# Patient Safety America Newsletter

August 2019 http://PatientSafetyAmerica.com John T. James, Ph.D.


*Question: What is Beers List? a) risky devices b) risky drugs c) risky hospitals d) risky microbes*

## Dealing with Depression

Major depressive disorder (MDD) happens to 10 % to 15 % of people sometime in their life. Traditional interventions for MDD include antidepressant drugs and psychological counseling. Three MDs described evolving issues in the treatment of depression in *JAMA* that may help those with MDD. They focus on 3 options to traditional approaches.

The first option is exercise. They cite a meta-analysis of resistance exercise that indicated moderate to large success with relief of MDD symptoms. The writers did not discuss the sustainability of this intervention. As one ages, performing exercise becomes more challenging.

A second option was improvement in nutrition. Diets high in vegetables, fruit and whole grains seem to support improved mood. It seems that high quality studies have shown improvement of MDD when a Mediterranean-style diet is adopted. For now, these studies lack long-term follow-up, so these interventions need further evaluation.

The third recommendation is use of the drug ketamine, which has been recently approved by the FDA for resistant depression. Intravenous administration of this stuff results in immediate relief of major depressive symptoms, but the relief fades in a few weeks. Effective doses do not pose a risk of serious side effects. In addition, some anti-inflammatory drugs show promise in relief of depression symptoms.

If I were in need of relief from depression, I'd try exercise and diet improvement first. Those are most likely to work with social support to continue them over the long term. As a last resort, I'd try to use of drugs under the watchful eye of a patient-centered physician.

## Suicide Rates among Young Adults

Increases in the suicide rate among young adults in the U.S. is concerning. Not only does this desperate act take a life, it leaves behind family to grieve and wonder what went wrong. I once met a woman whose teenage daughter committed suicide 25 years previously. She was brought to tears as she described her grief that had persisted for a quarter of a century. In a research letter in the *JAMA*, investigators report that, based on CDC data, suicide rates in young adults (15 to 24 years old) have increased 30% from 2000 to 2016. The investigators probed 2017 data on suicides to glean differences in rates and changes based on age groups and gender.

Suicide rates increased in adolescents (15 to 19 years old) and the older group (20-24) in 2017 when compared to 2000. The increase was greatest

for young males. Suicide rates in young males tended to be about 3-4 times the rate in young females. The authors admit that better reporting of suicides may contribute to the apparent increases. They speculated that more use of opioids or increasing depression may be the root cause. I happen to know of a 15-year old male who committed suicide 2 weeks after starting to use an anti-depressant.

In order to make these troubling observations actionable for readers, I'm including some links to ways that depression and potential suicide might be discoverable before it's too late. A recent study provided a predictive tool as a way to anticipate the possibility of suicide in young adults.

## Digital Addiction in Children

Our lives are permeated by electronic devices that may serve us or curse us. One of the most disappointing things I observe is families eating a meal in a restaurant. If there is any crowd in the establishment, there will be at least one family with everyone using a digital device to be elsewhere. To me this is sick. Times out as a family are important to building family relationships. The World Health Organization has recognized 'digital addiction' as a diagnosable condition. An MD wrote his viewpoint in the *JAMA*. The author notes that addiction may result from a combination of genetic predisposition and exposure to opportunity. Since the latter is everywhere in our culture, those with a predisposition are most vulnerable.

The MD explains that exposure to digital media has a 'U' shaped dose response curve. If the exposure is extremely low, the person is left out of useful access, whereas, if the exposure is too high, then addiction may happen. One study reported that children using digital media for 1 hour per day were 12% less likely to show depression than those not using it. If the use went up to 3 hours per day, the risk of depression increased 19%, and at 5 hours per day the risk was increased by 80%.

The author points out that the situation is more complex than simply time spent. It also depends on what is being done during the digital time. For example, on-line participation in a support group may be decidedly positive. He also points out that media companies have been capturing data on how youth (and others) use devices. Researcher's access to such data could yield better understanding of digital addiction. I might point out that such companies have a clear interest in keeping users at least mildly addicted to use of a device that offers access to their product lines.

In my opinion, children's use of digital media should be restricted to no more than 2 hours per day unless the use offers a clear positive influence. Children may learn about their world or exciting past worlds (dinosaurs fascinate children) from material on digital media, and they may be challenged mentally to solve problems that matter. Engaging with violent media offerings with the goal of killing one's opponents has nothing but destructive influences. Digital media may offer the opportunity to harm children and adolescents with cruel words. The bottom line is that parents must rigorously control their children's use of media.

## Beers List – Not on the Menu

Typically, when eating in a restaurant, I like to check the beer list for the brands I like. Just so you know, my favorite is Alaska Amber, but I might settle for a Fat Tire or Blue Moon. A much more important 'menu' is Beers List, a compilation of medications that should not be given to those over 65 or given only with caution. A clinical pharmacist tells the story of an 87-year-old woman who was given several inappropriate drugs, resulting in a cascade of events leading to delirium. Her diagnosis: drug-induced delirium. The writer works in a position where many elderly patients are seen that

are on Beers List medications. The author notes that non-medical folks have no clue about Beers List, and practitioners too often prescribe drugs for the elderly from that list. If you are caring for an elderly person and a new drug is prescribed to them, then ask the prescriber if it is on Beers List. Do not bet your loved one's health that their clinician checked it before writing the prescription.

