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Richard T. James Jr. M.D.

Editor/Publisher.

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### *Associated With Lower Mortality.*

#### **7-1 VEGETARIAN DIET PATTERNS AND MORTALITY: The Adventist Health Study 2**

Previous studies have identified correlations between various dietary factors and reduced mortality: nuts, fruit, cereal fiber, polyunsaturated fatty acids, omega-3 fatty acids, green salad, Mediterranean diet, plant based diets, and vegetarian diets.

Dietary components associated with increased mortality: high glycemic load, meat, red meat, processed meat, eggs, potatoes, and animal-based low carbohydrate.

Vegetarian diets (VD) have been associated with reductions in hypertension, metabolic syndrome, diabetes, and ischemic heart disease, which might be expected to result in lower mortality.

This study evaluated the association of VD with mortality in a large American cohort including many vegetarians.

#### **STUDY**

1. The cohort included 96 469 Seventh-day Adventists men and women recruited at churches between 2002-2007. All were over age 25. None had a history of prior cancer or CVD. After exclusions, 73 308 individuals remained.
2. Determined numbers and causes of death through 2009.
3. Obtained usual dietary intake during the past year by a self-administered quantitative food frequency questionnaire of more than 200 food items.
  - Vegans consumed eggs/dairy, fish and other meats less than 1 time/month. (8%)
  - Lacto-ovo-vegetarians consumed eggs/dairy 1 time per month or more, and fish and all other meats less than 1 time per month. (29%)
  - Pesco-vegetarians consumed fish 1 time per month or more, but all other meats less than 1 time per month. (10%)
  - Semi-vegetarians consumed non-fish meats 1 time/month or more, and all meats combined (fish included) 1 time/month or more but not more than 1 time/wk. (5%)
  - Non-vegetarians consumed non-fish meats 1 time/mo or more and all meats combined (fish included) more than 1 time per week. (48%)
4. For some analyses, the 4 categories were combined as “vegetarians”.
5. Calculated mean duration of adherence to dietary patterns by a follow-up questionnaire asking participants to characterize their consumption of meat and dairy in previous decades.

## RESULTS

- 1 Vegetarian groups tended to be older, more highly educated, more likely to be married, to drink less alcohol, smoke less, exercise more and be thinner. Mean duration of adherence to current dietary patterns varied from 19 to 39 years for vegetarians and 48 years for non-vegetarians.
2. Of postmenopausal women, far fewer vegans were receiving hormone therapy.
3. The mean follow-up time was 5.8 years. During this time, there were 2570 deaths. (Overall mortality rate = 6 deaths per 1000 person-years. )
4. Mortality rates according to dietary pattern:

	Death rate per 1000 person-years
Vegans	5.4
Lacto-ovo	5.6
Pesco	5.3
Semi	6.2 (not significant)
Non-vegetarians	6.6

5.
 

	Death (Hazard Ratio)			
	All cause	Ischemic heart disease	Cardiovascular disease	Cancer
All 73308				
Vegetarian	0.81	0.81	0.87	0.97
Non-vegetarian	1.00 (Reference)			

In men, HR was much lower than for women except for cancer

6.
 

	Death (Hazard ratio)	
	Renal	Endocrine
All 73308		
Vegetarian	0.48	0.64
Non-vegetarian	1.00 (Reference)	

Again, higher mortality in women

## DISCUSSION

1. There was an overall association of vegetarian dietary patterns with lower mortality compared with non-vegetarian dietary patterns.
2. There was also lower mortality in vegans, pesco- vegetarians, and lacto-vegetarians compared with non-

vegetarian diet.

3. Vegetarian diets have been associated with more favorable levels of cardiovascular risk factors—lower saturated fat, and higher fiber.
4. There were also reductions in mortality with endocrine disease (diabetes), and renal failure. Previous studies of vegetarian diets have reported reduced risk of incident diabetes, prevalent diabetes, hypertension, and the metabolic syndrome.
5. No significant reductions in cancer incidence were detected.
6. Effects were generally stronger and more significant in men than in women. More study is needed to evaluate the difference.
7. Strengths of the study include: the large number of participants; diverse nature of the cohort in terms of sex, race, geography, and socio-economic status, which enhance generalizability. The low use of tobacco and alcohol makes residual confounding less likely. The shared religious affiliation leads to greater homogeneity across several possible unmeasured confounders,
8. The analysis is limited by the relatively short follow-up. However, a shorter follow-up may have biased the associations toward the null.
9. The perceived healthfulness of the vegetarian diet may be a major motivation for Adventists.
10. The evidence that vegetarian diets, or similar diets with reduced meat consumption may be associated with lower risk of death, should be considered carefully as individuals make dietary choices and by those offering dietary guidance.

