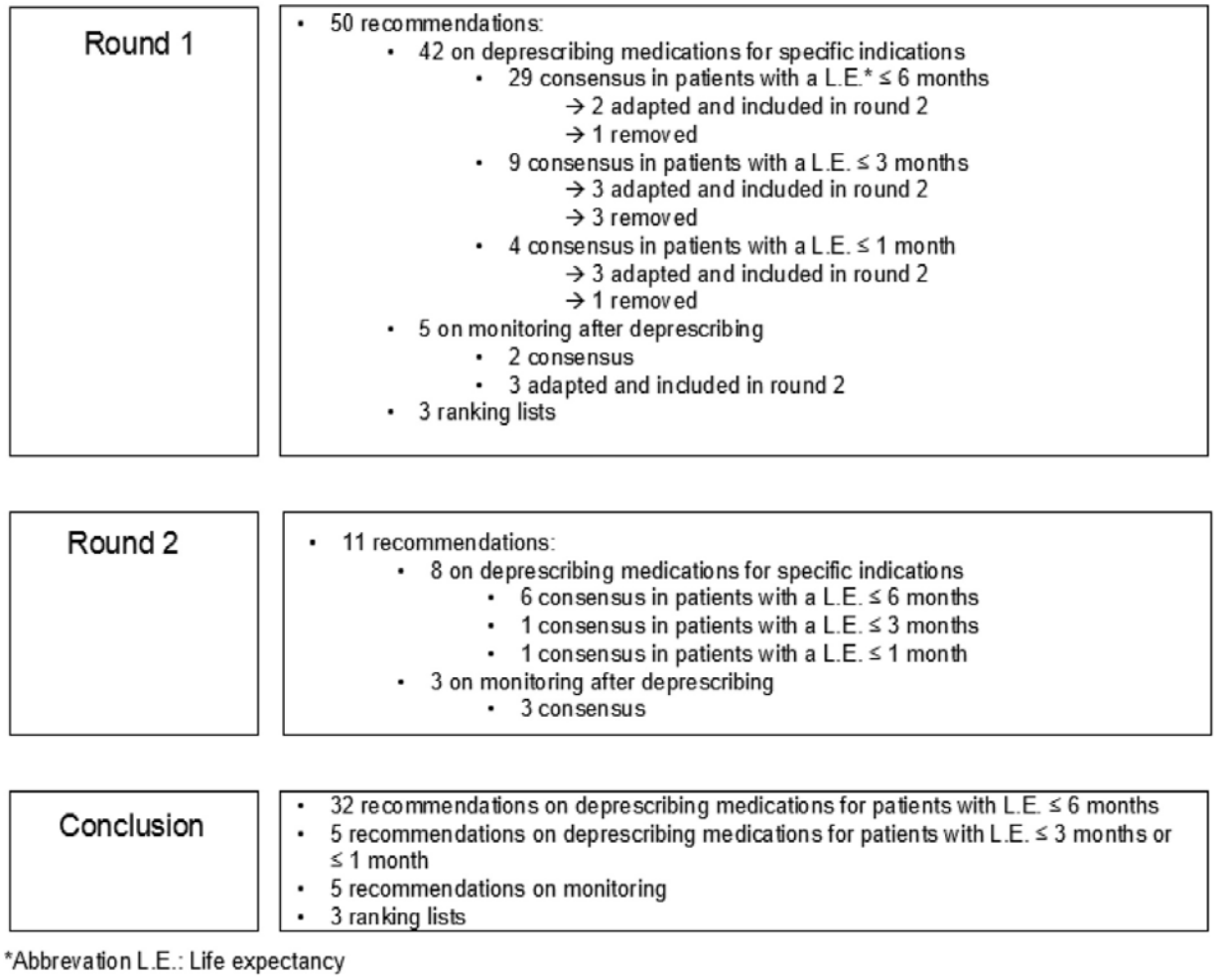
Deprescribing

47 experts in palliative care or "other relevant disciplines" from 10 countries participated in Delphi rounds to develop recommendations for 42 medications in the last 6 months of life

Secondary aim: recommendations for symptom monitoring and prioritization of what to stop in what order if there are multiple medications

Used a 5-point Likert scale

76% of cases consensus was reached



*Abbrevation L.E.: Life expectancy

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Elsten E, et al. **Recommendations for Deprescribing of Medication in the Last Phase of Life: An International Delphi Study.** JPSM.

