Palliative Care Chat Episode 6
Dr. Kathryn Walker and Dr. Lynn McPherson
Speed Dating Tips – Part 1

Lynn McPherson: Hello. This is Dr. Lynn McPherson and welcome to Palliative Care Chat, the podcast brought to you by the online Master of Science and Graduate Certificate program at the University of Maryland. I'm joined today by Dr. Kathryn Walker, who is the Senior Clinical and Scientific Director of Palliative Care with MedStar Health in Baltimore and Washington DC. She was also an associate professor at the University of Maryland School of Pharmacy and she is my speaking partner for Speed Dating with the Pharmacy Ladies that we've done for several years in a row at the academy meeting. How are you today, Miss Kat?

Kathryn Walker: I'm doing well. Happy to be here. Thanks for having me.

Lynn McPherson: Oh, wonderful, wonderful. Shall we share the love and do a few speed dating tips for our studio audience here?

Kathryn Walker: I think so. I think we've picked some of our favorites, so let's go.

Lynn McPherson: Okay. You kick us off.

Kathryn Walker: Okay. The first one is Lidoderm patches and we talked a little bit about this at the academy meeting as being kind of a newcomer on the market on OTC market anyway, because we're used to Lidoderm patches. Now there's an OTC option of Lidocaine patches, so Salonpas, Lidocare and Aspercreme. Looks like they have the same directions of removing after a couple of hours, but we know from Lidoderm patches that you can keep them on for 24 hours at a time and replace daily and you actually use yours for multiple days, don't you Lynn?

Lynn McPherson: Mm-hmm (affirmative) because there's 700 milligrams in that patch, so I often will let the patient wear it for three days straight before we switch to a new patch. It's a big cost savings.

Kathryn Walker: That's right, so we're not sure what the deal is with the OTC. There's not a lot of data our there yet, but I'm sure it will becoming, so something to keep, just keep our eyes out for. It might be a cheaper alternative, we'll see. It looks like there about two dollars a patch, so at this point, not a lot cheaper, but the jury's still out. We know with Lidoderm patches, that studies that have replaced them daily instead of using them those 12 hours on or even every 12 hours for continuous days showed that it did not get a significant systemic concentration, so 1/7 of the antiarrhythmic effect was seen and 1/25 of the toxic concentration was seen, so we'll see. It might be a new trick in our toolbox.

The next one would be a topical Capsaicin patch, keeping on the patch tips here. I think this is another decent option for local pain relief. It has less burning than the cream, but remember it's still kind of a local, place it at the site of action type

of patch, so I think it's something that, you know, it can be useful. It seems to be helpful and I think the case that we were talking about might be a good scenario to consider using it as, for instance, post-op knee replacement, if you're taking an opioid, sometimes that's a little too much, but then without it, you're still kind of in pain, this might be a kind of nice in between. And then the next slide we have here is just the Amazon reviews here, so we said if it's not an Amazon, who needs it? This is, you know, it's not quite Cochrane, but there's a good feedback there to show us.

Lynn McPherson: Hey if Amazon doesn't sell it, you don't need it. Am I right or what?[crosstalk 00:03:29]

Kathryn Walker: You don't need it.

Lynn McPherson: I think if a day goes by that I don't spend money on Amazon, they may collapse. Luckily they're on very firm ground. You know, another patch that I have fallen dead in love with recently, I hurt my back recently and I bought one of those thermal wraps and they're supposed to last eight hours, but it actually lasted about 12 hours and it was pretty awesome. Have you ever tried one of those?

Kathryn Walker: No. I'm putting it on my list though.

Lynn McPherson: Pretty sweet. You're going to try to nab that for your kit for next year aren't you? I know you.

Kathryn Walker: I got dibs on it.

Lynn McPherson: All right, so, I tip I'd like to share is blogs and pods and apps. Oh my, that's even hard to say. Some of my favorites. So, I'm very fond of Pallimed.org, it's a blog all about hospice and palliative medicine. I'm very fond of it. So the other thing is, they sponsor #hpmchat Wednesday nights at 6 p.m. pacific, 9 p.m. east coast time and very enjoyable. I just put this as a standing appointment in my calendar and if I can make it great, if I can't that's okay too, but it's very enjoyable to talk to people all over the world at the same time. They have a theme each week, it's very interesting, so you have to be hip to twitter.

Another podcast and blog that I like is GeriPal, so GeriPal.org. I had to laugh because in January they proclaimed a podcast with Dame Cicely Saunders, which I thought, "Boy, that's gotta be a trick. Hasn't she been dead for like five or ten years?" But actually it was from an old recording, but it was pretty interesting I think.

And of course, I'm extremely biased because I think the best podcast in the universe is this one, Palliative Care Chat, and we had some drama with our last 2 podcasts with that big study about delirium from Australia. We had one practitioner criticizing that trial and then the principal investigator did a podcast

with us and she was explaining their methods as rational and so forth, so very interesting.