## CONCLUSION

Vegetarian dietary patterns were associated with lower mortality.

JAMA Internal Medicine Jul 8, 2013; 173: 1230-38 Original investigation, first author Michael J Orlich, Loma Linda University, Loma Linda, CA

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*Several points were not explained:*

*Why vegetarian diets were more beneficial in men than in women.*

*Why postmenopausal women vegetarians were able to avoid hormone therapy.*

*I recall an article I abstracted years ago from The Adventist Health Study reporting a possible protective effect of nut consumption on risk of coronary heart disease.*

*This gives me the opportunity to review the Mediterranean Diet and the Metabolic Syndrome. (Source: Wikipedia)*

*Mediterranean Diet: The traditional diet in Greece, Italy, and Spain:*

*Olive oil, legumes, unrefined cereals, fruits, vegetables, fish (moderately high consumption), dairy (moderate, mostly cheese and yogurt), meat and meat products (low consumption).*

*The article did not mention oil consumption.*

*The MD does not differ greatly from the vegetarian diet. Reduced risks of CVD have been associated with the MD.*

*Metabolic syndrome: A combination of medical disorders that, when occurring together, increase risk of CVD and diabetes. Several authorities define it somewhat differently.*

*The International Diabetes Federation:*

*Central obesity and/or body mass index > 30, AND any 2 of the following*

*Raised Triglycerides: > 150 mg/dL*

*Reduced HDL-cholesterol: less than 40 mg/dL*

*Blood pressure: over 130*

*Raised fasting plasma glucose: over 100 mg/dL*

*The Metabolic Syndrome is not often mentioned now in the literature I read. I believe most primary care clinicians note and treat risk factors on an individual basis*

*Commentary by Robert B. Baron University of California, San Francisco follows the article and makes several important points:*

*Meat production, compared with vegetable production, is wasteful and has an adverse environmental impact.*

*For patients using vegetarian diets, clinicians and dietitians need to assess intake of total calories, added sugars and sugary drinks, refined grains, salt, trans fats, alcohol, nuts and oils. Vegetarian diets can represent a wide spectrum of nutrient intake, and it is the clinician's responsibility to help the patient determine the potential benefits and harms of a particular diet.*

## ***Review And Update***

### **7-2 HERPES ZOSTER**

There are more than 1 million cases of HZ in the US each year. The major risk factor is increasing age. Unvaccinated persons who live to 85 years have a 50% risk of HZ. About 3% of these require hospitalization.

With increasing time after varicella infection, there is a reduction in the level of T-cell immunity to the varicella virus. (VCV)

Immuno-compromised persons with impaired T-cell function are at increased risk. Post-herpetic neuralgia (PHN) is often defined as pain persisting for 90 days after onset of the rash. Pain may persist for months or years. It is common. It may be severe, interfering with sleep and activities of daily living, and causing anorexia, weight loss, fatigue, depression, withdrawal from social activities and employment, and loss of independent living. Risk of PHN increases with age, and in patients who have severe pain at onset of the HZ or a severe rash with a large number of lesions.

Various neurological complications may occur: facial palsy (Bell), syndrome of ear pain and vesicles, numbness of anterior tongue, and facial paralysis (Ramsay Hunt), transverse myelitis, transient ischemic attacks, and stroke. Ophthalmologic complication due to involvement of the trigeminal nerve can be severe.

Tingling, itching or pain may occur for 2 to 3 days before the rash. Prodromal pain involving a dermatome in the abdominal region may be misleading.

The rash usually lasts for 7 to 10 days.

Some have pain in the absence of rash (zoster sine herpette), which may be difficult to diagnose.