Deprescribing – ≤ 6 months life expectancy

Medication	Recommendation (Consider deprescribing….)	Agreement
ACE-inhibitors or ARBs	If for primary prevention of diabetic nephropathy	93.6%
Beta-blockers	Taper if prescribed for mild-moderate HTN	90%
Calcium channel blockers	If prescribed for mild- moderate HTN	78%
Diuretics	In case of decreasing fluid intake or increasing fluid loss (diarrhea, vomiting, excessive sweating)	100%
Lipid modifying	If for primary or secondary prevention; if >12 mos since last incident	100%; 97.9%
Antiplatelet	If for primary prevention or if high-risk bleeding	88%
Warfarin	If for uncomplicated DVT or PE without cancer and ≥ 6 months prior, or if high risk bleeding or if uncontrolled HTN	88.6%
DOACs	If high risk bleeding or if uncontrolled HTN	100%
Insulins	Change fast-acting or mealtime insulins to simpler regimen if irregular intake, lower long acting doses if clinical deterioration	86.7%, 90.9%
PPIs	If prescribed for an ulcer/esophagitis or no clear history of GI bleed, GERD, NSAIDs or steroids	88.6%

Deprescribing – ≤ 3 months life expectancy & order

Medication	Recommendation (Consider deprescribing….)	Agreement
ACE-inhibitors or ARBs	If prescribed for mild-moderate hypertension	89.4%
Beta-blockers	Taper and if possible stop if prescribed for management of stable coronary artery disease	74.4%
Diuretics	If prescribed for mild-moderate hypertension	78.8%

Table 4
Order of Deprescribing of Medication

Medication Class	Indication	Medication	Rank Order	Mean Rank (Standard Deviation)	Median (Standard Deviation)
Antihypertensive agents	Hypertension	Central acting antihypertensive medication	1	1.64 (0.962)	1 (0.954)
		Peripheral alpha blocker	2	2.48 (1.302)	2 (1.285)
		Diuretics	3	3.85 (1.544)	4 (1.587)
		Beta-blocking agents	4	4.09 (1.646)	4 (1.632)
		Calcium channel blocker	5	4.27 (1.281)	4 (1.317)
		ACE-inhibitor/ Angiotensin II blocker	6	4.67 (1.242)	5 (1.215)

Recommendations for deprescribing order for insulins and other diabetes medications AND monitoring after deprescribing are in the paper!

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End-of-Life Signs and Expected Time

ROUGHLY 3 DAYS:

- Apnea
- Cheyne-Stokes Breathing
- Secretions
- Dysphagia of liquids
- Decreased consciousness
- Peripheral cyanosis
- Absence of radial artery pulse
- Mandibular movement with breathing
- Urine Output <100 ml
- Nonreactive pupils
- Decreased response to visual stimuli
- Inability to close eyelids
- Decreased response to verbal stimuli
- Drooping of the nasolabial fold
- Hyperextension of the neck
- Grunting of vocal cords
- Upper gastrointestinal bleeding

Prevalence of End-of-Life Symptoms

2013 systematic review study that analyzed data representing 2,416 patients from multiple settings on the prevalence of signs and symptoms of imminent death:

- Dyspnea = 56.7%
- Pain = 52.4%
- Secretions = 51.4%
- Confusion 50.1%

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https://doi.org/10.1177/1049909112468222

Case

- After a good conversation with Mr. J's daughter, you recognize that his aspiration pneumonia is a life-limiting event. As a retired professor who loved exploring the mountain west, he has not had good quality of life for a few years.
- The plan is to send him back to the facility with hospice.
- Overnight, he has an aspiration event. He is now on 5 L O2 via face mask and is somnolent. The night team gave him 1 dose of ceftriaxone.
- You call the daughter, and learn that he didn't have a preference of being home at the end of his life. His daughter wants to be present and is driving to your hospital from her home a few hours away.
- You are waiting for her arrival to transition him to comfort measures.

The Case Continues…

- Your patient's breathlessness improves slightly with opioids, but he is still very symptomatic
- The patient is opioid naïve and is using morphine 4 mg IV every 4 hours as needed. His oral morphine equivalent per day is ~36-40 mg a day
- He is restless most of the time and his respiratory rate is consistently over 20 breaths per minute
- You want to start an opioid infusion but not sure if it is the right time…

Opioid Infusions at End of Life

Retrospective study looking at "inappropriate" use of opioid infusions at end of life of 193 patients

- 44% were potentially inappropriate at one AMC

"Inappropriate" infusions defined as:

- ***Starting in patients receiving < 50 mg oral morphine equivalents in preceding 24 hours***
- ***Starting in patients Using < 3 PRN boluses who had a frequency > q 2 hours***
- Increasing infusion rate > 3 times in 24 hours

Led to more frequent patient and staff distress

Bottom line:

- Avoid continuous opioid infusions *unless patient is receiving > 50 mg morphine equivalents* consistently over a few days
- Utilize frequent PRN boluses (≤ 2 hours) and take your time to assess the need for an infusion

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Yeh JC, et al.. **Are Opioid Infusions Used Inappropriately at End of Life? Results From a Quality/Safety Project.** J Pain Symptom Manage. 2022 Sep;64(3).