Some apps that are pretty interesting. The CDC has an app out now about the opioid prescribing guidelines that came out in 2016, so it's pretty interesting. They give summaries of each of the key points of the 12 recommendations and they have for each of those an alternative treatment fact sheet.

Another app I'm really crazy about now is called Drug Drug Interactions in opioid therapy with a focus on Buprenorphine and methadone, and boy, methadone wrote the book on drug interactions. It makes Warfarin look like a big old sissy, so this is an excellent app to have handy. What do you think Kat? Pretty good [crosstalk 00:06:04]

Kathryn Walker: We're going to have to do some tips on that next year for sure.

Lynn McPherson: Totally.

Kathryn Walker: I'm taking notes. My next tip is for inhalers. We love tips on inhalers because goodness gracious, they are so many issues with inhaler errors. When you think about using inhalers correctly, there's lots of tips and giving written instructions and what not, but one thing that's really useful, it's really hard for providers, there's new inhaler devices coming on the market all the time. You hold this one like a hamburger, you hold this one like a regular one and it can get really confusing. This website is a good place to go, it's www.use-inhalers.com and what I really like about it is you can click on the specific inhaler and it will show you a teaching video. It's great to use. You can use it with patients and it comes in multiple languages, definitely this is a gem. So, go look it up, it's good one.

Lynn McPherson: So how many inhalers can you think of? So we've got the Diskus, we've got the Handihaler. What else do we have?

Kathryn Walker: Oh my goodness.[crosstalk 00:07:14]

Lynn McPherson: Like a million of them. Twisthaler, Autohaler, Flexhaler, good grief, you could stay up[crosstalk 00:07:20].

Kathryn Walker: What about the Turbohaler? That sounds like, "Woo!" That's a high pack one.

Lynn McPherson: I think don't light any matches around the Turbohaler, that's what I think.

Kathryn Walker: I think that sounds like a cartoon character.

Lynn McPherson: A wise course of action. Well, I think we should talk about magic mushrooms for few minutes. I am just absolutely intrigued by the use of psilocybin. Two big trials came out recently, the latter part of 2016. Psilocybin producing substantial and sustained decreases in depression and anxiety in patients with life threatening

cancer, a randomized double blind trial that was in the Journal of Psychopharmacology and then we also have rapid and sustained symptom reduction following psilocybin treatment for anxiety and depression in patients with life threatening cancer also in the same Journal. The same study group is done in different settings.

So what is psilocybin? It's a hallucinogenic drug, so these two different randomized controlled trials were looking at exactly that, depression and anxiety, so kind of the existential angst that comes along with late stage and high-risk cancers. And the study one they used either psilocybin .3 milligrams per kilo or 250 milligrams of Niacin, so the patient felt a little something and they weren't quite sure what was going on. Then, they crossed over to the other treatment seven weeks later and they found no serious psychological or medical adverse effects attributed to either substance, no pharmacologic interventions were necessary. The person goes into a room with a psychotherapist, they swallow this capsule of psilocybin, this hallucinogenic mushroom, and they lie down on the couch with headphones and an eye mask on and they say that these images kinda shoot by. What are the results? That we see significant reductions in anxiety and depression and an anxiolytic and antidepressant response rate seen immediately after psilocybin and sustained for 26 weeks. There were some transient side effects such as an increase in blood pressure and heart rate, headache and nausea, and a little bit of transient nausea. But I think this is pretty interesting.

Study two, same sort of thing. Two sessions of the same treatment separated by five weeks, looking at mood, attitudes, behaviors, depression and anxiety. No significant adverse effects and the response rate, holy moly, 80% with overall symptom remission at six months, about 60% for depression and anxiety.

So, how does this work? It sounds like a magic bean to me. They were hypothesizing the alterations of consciousness are reported through activation of the serotonin receptors, which could interrupt the circuitry of self-absorbed thinking. I do kind of enjoy self-absorbed thinking, how about you?

Kathryn Walker: I'm not sure I want to interrupt that actually.

Lynn McPherson: Yeah, leave me be. I'm pretty happy with that. But anyway, this is highly prevalent, people who are profoundly depressed. This may be something of therapeutic value, so I think it's very interesting. [crosstalk 00:10:17].

Kathryn Walker: When you read the descriptions of what people explain, it does sound fairly magical, I have to admit.

Lynn McPherson: It does. So the line forms behind me.

Kathryn Walker: Yeah, shooting stars, I mean goodness, and surrounded by childlike love. This sounds very psychedelic. Love it.

Lynn McPherson: That's right. Okay, back to you.

Kathryn Walker: Alright, so mind taking a little bit of a different turn here. We're going from the head down to the tail and we're talking about AMITIZA. One of the warnings that came out, we know AMITIZA, lubiprostone, is used for re induced constipation, chronic and idiopathic constipation as well, and irritable bowel syndrome. But syncope and hypertension have been reported in post-marketing surveillance, usually it's with the 24 microgram [inaudible 00:11:12] dose and it happens more early in therapy. When you stop it, the medication, it will resolve. But one thing you want to be careful of is a lot of our patients have hypertension medications on board, so this is definitely something we want to make sure we're paying attention to because our patients have other risks for syncope and hypertension as well. We don't need anything else, especially because AMITIZA is not that useful of a laxative what most of us think, we're not going to get a lot of laxation out of it anyway.