Most cases can be diagnosed clinically. Atypical cases may require direct immuno-fluorescence assay for VCV antigen, or polymerase-chain-reaction assay for VCV DNA.

#### **Treatment:**

Antiviral therapy: acyclovir (Zovirax), valacyclovir (Valtrx) and famcyclovir (Famvir) are approved. The oral bioavailability and blood levels are higher and more consistent for 3-times daily famcyclovir and valacyclovir than for acyclovir 5-times per day. Given within days of onset of the rash, these 2 drugs hasten the resolution of lesions, reduce viral shedding, and decrease the severity of acute pain. They do not reduce the incidence of PHN. They should be started as soon as possible. In the absence of complications, they should be given for 7 days.

Glucocorticoids: The use of glucocorticoids with antiviral therapy for uncomplicated HZ remains controversial. Owing to their immuno-suppressive properties, they should not be given without concomitant antiviral therapy.

Some trials have reported a benefit of a tapering course of prednisone—reduction in acute pain and accelerated healing.

They should be avoided in patients with diabetes, hypertension, peptic ulcer, or osteoporosis. Caution for use in the elderly because of increased risk for serious adverse events.

Acute pain: NSAIDs and acetaminophen for mild pain, opioids for severe pain. Gabapentin is less effective than opioids. Lidocaine patches may reduce pain. (Apply to intact skin.)

Eye disease associated with HZ; Consultation with an ophthalmologist is required.

Post-herpetic neuralgia: A challenge. Medications shown to reduce pain: opioids, topical lidocaine, anticonvulsant agents (gabapentin; pregabalin), tricyclic antidepressants (nortriptyline), and capsaicin. Combinations may be more effective, but cause more adverse effects.

#### Prevention of HZ and PHN:

Live, attenuated vaccine is recommended by the Advisory Committee on Immunization Practices for persons over age 60. (It is approved for those over age 50.)

Efficacy to prevent HZ: age 50-59 – 70%; 60-69 – 64%; over 69 – 38%. Reduction in risk remains significant for up to 5 years.

Efficacy to prevent PHN: 66% for all ages.

The increased risk of severe disease in elderly people and the effect of the vaccine in preventing PHN strongly favors vaccination in older patients.

The vaccine can be given to patients who have a history of HZ. The optimum time for administration after an episode of HZ is not clear. A delay of 3 years is reasonable.

#### Infection control:

HZ can be transmitted to susceptible persons in whom varicella may develop. Contact precautions should be used.

#### Areas of uncertainty:

The duration of immunity. The need for booster doses.

NEJM July 18, 2013;369:277-63 “Clinical Practice” by Jeffrey I Cohen, National Institutes of Health, Bethesda MD

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*I enjoyed this review.*

*Primary care clinicians should insist that their patients on reaching age @ 65 take the vaccine, and follow-up for compliance. If there are one million cases of HZ yearly, there must be many thousands of cases of PHN each year. If vaccine prevents 66% of cases, thousands will be spared the agony of PHN.*

*I hope we will soon learn of the duration of immunity and the need for boosters.*

***A Longer Duration Of Obesity Starting In Young Adulthood Is An Important Factor Associated With Cac And Its Progression During Middle Age.***

**7-3 ASSOCIATION BETWEEN DURATION OF OVERALL AND ABDOMINAL OBESITY BEGINNING IN YOUNG ADULTHOOD AND CORONARY ARTERY CALCIFICATION IN MIDDLE AGE: Coronary Artery Risk Development in Young Adults (CARDIA) study**

Subclinical atherosclerosis, identified by coronary artery calcification (CAC), progresses over time and predicts the development of coronary heart disease (CHD) events.

Established risk factors for CHD include older age, male sex, elevated BP, diabetes, cigarette smoking, and abnormal levels of LDL- and HDL-cholesterol.

Overall and abdominal obesity are also important risk factors for the presence and progression of CAC. Less studied is the influence of duration of obesity, an independent risk factor for coronary atherosclerosis.

With the tripling of rates of obesity in adolescents over the past 3 decades, young individuals are experiencing greater accumulative exposures to overall adiposity during their lifetimes. They also are experiencing greater exposure to abdominal obesity, which is a risk factor independent of overall obesity.