Case Continues

Even after treating the patient's dyspnea with an opiate infusion, he continues to be intermittently agitated.

His last bowel movement was two days ago. His abdominal exam is unremarkable – soft, nontender. He has been urinating regularly, and bladder scan shows he is not retaining.

What do you do to treat his delirium?

Haloperidol for Treatment of Delirium in the ICU (AID-ICU Trial)

Table 3. Primary and Secondary Outcomes.*

Outcome	Haloperidol	Placebo	Adjusted Absolute Difference (95% or 99% CI)†	Adjusted Relative Risk (95% or 99% CI)†	P Value
Primary outcome					
Days alive and out of hospital at 90 days — raw mean no. (95% CI)‡	35.8 (32.9 to 38.6)	32.9 (29.9 to 35.8)	2.9 (−1.2 to 7.0)§	NC	0.22¶
Death — no./total no. (%)‖	182/501 (36.3)	210/485 (43.3)	−6.9 (−13.0 to −0.6)**	0.84 (0.72 to 0.98)	
Length of hospital stay — raw mean no. of days (95% CI)††	28.8 (26.7 to 30.8)	26.4 (24.4 to 28.5)	2.3 (−0.6 to 5.1)§	NC	
Secondary outcomes					
Days alive without delirium or coma — raw mean no. (99% CI)‡‡	57.7 (53.4 to 62.0)	52.6 (48.0 to 57.1)	5.1 (−1.2 to 11.3)§	NC	
Days alive without mechanical ventilation — raw mean no. (99% CI)	57.9 (53.7 to 62.2)	53.9 (49.5 to 58.3)	4.0 (−2.2 to 10.1)§	NC	
Serious adverse reaction in ICU — no./total no. (%)	11/501 (2.2)	9/486 (1.9)	0.4 (−1.9 to 2.7)**	1.20 (0.33 to 5.45)	
Use of rescue medication — no./total no. (%)§§	288/501 (57.5)	302/486 (62.1)	−4.0 (−11.8 to 3.6)**	0.93 (0.82 to 1.06)	
Days with use of rescue medication per patient — raw mean no. (99% CI)	2.9 (2.3 to 3.5)	2.9 (2.3 to 3.4)	0.1 (−0.7 to 0.9)	NC	

Multi-center, blinded, placebo-controlled trial in European countries looking at 1000 adult ICU patients with delirium using CAM-ICU or ICDSC

Received 2.5 mg IV haloperidol three times a day plus PRN

Median daily dose 8.3 mg (haloperidol) and 9.0 mg (Placebo) over a median course of 3.3-3.6 days

Society of Hospital Medicine

Andersen-Ranberg, Nina C., et al. "**Haloperidol for the treatment of delirium in ICU patients**." New England Journal of Medicine 387.26 (2022): 2425-2435.

Haloperidol for Treatment of Delirium in the ICU: Bottom Line

- No signs of overt harm by using haloperidol
- No evidence of worse mortality and likewise no evidence of improved mortality (though absolute percentage lower in the haloperidol group)
- Intent to use Haloperidol is usually to improve symptoms and not to lower LOS or improve mortality
- Use of rescue medications were similar in both groups so was haloperidol useful?
- Very few patients had underlying cognitive disorders in the study
- Jury still out... ***but this trial shows it may be safe with judicious use***

Society of Hospital Medicine

Andersen-Ranberg, Nina C., et al. "**Haloperidol for the treatment of delirium in ICU patients**." New England Journal of Medicine 387.26 (2022): 2425-2435.

Olanzapine and Non-Chemo Nausea/Vomiting

Retrospective study of 78 patients looking to see if adding olanzapine would decrease # of doses of other anti-emetics administered pre/post olanzapine (65% had cancer)

- Secondary outcomes: tolerate orals, improved appetite

Initial dose was 2.5 mg/day and Average dose at final dose titration was 4.97 mg a day

Resulted in:

1. A decrease in median number of doses of other anti-emetics from 1.6 to 0.6
2. Improvement in appetite *(p<0.001)*

Only 32 out of 78 patients could be assessed for QTc and 6 of these had prolonged QtC

- These patients had other medications that contributed to a prolonged QTc

Society of Hospital Medicine

Bonar S, et al. **Olanzapine for Non-Chemotherapy Related Nausea and Emesis in Patients with a Palliative Care Consult.** J Pain Symptom Manage. 2023 Oct;66(4):e455-e459.