## Managing Your Pain without Narcotics

An MD wrote in *The New England Journal of Medicine* what seems to me to be a comprehensive, readable review of options for management of pain without narcotic drugs. She notes that acute pain is the most common cause of visits to the emergency room. Chronic pain never was well managed with opioids, so where does that leave doctors that need tools to manage pain?

There are several options. Psychological management may include educating the patient to manage his pain. Using supervised exercise along with hypnosis, biofeedback and stress management may work. Another approach is non-narcotic pain management, perhaps supplemented with antidepressants. Anti-epileptics may also help manage pain. Local pain can be managed effectively with topical patch applications, typically containing lidocaine. There are also what the author calls 'complimentary' strategies. These include meditation, acupuncture, yoga, massage, and biofeedback. Ultimately, surgery may be necessary. The writer notes that research is underway to use individual patient biomarkers to identify which strategy may be most effective for that patient.

Where does all this leave the patient who has serious pain? I'd point to shared-decision making with your doctor. Read up on ways to manage the kind of pain you have and insist on trying some of the non-invasive approaches to relief. One of these I have used is to simply give the source of pain some rest. If your back hurts, then limit the weight you lift or find safer ways to lift things. If you must run and your knees hurt, then at least run on softer surfaces than concrete or asphalt, and run a few less miles. The runner's high may be addictive; I remember.

## Time for Shared Decision Making

The time clinicians spend in shared decision making with patients is limited. Three experts wrote their viewpoint on physician time in the *JAMA*. They pointed out that older folks with several comorbidities are a special challenge because the physician must carefully elicit the patient's preferences. Patients may expect and need more time with their doctor than the doctor may be willing or able to spend. Clinicians should communicate to the patient that they have allotted time for shared-decision making. Ultimately, time must be viewed like money – there is only so much to be spent, so spend it wisely and *for* the needs of your patient. In my opinion, there is a critical role for patients in shared-decision making. Do your homework and know beforehand what questions you wish to ask. Be ready to explain your priorities. Respect your doctor's time.

## Medication Safety Advisories in Four Developed Countries

Ideally, cognizant groups weighing the risks and benefits of identical medications would all conclude when a safety warning should be issued to protect patients from harm. A large team of experts asked if this is true for warnings issued by the U.S., U.K., Australia, and Canada. The investigators identified 1440 safety advisories among the 4 countries involving 680 issues.

The following number of advisories were issued: U.S. 265, U.K. 344, Canada 317, and Australia 183, and the respective 'discordant rates' were 59%, 50%, 48%, and 70%. The combined concordance rate was only 10%, suggesting huge differences in the communication of warnings to clinicians and the public. The authors suggest that it may be time to revisit policies in the surveyed countries to discern whether these are protective.

To me this suggests that there is not agreement on criteria that should be used to issue advisories to protect the public. The criteria should somehow be evidence based, and that evidence should be considered by the regulators in each country. Intelligent and informed expert groups are bound to disagree at times, but the data show the need for improvements. If I were prescribed a new drug, I'd surf the web to see if a safety warning had been issued by *any* developed country other than the U.S. If I found 2-3 or more of these, I'd have a serious discussion with my doctor.

## Doctors and Marketing of Unproven Stem Cell Treatments

Many of us have noted the advertising of stem cell treatments in newspapers and magazines. A research letter in *JAMA* asked how often doctors are involved in the marketing of unproven treatments. It seems that there are 700 stem cell clinics in the U.S. marketing unproven procedures. The investigators examined clinics in Florida, California, and Texas, states with many of these clinics. There were just over 600 physicians associated with the 166 clinics advertising unproven treatments in 2018 in the 3 states. Many of the physicians involved in these clinics were practicing outside their expertise.

Only 8 of the 51 state medical boards had taken any action against physicians performing unlicensed procedures. Patients should be aware that many stem-cell interventions are not proven to be effective. Scientifically proven stem-cell interventions usually involved hematopoietic (blood forming) interventions.

## A Time for Dialysis

In 2010 a study was published showing that starting dialysis at a GFR (glomerular filtration rate) of 10 to 15 is no better than starting at a GFR of 5-7. A large team of investigators wondered if this finding had changed the start-time of dialysis in Canadians. They looked at start GFRs from 2006 to 2015 in more than 28,000 Canadians (except Quebec) with a mean age of 65 years.

Between 2006 and 2010 the percentage of early initiation climbed from 36% to 41%. Following the publication of the trial, the percentage of early initiation fell from 37% to 30%. The authors take this finding as news that the trial made an impact on the rate of starting dialysis earlier than is warranted by evidence. Apparently, Canadian guidelines from the Canadian Society of Nephrology were adjusted in 2014 to recommend not starting dialysis until the patient's GFR is below 6 or symptoms appear. Despite this guideline, it seems that two years later in 2016, almost 1/3rd of patients were started earlier than this guideline specifies. Were they having symptoms?

If dialysis were recommended to a patient for whom I was advocating, I'd ask some hard questions about the rationale for the start GFR. What is the patient's GFR? Is the patient having symptoms? Starting dialysis is serious, expensive and erodes the patient's independence.

NATIONAL QUALITY FORUM MEMBER

Answer to this month's question: (b) drugs that may pose high risk to elderly patients

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