This study investigated whether the duration of overall obesity and abdominal obesity over a 25-year follow-up beginning in early adulthood is associated with CAC and its progression in midlife.

**STUDY**

1. This prospective multicenter community-based study entered 5115 healthy adults aged 18 - 30 (mean 25) in 1985-86. None had overall obesity (defined as body mass index of 30 and over). None had abdominal obesity (defined as waist circumference over 102 cm in men and over 88 cm in women).
2. After 25 years, 3272 remained—the subjects of this study.

3. Determined overall and abdominal obesity at years 2, 5, 7, 10, 15, 20, and 25 after baseline.
4. Presence of CAC was measured by CT at year 15 and at year 25. Ten –year progression of CAC (2000-2010) was defined as incident CAC in 2010 or an increase in CAC-score of 20 Angstrom units or greater.

## RESULTS

1. Overall, CAC was present in 28%. The mean CAC score was 25 Angstrom units--18% had a CAC score of 1-50; 4% a score of 50-100. and 6% a score of more than 100.
2. The presence and extent of CAC were strongly associated with overall and abdominal obesity—38% of participants with more than 20 years of overall and abdominal obesity had CAC compared with 25% of those who never developed overall obesity or abdominal obesity.
3. Twenty-eight % of those with over 20 years of obesity had CAC scores of 1-50 vs 15% of those with 0 years of obesity.
4. The rates per 1000 person-years of CAC were higher with longer duration of obesity.
5. During follow-up:
 

Developed overall obesity (OA)	40%
Developed abdominal obesity (AO)	41%
6. Rates of CAC per 1000 person-years:
 

Participants who experienced more than 20 years of overall obesity vs	
0 years of overall obesity	16 vs 10
Who experienced abdominal obesity	17 vs 11
7. Twenty-five % of those with more than 20 years of overall obesity experienced progression of CAC vs 20% in those with 0 years of progression.
8. After adjustment for BMI and WC, and potential confounders, the hazard ratios for CAC for each additional year of overall and abdominal obesity were 1.02 and 1.03.

## DISCUSSION

1. A longer duration of obesity starting in young adulthood is an important factor associated with CAC and its progression during middle age.
2. Compared with those who were never obese, those with the longest duration of obesity had the highest

odds of progression of CAC. This suggests that the longer duration of exposure to adiposity, as a result of the obesity epidemic and earlier age at onset, will have important implications on the future burden of coronary atherosclerosis and on the rates of clinical cardiovascular disease in the US.

3. The primary strength of this study is the replicated objective assessments of BMI and waist circumference every 2 to 5 years by a standardized protocol during a long follow-up period.
4. A longer duration of obesity was associated with higher levels of BP, insulin, C-reactive protein, and triglycerides, and greater use of anti-hypertension and lipid-lowering drugs, high rates of diabetes, and lower HDL-cholesterol during follow-up. These potential intermediate factors attenuated, but did not statistically explain, the association between the duration of obesity and the presence and progression of CAC.
5. A number of studies have shown that the deleterious effects of a higher degree of adiposity on CAC and its progression may be explained at least in part by these intermediate factors.

## CONCLUSION

Longer duration of overall and abdominal obesity was associated with subclinical coronary heart disease and its progression throughout midlife.

Preventing, or at least delaying the onset of obesity in young adulthood may lower the risk of developing arteriosclerosis through middle age.

JAMA July 17, 2013; 310:280-88 Original investigation, by The Coronary Artery Risk Development In young Adults (CARDIA) Study, first author Jaref P Reis, National Heart, Lung, and Blood Institute, Bethesda, MD.

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*I congratulate the investigators on their persistence and dedication over a quarter of a century of observation.*

*I now believe duration of obesity is firmly fixed in the network of risk factors for CHD. As the authors state, this is especially important to younger patients. But many younger patients without obesity will develop CHD, based on the mixture of other risk factors. All should be treated.*

*Obesity per se may not lead to CAC.*

## *Stark Differences In The Rate Of Brand-Name Medication Use*

### **7-4 BRAND NAME PRESCRIPTION DRUG USE AMONG VETERANS AFFAIRS AND MEDICARE PART D IN PATIENTS WITH DIABETES**

Medicare Part D (M-P-D) drug benefit provides drug coverage to nearly 30 million beneficiaries at an annual cost of \$60 billion.