We definitely don't want it to be causing harm if it's not going to do good and it's fairly expensive. It's definitely something where you think of the number needed to treat. 13 people would need to be treated in order for one to benefit and it cost about $350 a month. That's an expensive item to give it a shot for those one out of 13 people, especially if there's a risk of hypertension on board.

Lynn McPherson: Boy, that better be a magical experience, speaking of magical experiences. Better be a moving experience.

Kathryn Walker: That's right. The other tip, also having to do with lubiprostone, is for methadone induced constipation. It's interesting, so the chloride channel activator that the mechanism of lubiprostone CIC 2 and it promotes fluid secretion and then increase motility, which is how it works. Methadone is thought to interfere with these chloride channel receptors and that's what's activated by lubiprostone. Even though it's indication is for opioid induced constipation, methadone does not count, because their mechanisms do not work together. I think we love methadone, so this would be hard one. I'm not sure that I would pick lubiprostone over methadone.

Lynn McPherson: No contest in my book.

Kathryn Walker: No, and I think one of my favorite parts of this tip when we did it was the MC Hammer picture that said, "Lubi can't touch this." Before I break out into an MC Hammer song, you might want to move on.

Lynn McPherson: Let's save that for the next podcast, shall we?

Kathryn Walker: Okay, my singing will come.

Lynn McPherson: Alright and I'm going to wrap up with one last tip in this podcast which is the American Diabetes Association updated their guidelines for the treatment of diabetic neuropathy and I'm only bringing this up because I hear time and time again for our patients admitted to hospice, "I can't believe I had to be dying before somebody paid attention to the pain in my feet." So, of course, we do a magnificent job in assessing all the different pains the patient has and often we are the first people to really take this seriously. In these guidelines, they did talk about the overall prevention of diabetic neuropathy, such as with Type 1 working to control the blood glucose to prevent or delay the onset of the distal symmetric polyneuropathy and cardiovascular autonomic neuropathy. And for Type 2, is to mostly to prevent or slow the diabetic neuropathy as well and using a multifactorially approach to target hyperglycemia.

With regard to the pain management, they have come out now and said pregabalin and duloxetine should be considered initial therapy, but we may consider gabapentin when you consider socioeconomic status, comorbidities, and potential drug interactions. The tricyclic antidepressants are effective but of course, they are not FDA approved, but that wouldn't stop me, but you do have to be careful with the side effects.

I do think, probably, pregabalin is the least offensive of those drugs we just talked about. Gabapentin, it seems like it takes forever and a day to titrate to where you're going because it's so sedating. I find it interesting that even though pregabalin and gabapentin cause the exact same side effects with the exact same prevalence, it seems like you can get to where you're going with pregabalin in about a week whereas gabapentin can take you literally a couple of months to get to where you're going and a lot of our hospice patients don't have that luxury. The TCA's, of course, be very careful with your heart block patients and they're very strong anticholinergics and sedation and orthostatic hypotension. And then these guidelines, they said opioids are not recommended as first or second line. So let's make sure we maximize our coanalgesics.

Speaking of duloxetine, I was very intrigued by this study done by two pharmacists at a VA, where they did a head to head study evaluating the percentage of patients who were able to achieve a therapeutic dose of duloxetine versus venlafaxine for neuropathic pain, which they did not specify which kind of neuropathic pain it was, but they looked at the time it took to reach the therapeutic dose and any adverse effects associated with treatment. They did this because they always used to reach for venlafaxine because it's a generic product, but now duloxetine is also available as a generic, so the cost is no longer a barrier. They did find that the duloxetine, significantly more patients were able to achieve a therapeutic dose, so 70.5% with duloxetine at 60 milligrams a day versus 54% with venlafaxine long acting 150 to 225 milligrams a day. They got to the therapeutic dose much more quickly with duloxetine, about a week versus about a month with venlafaxine. They hypothesized, this is a very effect alternative for people who don't respond to venlafaxine.

I've never been a big fan of venlafaxine. It seems like if a patient misses one dose, they already seem to have those withdrawal symptoms and you gotta worry about the blood pressure and so forth. So, I was very pleased to see this study. We'll see what happens with that. What do you think Dr. Walker, pretty cool tip?

Kathryn Walker: Pretty cool tip. I like it. It's a good one to end on.

Lynn McPherson: There you go. Well, this is Part One of what Kat and I are doing for Speed Dating. We will be doing Part Two, so stay tuned for that. I would like to thank Dr. Kat Walker for joining me today for this podcast and I'd like to thank you for listening to the Palliative Care Chat podcast. This is Dr. Lynn McPherson and this presentation is copyright 2017 University of Maryland. For more information on our completely online Master of Science and Graduate Certificates in Palliative Care, or for permission request regarding this awesome podcast, please visit graduate.umaryland.edu/palliative. Thank you.