Olanzapine and Non-Chemo Nausea/Vomiting Bottom Line

For non-chemotherapy related Nausea and Vomiting, not limited to cancer patients, consider adding low dose Olanzapine starting at 2.5 mg qhs as an *adjunct* medication

Be mindful of QTc prolongation

Be mindful of having two dopamine antagonists on board (e.g. olanzapine and prochlorperazine)

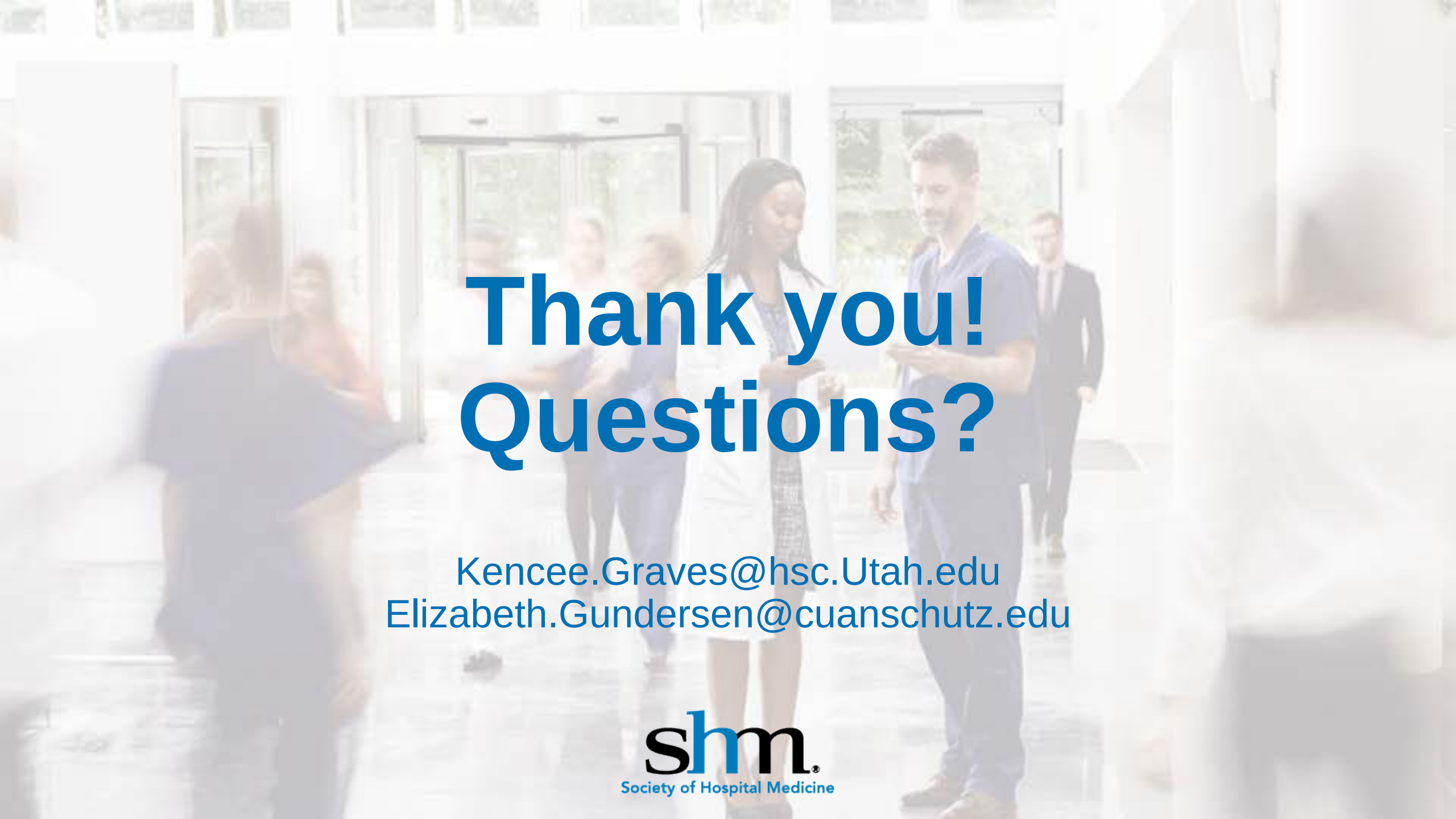
This study supports the 2020 Navari study (JAMA Oncology) in cancer patients showing benefits of 5 mg/day and decreased use of PRN rescue anti-emetics, ~2 to near 0

Society of Hospital Medicine

Bonar S, et al. **Olanzapine for Non-Chemotherapy Related Nausea and Emesis in Patients with a Palliative Care Consult.** J Pain Symptom Manage. 2023 Oct;66(4):e455-e459.

Summary

- Most patients want to die at home but many die elsewhere
- Hospitalists are well positioned to identify patients with serious illness…
- And have goals of care conversations
- Use functional status to establish prognosis
- Words matter
- New literature for CKD
- Guidance on deprescribing
- Many signs that help estimate time at the very end



Thank you!
Questions?

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Society of Hospital Medicine