Per capita costs of drug prescribed by M-P-D varies more than two-fold across hospital referral areas, with 75% of the variation due to use of more expensive drugs.

In principle, greater reliance on generic drugs could save taxpayers substantially without compromising care.

Medicare contracts with more than 1000 private plans to administer drug benefits, each using a distinct formula for cost-sharing arrangements.

The VA has taken a different approach. Benefits are managed by a central pharmacy benefits manager with a single formulary. This has substantially lowered pharmacy spending.

This study compared 2 national cohorts of older adults with diabetes receiving drug benefits, compared use of brand name drugs overall and by geographic region, and estimated how spending would change if use of brand-name drugs in 1 system mirrored the other.

#### **STUDY**

1. Included 1 061 095 P-D beneficiaries and 510 485 veterans age 65 and older. All had type-2 diabetes. All filled a prescription for diabetes medication in 2008.
2. Four medications were commonly used: oral hypo-glycemic, long acting insulin, statins, and ACE inhibitors or angiotensin receptor blockers.
3. Categorized prescriptions as brand-name or generic. In the VA, brand-name drugs among these 4 were non-formulary, and were available only with prior authorization.
4. Determined the proportion of patients filling at least 1 prescription for a brand-name medication (or insulin analogue). Calculated the % of 30-day prescriptions dispensed as brand-name for oral products and the % of units dispensed as analogues of insulin.

#### **RESULTS**

1. Mean patient age = 75; VA patients were predominately male.
2. Variation in brand-name drugs: P-D patients were nearly 3 times more likely to take brand-name oral

hypoglycemic drugs (35% vs 13%), long acting insulin analogues (75% vs 27%), brand-name statins (51% vs 18%), and brand name ACE inhibitors or ARBs (52% vs 20%).

3. Use of brand-name drugs was greater in plan D than in the VA in 298 of 306 hospital referral regions.

4. Spending calculations: Across the 4 medication groups, spending in P-D would have been \$1.4 billion less (39%) in 2008 if brand name drug use was similar to that of the VA.

## DISCUSSION

1. This analysis reveals stark differences in the rate of brand-name medication use.

2. Had patterns of medication use in P-D mirrored those of the VA, there would have been a savings of more than \$1 billion in 2008.

3. There were wide regional variations in brand-name drug use in both systems, suggesting that non-health factors play a major role in such variation.

4. There are opportunities to improve efficiency without harming quality of care or access to effective medications.

5. Strong evidence shows similar effectiveness of generic vs brand-name drugs in the 4 classes studied.

6. Although some clinicians recommend insulin analogues to individual patients rather than neutral protamine Hagedorn insulin because of lower rates of symptomatic nocturnal hypoglycemia, their overall effectiveness is similar, and the difference in prevalence of nocturnal hypoglycemia alone is unlikely to explain why 3 of every 4 P-D patients received analogues vs 1 in 4 VA patients.

## CONCLUSION

There were large differences in rate of brand-name drug use among patients with diabetes in P-D and the VA.

The differences likely reflect structural differences in formulary management between the 2 systems.

Physicians should consider costs and value in their prescribing.

Annals Internal Medicine July 16, 2013; 159:1-5-114 first author Walid F Gellad, Veterans Affairs Pittsburgh Healthcare System, Pittsburgh PA

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*Physicians often do not know the costs of drugs they prescribe.*

*I abstracted this article mainly because I believe the same message could be applied to primary care practice.*

*Many prescriptions for generics are now available from local pharmacies for \$4.*

*If there would be \$1 billion saved in treating one disease, there would be massive savings across all conditions for which drugs are prescribed.*

*I believe the overuse of brand name drugs vs available generics is due to the skill of pharmaceutical company marketing departments.*

### ***When Patients Lack Decision-Making Capacity***

#### **7-5 WHEN PREVIOUSLY EXPRESSED WISHES CONFLICT WITH BEST INTERESTS**

When patients lack decision-making capacity (DMC), physicians and surrogates often must address situations that were never previously discussed. They must balance respect for the patient's previously expressed values and preferences with actions in their best interest at the present moment.

Advanced care planning (ACP) can make decisions easier. However, many clinical decisions for patients who have lost DMC arise in unforeseen circumstances.

Formal legal documents (and more commonly, conversations) can make clinical decisions both easier and harder. Confusion and ambivalence about how to make the best decision can place a substantial emotional and moral burden on surrogates and physicians. Negative feelings sometimes last for years.

Ethicists have argued for an increased role of the best interests standard. However, in a particular clinical situation, clinicians may lack practical guidelines on how to consider the current best interests of a patient who lacks DMC and how to weigh them against previously stated preferences.

These authors present a practical conceptual framework of 5 factors to address this need. The framework is meant to ensure that key issues are considered. It relies on conversations between the physician and the surrogate to ascertain the patient's values and thinking during ACP. (If a surrogate is not available, factors beyond the scope of this article will need to be considered. An Ethics Committee may be involved.)

#### **1. Is the clinical situation an emergency?**

Is the clinical situation an emergency that allows no time for deliberation? If so, the clinician should immediately determine if the patient's previously expressed wishes have been translated into actionable orders such as do not attempt resuscitation (DNAR). However, in the absence of a clear DNAR order, or immediate clear and unambiguous input from the legally recognized surrogate, clinicians should initiate CPR. An advanced directive stating that life sustaining measures are not desired in the case of terminal illness does not imply that the patient would not want an attempted resuscitation in all circumstances. In the absence of an unambiguous order prohibiting life sustaining

treatment in an emergency, the best interest of the patient is to prolong life until there is some time for deliberation.

2. In view of the patient's values and goals, how likely is it that the benefits of the intervention will outweigh the burden?

Overriding previously expressed preferences should be considered in the light of the benefits and burdens of the proposed interventions and its alternatives. The physician might ask "What is the probability of restoration of function for the patient? What is her likelihood that the intervention will cause more burdens than benefits?" If the possibility of restoration of function is low, the burdens of intervention may outweigh the benefits.

3. How well does the advanced directive fit the situation at hand?

The physician and surrogate must consider how well previously expressed wishes fit the situation at hand and how clearly they were expressed.

4. How much leeway did the patient provide to the surrogate for overriding the AD?

The degree of leeway granted by the patient to a surrogate to override previously stated wishes may help guide decisions. Many patients want their loved ones to have some flexibility to adapt decisions to unforeseen circumstances. Currently, few ADs capture patient preferences for leeway. Because all future circumstances cannot be anticipated, patients should choose a surrogate they can trust to interpret their values and goals for a situation that had not been considered. Allowing leeway does carry ethical risks. Leeway might be seen as an erosion of autonomy for a patient who cannot object. The patient must trust the surrogate to make the best decision. But leeway is not routinely incorporated into ACPs.

5. How well does the surrogate represent the patient's best interests?

It is important to consider how well the surrogate is representing the patient's best interest. In some cases, surrogates may be so overwhelmed by their emotional needs that they act in their own interests rather than those of the patient. Some surrogates can't bear losing the loved one. "I can't let her go." The physician would then need to address how the patient would want to be treated under the present circumstances. This may take time and several conversations. In rare cases, the surrogate may have strong conflict of interest such as to receive an inheritance—what is best for the surrogate, not the patient. The clinician may then seek an ethics consultation or contact adult protective services.

Physicians should use open-ended questions and empathetic comments that respond to the emotional stress the surrogate is experiencing. Physicians should help surrogates deliberate by summarizing their

statements about the patient's values and link those values to the decisions at hand. Physicians should offer a recommendation based on the patient's values.

Conclusion: Conflicts between a patient's previously expressed wishes and what is thought to be in his or her best interests can create confusion, ambivalence, and substantial emotional and moral burdens for surrogates and physicians. While there is no absolute answer that applies to all patients, the authors propose a new 5-question framework and show how it can be applied in specific cases to help clinicians and surrogates think through the relevant issues and come to ethically appropriate decisions.

JAMA Internal Medicine July 8, 2013;173: 1241-45

"Clinical Review and Education: Special Communication, first author Alexander K Smith, University of California, San Francisco

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*I disagree with the authors point about attempting CPR to prolonging life in an emergency. Prolonging life for some patients is not in their best interest. For example, an elderly patient with advanced dementia. Sometimes prolonging life is cruel. The patient will continue a life of suffering. I believe a judgment can be made quickly even if the patient is new to the attending physician.*

*How actively we attempt to prolong life depends on what the individual patient has to come back to. A 23 year old person may have years of productive independent life. A 93 year old has little to look forward to—as the authors state, when there is little possibility of restoring meaningful function. In some cases, as for an elderly woman who is looking forward to a granddaughter's wedding, prolonging life would be reasonable.*

*Everyone approaching an elderly age should plan ahead, making our decisions clear to all concerned. One surrogate should be appointed. I, and I am sure many other clinicians have had the stressing experience of a family with 2 surrogates who disagree about everything.*

*The article did not mention the role chaplains play in helping families to decide on the best way. We should look to them for assistance in determining whether the patient is "at peace".*

*I believe more elderly patients are acknowledging that death is a normal part of life, and accepting it with serenity.*

*There are strong cultural differences regarding death. We should be aware of them.*

## ***The Case For Improving End-Of-Life Care Is Compelling.***

### **7-6 BEST CARE FOR THE DYING PATIENT**

What we want for the people we love and for ourselves is to die in the place of our choice and to experience a “good death”—dignified, free of pain, and surrounded by those we love.

Ascertaining and documenting patients’ preference is an important marker of the quality of care.

In England, 53% of deaths occur in hospitals, whereas 63% indicate a preference to die at home. Thousands have an unmet need for palliative care. Health inequalities are common in the end of life. The case for improving end-of-life care is compelling.

Preferences can depend on the quality of care that the patient and care takers experience. The preference to die at home depends on whether adequate support is given at home.

We must integrate the model and values of hospice care into the mainstream and deliver best care for dying patients regardless of place of care.

What constitutes adequate support?

The authors identify 10 key elements for achieving best care for the dying patient:

1. Recognition that the patient is dying.
2. Communication with the patient (wherever possible), and always with family and loved ones.
3. Spiritual care
4. Anticipatory prescribing for symptoms of pain, respiratory tract secretion, agitation, nausea and vomiting, dyspnea.
5. Review of clinical interventions should be in the patient’s best interest.
6. Hydration review, including the need for commencement or cessation.
7. Nutritional review, including commencement or cessation.
8. Full discussion of the care plan with the patient and care givers.
9. Regular reassessment of the patient.
10. Dignified and respectful care after death.

BMJ July 27, 2013; 347: 8 (BMJ2013;347:f4503)

Commentary, first author John E Ellershaw, University of Liverpool, UK

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*The article recommended a web site which may be helpful [www.dyingmatters.org](http://www.dyingmatters.org)*

*I live in a community that has a superior hospice-palliative care group. The two go together.*

*Don't forget the caregivers. Care-giving may be exhausting. They need help. Primary care givers may enable to arrange some relief.*

***More Than Half Of US Adults Take Supplements On A Regular Basis.***

**7-7 DATABASE ALLOWS RESEARCHERS, PATIENTS TO SCRUTINIZE SUPPLEMENTS**

The Office of Dietary Supplements (DS) of the NIH has created a free searchable database of dietary supplement ingredients. [www.dsld.nlm.nih.gov](http://www.dsld.nlm.nih.gov)

More than half of US adults take supplements on a regular basis.

The database now contains information on about 17 000 dietary supplements. It will be updated regularly and eventually contain 55 000 supplements on the US market.

By law, any product labeled as a dietary supplement must carry a Supplement Fact panel that lists its contents and other added ingredients such as fillers, binders and flavorings. The database includes directions for use, health-related claims, and any cautions from the label.

Hundreds of DS are added to the marketplace each year. Some are removed. Product formulations are frequently adjusted, as are information on labels.

The DB will be updated regularly to incorporate most of the more than 55 000 DS in the US marketplace.

JAMA July 24, 2013; 319:361 "News and Analysis" by Bridget M Kuehn, JAMA Staff and the Website.







